Hospital
CEO's
Speech

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Universal Coverage	Guaranteed Voluntary measures tried first. If 95% of the population is not covered by 2000 through voluntary measures, a Commission makes recommendations to achieve universal coverage, which Congress must consider on a fast track. If Congress does not act on the recommendations, fall back responsibilities for employers and individuals implemented in 2002 If 95% coverage is achieved through voluntary means, Commission makes recommendations to achieve universal coverage, which Congress must consider on an expedited basis	Not guaranteed Voluntary measures (insurance reforms, subsidies, etc) aimed at increasing access to coverage. No target specified for reducing number of insured
Subsidies During Voluntary Period (1997-2002)	**Individual Subsidies:** Premium subsidies (Federally financed, state administered) for individuals up to 200% poverty. Full subsidy below 100% of poverty, sliding scale to 200% of poverty Additional subsidies for children and for pregnant women up to 300% of poverty. Full subsidy below 185% of poverty, sliding scale to 300% of poverty Cost Sharing subsidies available to individuals with family incomes below 150% of poverty to reduce high-cost-sharing to low-cost-sharing levels, if no low-cost-sharing plan is available **Employer subsidies:** Available to employers for classes (eg. part-time, full-time) of previously uninsured workers. Subsidies last 5 years	**Individual Subsidies:** Premiums subsidies (federally financed, state administered) for individuals up to 150% of poverty. Full subsidy below 100% of poverty, sliding scale to 150% of poverty Subsidies for families between 100-150% of poverty may be partial if funding not sufficient for full subsidies No provision No provision **Employer subsidies:** No provisions

SUMMARY COMPARISON OF
MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION

PROVISION	MITCHELL BILL	DOLE BILL
Back Up to Voluntary Efforts	**Employer responsibility:** No employer responsibility at enactment If 95% of population not covered by 2000, Commission makes recommendations to achieve universal coverage which Congress considers on a fast track. If no action, beginning in 2002 employers in states with less than 95% coverage are responsible for paying 50% of their workers premiums Firms with fewer than 25 workers are exempted from premium contribution requirements Large employers (500+) may self insure. Must offer at least 3 plans All small employers must offer option to join a Health Insurance Purchasing cooperative. Small employers which choose to offer any private community-rated plan must offer at least 3 plans **Individual responsibility:** None at enactment In states where employer responsibility is triggered, individuals are required to have insurance and must pay a portion of premium not covered by employer Premium subsidies available	**Employer responsibility:** No provision **Individual responsibility:** No provision
Benefits	Standard benefits package must be offered by health plans. Health plans also may offer high deductible alternative with limits on risk selection Both standard and alternative packages are without lifetime limits, and must include 16 categories of covered services Standard package must have actuarial value equivalent to FEHBP Blue Cross standard option plan. Alternative package has lesser actuarial value	Establishes standard basic benefits package, but permits additional plans covering same benefits. Result: risk selection Lifetime limits prohibited. Standard package (FedMed) but does not list categories of benefits FedMed to have an actuarial value equivalent to FEHBP plan with the highest enrollment

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Benefits - Cont'd	National Health Benefits Board established in HHS responsible for clarifying services covered in standard package, establishing 3 cost sharing schedules for standard package and one cost sharing schedule for high deductible package	Secretary of HHS will specify covered services under FedMed plans. Secretary will establish 3 cost sharing schedules for FedMed
	No cost sharing for preventive and prenatal services	No provision
	Board to establish criteria for medical necessity and appropriateness	Secretary will establish criteria for medical necessity and appropriateness
	Board must seek parity for mental illness and substance abuse services, but cannot impose burdensome cost sharing on other services to do so	Secretary must give priority to parity for mental health and substance abuse, needs of children and vulnerable populations, and prevention
Supplemental Benefits	Two types of supplemental health benefits plans may be offered; Supplemental health plans to cover benefits either excluded or covered in limited duration or scope in the standard benefits package; and supplemental cost-sharing plans to cover deductibles and co-insurance requirements of standard health plans. Health plans may not link the pricing of a supplemental plans nor link the pricing of supplemental plans to that of the standard health plan	Health plans may offer supplemental packages to the FedMed package, but may not require the purchase of supplemental policies nor link the pricing of a supplemental package to that of the standard package
	Supplemental health plans may be sold by any insurer to any individual. Supplemental cost sharing may only be sold by insurers to those persons enrolled in their own standard benefits plans	Similar requirements
	Supplemental policies are subject to limited insurance reform rules governing standard benefits plans	
New Benefits for Elderly and Disabled	New Medicare coverage for prescription drugs (see below)	No provision
	New long term care programs for home and community based services and for nursing home care (see below)	No provision

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Choice of Health Plans and Providers	Employers must offer at least 3 health plans (fee for service, point of care, and HMO) if available	No provision
	Health Insurance Purchasing Cooperatives must offer at least 3 health plans if available	No provision
	Health plans must contract with or pay every essential community provider in their service area in category I; and one from each category in category II	No provision
Health Insurance Purchasing Cooperatives	States may certify one or more Health Insurance Purchasing Cooperatives in each community rating area. Participation is voluntary and open to all individuals and to employers (and their workers) with fewer than 500 workers	States may establish small group purchasing cooperatives. Participation is voluntary and open to individuals and employers (and their workers) with fewer than 50 workers
	HIPCs must offer at least 3 health plans, including a fee for service plan if available	No provision
Federal Employees Health Benefits Program (FEHBP)	Community rated individuals may enroll in FEHBP beginning in 1997. Premiums will be community rated under rules set by OPM. If no cooperative exists in an area, OPM shall establish and administer one. Supplemental plans developed by OPM for federal workers shall also be offered to community rated individuals	Self-employed individuals and small employers (size 2-50) may purchase health plans offered through FEHBP at same premium charged to federal workers, plus administrative charge
	Federal workers: FEHBP subject to overall Health Security rules. By 2005, OPM shall blend current premiums with community rates in each area	Federal workers: Program remains unchanged

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Insurance Reforms	Beginning with enactment, guaranteed renewability. Beginning in 1995, portability, guaranteed issue and availability, and a limit on pre-existing condition exclusions (6 months for previously uninsured people). Pre-existing condition limits end with universal coverage. Starting in 1997, additional insurance reforms include standard benefits package, and elimination of lifetime limits	Guaranteed issue and renewal of health insurance; portability, and a limit on pre-existing condition exclusions (up to 12 months waiting period for previously uninsured people)
	Starting in 1997, community rating with variations based on age, family size and geography (age variation 2:1 through 2004; phased down to 0 by 2010)	Modified community rating for firms with 1-50 employees -- rating variations based on age, family size and geography only, and age variation limited (4:1 for three years after implementation; 3:1 thereafter)
	Insurers required to cover unmarried children under 25 under family policies	No provision
	Risk adjustment across experience rated and community rated plans	Risk adjustment for small employer market (insured and self insured) only
Health Plan Standards	Health plans must meet insurance reform and delivery system reform standards which include: Quality assurance standards Consumer grievance process Comparative information to consumers Disclosure of UR protocols and financial incentives Marketing standards	Similar. Secretary of HHS to develop guidelines for health plan standards to include: Quality assurance standards Consumer protection, including comparative information to consumers Reasonable access to vulnerable population Financial standards Marketing Utilization management
	State anti-managed care laws preempted	Similar provisions

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Cost Containment	Competition among health plans is a primary mechanism. In addition, high cost health plans would be assessed 25% on the portion of their premium above a reference premium. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, Commission makes recommendations to Congress, which must act on them in an expedited fashion	By 1/15/98 the President would submit to Congress findings and recommendations on the effectiveness of private and public sector cost containment strategies
	A "Fail Safe" limit in federal health care spending would start in 1997: if costs exceed projected baseline, reform spending would be reduced (with special treatment of subsidies for pregnant women and children)	A "Fail Safe" limit in federal health care spending would start in 1996: If costs exceed projects baseline, subsidy spending would be reduced
Quality	National Quality Council, private-sector oriented, with representation from consumers, providers, health plans and experts to develop standards and measures of quality	Creates new agency within HHS to consolidate research activities on quality and consumer education
	Regional or State-based, non-profit, non-governmental Quality Improvement Foundations compete for grants to initiate quality improvement programs among health plans; focus on quality of care for entire populations; foster collaboration on quality among health professionals and consumers; disseminate information on best clinical practices; develop programs in lifetime learning for health professionals	No provision for quality improvement activities between health plans
	Health Plan Report Cards provide comparative information about quality of care and patient satisfaction for consumers	Creates State-based Consumer Value Program funded by unspecified demonstration grants including guidelines for consumer report cards States have six years to set up program
	State-based, private non-profit Consumer Information and Advocacy Centers disseminate Report Cards to consumers; assist consumers with enrollment and help resolve grievances. Authorization for funding in legislation	No comparable non-governmental consumer information or advocacy program
	Expands health care quality research by allocating 20% of the Health Research Fund for funding outcomes research and developing standards for practice guidelines that enhance patient decision making	Creates a Nation Fund for Medical Research out of voluntary donations, but allocates none of it to quality research

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Data/Information System	Public/private multipurpose electronic health information network	Similar provision
	Secretary of HHS with outside private advisors adopts standards for data, transactions, transmission	Similar provision
	Network intended to facilitate reduction of paper work, billing efficiency, health care research, and education of providers on effective treatment patterns	Similar provision
	Strong protections for privacy of information	Similar provision
State Responsibilities	States must submit plans to operate health care systems to Secretary of HHS by 1/1/97. States certify standard health plans, monitor performance of plans, establish grievance procedures, establish community-rating areas and health plan service areas, administer open enrollment periods, establish a risk adjustment methodology (including mandatory reinsurance), operate a Guarantee Fund	States continue to regulate insurance and will have responsibilities related to risk adjustment, pre-existing conditions amnesty period, and developing and disseminating comparative information on plans. States will certify health plans pursuant to Secretarial standards
State Flexibility	State single payer system: State-wide and/or community-rating area systems allowed	No provision
	State reform timetable: States may implement employer-individual responsibility on expedited basis	No provision
	Waivers: Continues existing state waivers granted for Medicare, Medicaid, and ERISA	No provision
	State Hospital Payment Systems: Allows certain existing reimbursement control systems and insurance reform systems to continue	No provision
Medicare Integration	Individual election to remain in Medicare contracting health plans. Enrollment of new Medicare contracting health plans. Enrollment of new Medicare beneficiaries and those who move	Secretarial study of individual election to remain in Medicare contracting health plans

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Medicaid Integration	Integration of Medicaid AFDC and non-cash recipients into certified health plans on or after 1/1/97 SSI/Dual Eligibles - Medicaid coverage for SSI and dual eligibles. States could opt to make capitated payments to plans for SSI recipients, but these enrollees would not effect the community rate. If state opts capitated payments, individual recipients may choose to remain in fee-for-service Federal/State Financing - States would make MOE payments for AFDC and non-cash based on 1994 baseline (includes non-cash DSH). Federal government funds premiums subsides for low income Wraparound Services - Medicaid services as a secondary payer for supplemental coverage for current Medicaid covered services not included in the basic benefit package. Medicaid coverage for children under 19 of extra scope and duration for services in the basic benefit package Disproportionate Share Hospitals - Gradual phase-out of DSH payments related to uninsurance levels, beginning in 1997. Vulnerable population adjustment program makes payment to hospitals once DSH phases-out	Integration of Medicaid AFDC and non-cash recipients into certified health plans (if funding is available) by 1/1/2000 Similar coverage except integration of SSI into managed care programs or certified health plans limited to no more than 15% each first 3 years and 10% each year thereafter. Premium rate negotiated. Once state opts for managed care, SSI recipients lose fee-for-service option States would make MOE payments for AFDC and related eligibles based on cost of providing defined benefit package services in year prior to implementation. Federal/State payments for integrated enrollees capped at Federal/State share of average premium Medicaid would provide supplemental coverage to those receiving premium subsidies for benefits not in the basic benefit package. States would determine which classes and categories of subsidized individuals would be eligible. Funding would be through a capped state entitlement National DSH limit lowered to 9% (from 12%), high DSH states reduced to 75% of current allotment in 1/1/97. Secretary would make recommendations for phase-in elimination of DSH
New Medicare Prescription Drug Benefit	New Medicare Part B coverage for prescription drugs Deductible determined by the Secretary to meet spending target set in statute. Coinsurance of 20%, after deductible is met, up to a maximum limit Beneficiaries may choose to receive benefits from health plan, traditional fee for service, or capitated drug benefit plans Part B premium increased to cover 25% of drug benefit costs; remaining costs financed through other Medicare savings	No provision

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
New Long Term Care Program for Home and Community Based Services	Eligibility based on level of disability, not age or income States establish programs, receive federal matching payments. New program coordinated with Medicaid, other long term care programs, and health plans Cost sharing for home/community-based services set at zero for individuals up to 150 % of poverty; gradually increases to $600 deductible and 40% coinsurance for individuals above 400% of poverty New programs phases in over 7 years beginning in 1998	No provision
Voluntary Public Insurance for Nursing Home Care	New Lifecare program under which individuals may elect to purchase public insurance for nursing home care. Benefits indexed to CPI. Actuarial premiums established to cover program costs. A 3-year waiting period for benefits applies to policies purchased in the first year. Thereafter, the Secretary of HHS has authority to establish waiting periods if necessary Secretary of HHS shall establish prospective reimbursement system for nursing homes	No provision
Medicaid Long Term Care Expansion	Asset limit increased from $2000 to $4000 for long term home care and personal care services Home and community based a waiver program liberalized (elimination of "cold bed rule" and institutionalization requirement for rehabilitation services) No provision	No provision Same provision Permits state plan option for home and community-based services in addition to waivers
Tax Credit for Working Disabled	$7500 maximum tax credit for up to $15,000/year of costs incurred for personal assistance services by working disabled	Same provision
Private Long Term Care Insurance Standards	Secretary of HHS, with NAIC, develops minimum standards for private long term care insurance. Standards include nonforfeiture of benefits, inflation protection options, limits on pre-existing conditions, marketing standards etc.	Minimum consumer protection standards not established for all plans, only for those eligible for favorable tax status. Some marketing requirements apply to all long term care insurance policies

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Medical Savings Account for Long Term Care	No provision	Establishes medical savings accounts that may be used, subject to limits, to pay for long term care services or insurance premiums
Investments in Health Care Delivery/Public Health		
Expanded Access for Vulnerable Populations	-Funding: $1.787 billion over 9 years. Grants and contracts are awarded to eligible health providers to develop community health groups to provide the standard benefits package in HPSA or directly to medically underserved populations. Grants and contracts are also made to expand existing health delivery sites and services and to develop new ones	-Funding not specified; 1) Medicare and Medicaid waiver demonstrations to promote network development; 2) Grants to private entities for use in planning and development of providers and plans. Technical assistance and grants to help establish networks, in underserved areas
Capital	-Funding: $261 million/9 years. Grants and loans are awarded for the capital cost of developing community health groups and expanding or developing new health delivery sites	Secretary may make loans for capital projects. Funding not specified
Enabling Services	-Funding: Authorizes $1.859 billion/9 years or transportation, community and patient outreach, patient and family education, translation, case management and home visiting	Funding for medical transportation in frontier and rural areas (funding not specified); Frontier states may implement proposal to preventative services including mobile preventive health services
Supplemental Services	Funding: $1.179 billion/9 years to cover services that would be otherwise excluded from coverage in the standard benefits program, e.g. mental health and dental services	Secretary studies the need for and design of a "Supplemental Rural Benefits Package"
Telemedicine	Grants to develop telemedicine capacity, including establishment of systems, transmission, training, equipment maintenance, etc. In addition, demonstration project to test Medicare reimbursement/coverage of telemedicine services	1) Creates Telemedicine Federal Interagency Task Force 2) Demonstration projects to promote telemedicine (500 million/year with 20% match from the entity)
Full Funding of WIC	Supplements existing appropriations for the supplemental food program for women, infants and children (WIC) with 2.4 billion in direct appropriations which will allow the program to serve all of the pregnant women, infants and children eligible for WIC benefits	No provision

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Domestic Violence	Prevention of domestic violence is included as one of the priorities for core public health funding. In addition, grants are available for the purpose of implementing and developing curriculum for identification, treatment and referral of victims of domestic violence.	No provision
Core Public Health	-Funding: $2.23 billion/9 years -Grants to States for core public health activities (for example health monitoring of populations, support for poison control centers, public information programs reduce risks to health including, tobacco, alcohol, etc)	-Funding: $400 million ('96-99) Grants to FQHCs and look-alikes to expand services to vulnerable population
Health Promotion/Disease Prevention	-Funding: $709.21 million/9 years -Grants to states for health promotion/disease prevention	Grants are awarded to states to develop and implement programs to improve maternal and child health. Funding not specified
School Health Services	-Funding: $2.4 billion/9 years -Grants to develop school-based or school-linked health services sites	No provision
School Health Education	-Funding: Authorizes $180 million ('95-2000) -Grants to develop and integrate comprehensive school health education programs for K-12	-Grants to states to establish comprehensive school health education and prevention programs for pre-school and elementary school -Funding: Authorizes such sums as may be necessary in '96-2000
Biomedical and Health Services Research	-Dedicated fund financed by 0.25% surcharge on all private health plan premiums for NIH biomedical and behavioral research and for AHCPR health services research on quality and outcome of care	-Establishes a National Fund for Medical Research from voluntary check-off of overpayment of taxes. Allocates this fund to NIH. No fund for quality or outcomes research
Mental Health/Substance Abuse	-Funding: $522 million/9 years -Requires states to integrate state mental health/substance abuse services with those offered by health plans by 2001 -Grants to states for comprehensive managed mental health/substance abuse integrated with general health delivery systems	No comparable provision

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Support for Graduate Medical Education	All payer support for residency training in addition to Medicare funds	No provision. Continued reliance on Medicare
	All payer support for indirect education costs of teaching hospitals, in addition to Medicare funds	No provision. Continued reliance on Medicare
	Payments to assist schools with costs of medical, dental and public health student education	No provision
	National Council on Graduate Medical Education established within HHS Council makes recommendations to Secretary on needed changes in specialty mix ratios. Council allocates residency positions to achieve specialty mix goals. Voluntary achievement of goals by specialty	Advisory Commission on Workforce appointed by OTA. Makes recommendations only
	Phase in to 55% of residents entering primary care training by July 1, 2001. Number of first year residents reduced to a number more closely related to the number of U.S. medical graduates	No provision
	Payments to support graduate nurse training programs. National Council on Graduate Nurse Training provides advice	No provision
National Health Service Corps	-Funding: $1.09 billion/9 years -20% of awards to advanced practice nurses; 15% for psychiatrists, psychologist or clinical social workers	Appears to limit funding for NHSC scholarships and loan repayment program to $20 million/year for '95-2000. (Current funding is $79.3 million). Similarly, limits AHEC funding to $20 million per year (current FY 1994 funding at $24 million per. year)
Tax Credit for Primary Care Providers	Tax credit ($1,000/mo. for MDs, $500 for non-MDs) for primary care providers in HPSAs for up to 5 years	Similar provision
Fraud and Abuse	Creates Fraud and Abuse Control Program coordinated by HHS and DoJ Establishes Anti-Fraud Account to fund program	Similar provision
	Authorizes AG/HHS to issue advisory opinions	Requires the issuance of interpretive rulings, additional safe harbors and fraud alerts

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Medical Malpractice	Limits attorneys contingency fees	Similar provision
	Periodic payments of awards	Similar provision
	Mandatory non-binding ADR, as adopted by the States	No provision
	No provision	Caps non-economic damages and limits punitive damages
	Mandatory certificate of merit	No provision
	No provision	Reduces statute of limitations in malpractice cases
Financing	Medicaid savings	Medicaid savings
	Medicare savings and receipts (summarized next page) (primarily to finance new prescription drug and long term care benefits)	Medicare savings (summarized next page)
	Tobacco excise tax increase	No provision
	Exclusion of health benefits from cafeteria plans	No provision
	Assessment on high-cost health plans	No provision
	Surcharge on health plan premiums to finance academic health centers and medical research	No provision

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Medicare Savings		
Part A	Reduce annual hospital update/reduce payments for hospital capital/revise DSH hospital adjustment/ extend OBRA 93 SNF update freeze/long-term care hospital moratorium/termination of separate IME payments/Extend Medicare-Dependent rural hospitals; extended MAFs and RPCHs ADDITIONAL PROVISIONS: rural transition grants; sole community hospitals with teaching programs payments; revised payment for rehab and long-term care hospitals/subacute care study/psychology services in hospitals/termination of separate IME payment/repeal Medicare/Medicaid data bank	Similar provisions: Reduce annual hospital update/reduce payments for hospital capital/revise DSH hospital adjustment/extend OBRA 93 SNF update freeze/long-term care hospital moratorium/lower IME payments/telemedicine grants to test payment improvement/extend Medicare - dependent rural hospitals/authorize MAF and RPCH expansions
Part B	Reduce 1995 physician update/MVPS to real GDP/separate payments for physician assistants and nurse practitioners/part B premium at 25% of costs ADDITIONAL PROVISIONS: MVPS upward bias; resources-based practice expense RVUs/high cost medical staffs/changes in underserved area bonuses/State MVPS demos/out patient department (OPD) formula driven overpayments/eye and ear hospital OPD special payments/ laboratory coinsurance/competitive bidding for other Part B items and services/prohibits extra billing/reduce durable medical equipment updates/changes to orthotics and prosthetics regulation	Similar provisions: reduce 1995 physician update/MVPS to real GDP/separate payment for physician assistants and nurse practitioners/part B premium at 25% of costs ADDITIONAL PROVISIONS: Cumulative growth targets for MVPS establishes PPS system for hospital outpatient services
Part A and B	Medicare secondary payer provisions/adjust home health payment methodology; extend Medicare Select to all States ADDITIONAL PROVISIONS: Establish home health copayments to 20%/extend centers of excellence/income related Part B premiums/extend Health Insurance (HI) tax to state/local workers/terminates GME	Similar provisions: Medicare secondary payer provision; adjust home health payment methodology; extend Medicare Select to all States

SUMMARY COMPARISON OF MITCHELL AND DOLE HEALTH CARE REFORM LEGISLATION		
PROVISION	MITCHELL BILL	DOLE BILL
Managed Care	Uniform open enrollment period/enrollment through third party/uniform termination of enrollment, extended lock-in Individual election to remain in certain health plans. Enrollment of new medicare beneficiaries and those who move (see Medicare Integration)	Similar provisions; uniform open enrolment/no enrollment through third party/optional extended lock-in Secretarial study of individual election to remain in certain health plans. (See Medicare integration) ADDITIONAL PROVISIONS: Comparative information materials/ change in geographic area for AAPCC computation/change in basis of computation/50/50 rule modification/cash rebates/competitive pricing demonstration/social HMO demos extended

A COMPARISON OF THE HSA, GEPHARDT, AND MITCHELL BILLS

FINAL 8/3

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Coverage	Universal coverage achieved by 1998.	Universal coverage achieved by 1999.	If 95% of the population is not covered by 2000 through voluntary measures, a Commission makes recommendations to achieve universal coverage, which Congress must consider on a fast track. If Congress does not act on the recommendations, then a 50-50 employer-individual mandate goes into effect for firms with 25 or more workers in States with less than 95% coverage. Firms with less than 25 workers are exempted. If 95% coverage is achieved through voluntary measures, then the Commission makes recommendations to achieve universal coverage, which Congress must consider in an expedited fashion.
Subsidies	Individual costs capped at 3.9% of wages. Workers earning up to 150% of poverty level and nonworkers with incomes of up to 250% of poverty eligible for subsidies. Employer costs would be capped at 7.9% of payroll; firms with fewer than 75 workers and average wages of less than $24,000 eligible for caps of between 3.5% to 7.9% of payroll.	Individuals under 100% of poverty would receive a full premium subsidy, which phases out between 100 and 240% of poverty. Employers with 50 or fewer workers and average payroll of less than $26,000 would be eligible for a tax credit which would reduce their liability for health premiums. Firms with under 25 workers would be eligible for a maximum credit of 40 percent of the Medicare Part C premium (50% of the employer share); firms with 26 to 50 workers would be eligible for a credit equal to 30% of the premium.	Individuals: Subsidies available for low-income individuals (up to 200% of poverty) beginning in 1997. Pregnant women and children up to 300% of poverty are also eligible for subsidies on a sliding scale. Temporarily unemployed people are eligible for enhanced income protection subsidies for up to 6 months. Employers who expand coverage to all employees also eligible for subsidies beginning in 1997 for currently uninsured employees and available for 5 years; firms pay the lesser of 50% of premium or 8% of newly-insured workers wages.
Employer / Individual Requirements	Employers required to contribute 80 percent of the average price plan in a geographic area. Subsidies available for small, low-wage firms (see above). All individuals required to have insurance and pay 20% of the premium, with subsidies available for low-income individuals.	Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Subsidies in the form of tax credits available to firms of 50 or fewer workers, based on average payroll. Small businesses could enroll workers in Medicare Part C. Individuals required to buy insurance. Employees of small (100 or fewer) businesses could choose expanded FEHBP or Medicare Part C (if low-wage). Unemployed covered under new Medicare Part C or private plan.	No required employer contribution until possibly 2002 (see Coverage). States could enact their own reforms, which could include employer requirements. Large employers (500 or more) must offer a choice of at least three plans (FFS, POS, HMO) to their employees and have option to self-insure; small firms must offer their employees option to join a HIPC and may provide choice of at least three plans through private insurer. Employers who contribute for any workers must contribute for all. No individual mandate until possibly 2002. However, workers must buy policies through employer-offered plans or their local HIPC to qualify for premium contribution from their employers.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Cost Containment	Competition among health plans is the main cost control mechanism. Limits on premium increases through a national health care budget, reducing to CPI plus per capita over 5 years for covered services. Incentives for individuals to choose lower cost plans. Slowdowns in growth of Medicare and Medicaid.	Competition among health plans is the main cost control mechanism, but this bill contains stronger public (Medicare Parts A,B, C held to strict spending targets) and private (backup of a hard trigger of Medicare-like fee schedules) cost containment than the Senate bill. A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 to control costs if expenditures were exceeding targets. Congress must either approve cost containment provisions along the lines of Medicare's payment methods or pass alternate measures to hold down health spending.	Competition among health plans is the main cost control mechanism. High cost health plans would be assessed 25% on the portion of their costs above a target. A National Cost and Coverage Commission would issue annual reports starting in 1999 on national and State trends. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, a Commission makes recommendations to Congress, who must act on them in an expedited fashion. A "fail safe" limit in Federal health care spending starting in 1997 included as backup protection; if costs exceed projected baseline, reform spending (except subsidies for pregnant women and children) would be reduced. (Also see Financing)
Financing	Cigarette tax increased $.75; assessment on self-insured plans; tax deductibility of cafeteria plans phased-out; savings in Federal programs.	Cigarette tax increased $.45. 2% surcharge on private premiums (not Medicare Part C). A portion of the premiums paid by non-enrolling employers would be retained during a transition period. Tax deductibility for health benefits which are part of cafeteria plans also eliminated.	Cigarette tax increased $.45. Includes an assessment on premiums of high growth plans. Also eliminates tax deductibility of health benefits as part of cafeteria plans. 1.75% surcharge on private premiums.
Insurance Reform	Interim insurance reforms, including portability, guaranteed renewal, and pre-existing condition limitations, all begin right away. Guaranteed issue, community rating, standard benefits package and elimination of lifetime limits begin when a State phases in to universal coverage (outside date: January 1, 1998).	Insurance reforms include guaranteed issue, guaranteed renewal, standard benefits package, ban on pre-existing condition exclusions and an end to lifetime limits. Insurers selling in individual and small group insurance markets must offer insurance at community rate (no age bands). Firms above 100 can self-insure Not clear when reforms implemented.	Beginning in 1996, portability, guaranteed renewal and a limit on pre-existing condition exclusions (6 months for previously uninsured) Starting in 1997, insurance reforms include guaranteed issue, standard benefits package, elimination of lifetime limits and community rating (modified until 2002 for age with a band of 2:1). Insurers required to cover unmarried children under age 25. Firms/groups above 500 can self-insure or buy experience-rated policies. Risk adjustment across experience-rated and community-rated plans.
Medicare	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1996-2000=$118.3 billion.	Retained and strengthened through added coverage for prescription drugs, mammography and mental health services. Medicare expanded through new "Part C' option for employees of small businesses, unemployed and others who don't receive insurance through the workforce, effective in 1999. Savings levels not yet clear, but are likely to be more than the Senate proposal.	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1995-1999 = $55 billion; 10 year figure = $278 billion.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Medicaid	All current Medicaid recipients choose from among community rated plans available through the regional alliance system. If a low cost sharing plan (HMO) is available at or below the weighted average premium, then AFDC and SSI recipients who choose that plan have their cost sharing reduced to $2 for a physician visit and $1 per prescription; the HMO must absorb this extra cost-sharing subsidy. If no low cost sharing plan is available at or below the weighted average premium, AFDC and SSI recipients can choose a high cost sharing plan and be subsidized down to the $2/$1 level. State and local governments pay the plan for most of this subsidy. "Wrap-around" benefits extended to AFDC and SSI recipients and "non cash" children.	Medicaid recipients with modified adjusted gross incomes under 100% of poverty would receive a full premium subsidy; those with incomes above 100% of poverty would be required to pay part of their premium. Medicaid recipients, like other individuals, could enroll in Medicare Part C or could apply a voucher toward the purchase of a private plan. All AFDC and SSI recipients get a full subsidy and they are eligible for supplemental benefits currently covered by EPSDT. Non cash recipients will receive the same subsidies as low-income people. Payments for supplemental would be made out of the Part C trust fund.	AFDC and non-cash recipients with incomes below 100% of poverty and pregnant women under 185% of poverty receive a full premium subsidy. Non cash recipients with incomes above 100% of poverty (who are not pregnant women or children) pay for part of their premium if they want coverage. AFDC recipients in HMOs pay 20% of the cost sharing amount otherwise required. Cost sharing is absorbed by the plan or paid for by the government.
Benefits	Comprehensive benefits include hospital and health professional services, preventive services (w/ no cost sharing), prescription drugs, mental illness and substance abuses services, pregnancy-related services (including abortion) and family planning. Three kinds of cost sharing offered: lower (HMO), higher (fee-for-service) and combination (PPO). Out-of-pocket costs capped at $1500/individual and $3000/family.	Similar to benefits offered in HSA. Includes benefits currently covered under Medicare as well as preventive services for children (with no cost sharing), preventive services for adults (some without cost sharing), prescription drugs, mental illness and substance abuse services, pregnancy-related services (which appear to cover abortion) and family planning services. Out-of-pocket costs capped at $1500/individual and $3000/family.	Sixteen categories of covered services in the standard package are specified in the bill, including nearly all those in the HSA package. Abortion and family planning are covered. A National Benefits Board will define scope and duration of services and can seek parity (ie some cost sharing) for mental illness and substance abuse services. Three cost-sharing schedules (as in HSA) will be specified by the Board. Individuals also have option of purchasing an "alternative standard" package with a high deductible. The actuarial value of the package is the value of the FEHBP Blue Cross/Blue Shield Standard Option.
Alliances/ Purchasing Cooperatives	Individuals in firms with 5000 or fewer workers must belong to a single, mandatory regional health alliance, which collects premiums and pay health plans on behalf of enrollees. Firms above 5000 have option to self-insure.	States could establish voluntary or mandatory health cooperatives. Health plans sold through a health cooperative would be sold at the community rate that would otherwise apply, adjusted by an administrative discount.	Health Insurance Purchasing Cooperatives (HIPCs) set up as voluntary competing non profit agencies responsible for contracting with plans and employers, enrolling individuals, collecting and distributing premiums and publishing information on plans. HIPCs must accept all enrollees and offer choice of at least a fee-for-service plan, a point-of-service option, and an HMO. If a HIPC not available in community-rated area, then FEHBP is required to sponsor a HIPC in that area. (see FEHBP)

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
FEHBP	Terminates on December 31, 1997 (except for employees abroad).	An expanded "Universal" FEHBP established after insurance reforms take effect and will contract on a competitive basis with community-rated plans. A small (less than 100 employees) employer has option to offer coverage through UFEHBP.	OPM contracts with a local HIPC, or will establish one, in each coverage area for federal employees. Premiums for federal workers will be based on current methodology and will not be age-adjusted. Workers in firms with less than 500 employees, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at an age-adjusted community rate. Federal workers and nonfederal individuals will pay same community-rated premium after the phase-out of age-rating in 2002.
Choice of Plan/Provider	Individuals guaranteed choice of menu of health plans, including one fee-for-service plan and a point-of-service option for HMOs. Any willing provider who accepts the fees, terms and conditions of any fee-for-service plan guaranteed the right to contract with that plan.	Individuals have choice of at least one fee-for-service, and one managed care plan, depending on what employer offers: Medicare Part C (for individuals not connected to the workforce, part-time and seasonal workers and low income persons and their dependents in firms with under 100 employees), UFEHBP (for employees of firms with less than 100 workers), vouchers to buy a private plan or a catastrophic plan with a medical savings account. Medicare Part C option will offer at least a fee-for-service and an HMO. Modified any willing provider clause: any qualified provider willing to accept the fees, terms and conditions of any plan (other than staff-model and group-model HMOs) is guaranteed the right to contract with that plan, though	Individual have choice of at least 3 health plans, including 1 fee-for-service plan. Small and medium sized employers must offer workers the chance to buy a policy through a HIPC and may also offer a choice of 3 plans, including a fee-for-service plan, and HMO, and a POS plan. Workers in firms with less than 500 workers, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at the age adjusted community rate. No any willing provider provision for any plan.
State Duties	Must establish alliances, assure enrollment and eligibility, regulate budgets, monitor quality standards and implement risk adjustment mechanisms. States could opt for single-payer, all-payer or other mechanism so long as coverage levels attained.	States can design individual reform programs, including a single payer option, so long as they meet coverage and cost control targets. States are responsible for implementing a long-term care program, an enrollment assistance program and solvency standards for self-insured plans.	States have ability to implement federal reforms on a "fast track", and could recapture federal savings from Medicaid integration. States could choose the single-payer option, and existing state waivers would be grandfathered. Responsibilities include certification of HIPCs and maintenance of effort for certain Medicaid recipients; States can pay per capita amount for SSI/Medicaid recipients who go into certified health plans.

PROVISIONS OF INTEREST TO SMALL BUSINESSES IN THE HEALTH SECURITY ACT, GEPHARDT, AND MITCHELL BILLS

8/3 4:30

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Mandates	Employers required to contribute 80 percent of the average price plan in a geographic area. Subsidies available for small, low-wage firms (see below).	Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Small businesses could enroll workers in new Medicare Part C or an expanded "Universal" FEHBP.	No employer contribution required until possibly 2002, after which time a 50-50 employer-individual mandate goes into effect only if 95% of the population is not covered and Congress has not acted on a coverage commission's recommendations. Firms with less than 25 workers are exempted from the mandate.
Subsidies	Firm costs would be capped at 7.9% of payroll; firms with fewer than 75 workers and average wages of less than $24,000 eligible for caps of between 3.5% to 7.9% of payroll.	Employers with 50 or fewer workers and average payroll of less than $26,000 would be eligible for a tax credit which would reduce their liability for health premiums. Firms with under 25 workers would be eligible for a maximum credit of 40 percent of the Medicare Part C premium (50% of the employer share); firms with 26 to 50 workers would be eligible for a credit equal to 30% of the premium.	Employers who expand coverage from existing levels to all employees eligible for subsidies for five years; firms pay the lesser of 50% of premium or 8% of newly-insured workers wages.
Cost Containment	Competition among health plans is the main cost control mechanism. Limits on premium increases through a national health care budget, reducing to CPI plus per capita over 5 years for covered services. Incentives for individuals to choose lower cost plans. Slowdowns in growth of Medicare and Medicaid	Competition among health plans is the main cost control mechanism, but this bill contains stronger public (Medicare Parts A,B, C held to strict spending targets) and private (backup of a hard trigger of Medicare-like fee schedules) cost containment than the Senate bill. A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 to control costs if expenditures were exceeding targets. Congress must either approve cost containment provisions along the lines of Medicare's payment methods or pass alternate measures to hold down health spending.	Competition among health plans is the main cost control mechanism. High cost health plans would be assessed 25% on the portion of their costs above a target. A National Cost and Coverage Commission would issue annual reports starting in 1999 on national and State trends. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, a Commission makes recommendations to Congress, who must act on them in an expedited fashion. A "fail safe" limit in Federal health care spending starting in 1997 included as backup protection; if costs exceed projected baseline, reform spending (except subsidies for pregnant women and children) would be reduced.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Self-employed	Self employed can deduct 100 percent of health insurance premium from taxes.	Self-employed can deduct 80% of health insurance premium.	Self employed individuals not eligible for employer-subsidized health insurance can deduct 50% of cost of premium for standard benefits package beginning in 1996 (remains 25% from 1993 to 1996). The 50% deduction will be reduced by a proportionate share if a self-employed individual with at least one full-time worker (who has been working for 6 months) provides less than 50% coverage to his worker.
Alliances/ Purchasing Cooperatives	Individuals in firms with 5000 or fewer workers must belong to a single, mandatory regional health alliance, which collects premiums and pay health plans on behalf of enrollees. (Firms above 5000 have option to self-insure).	States could establish voluntary or mandatory health cooperatives. Health plans sold through a health cooperative would be sold at the community rate that would otherwise apply, adjusted by an administrative discount.	Health Insurance Purchasing Cooperatives (HIPCs) set up as voluntary competing non profit agencies responsible for contracting with plans and employers, enrolling individuals, collecting and distributing premiums and publishing information on plans. HIPCs must accept all enrollees and offer choice of at least a fee-for-service plan, a point-of-service option, and an HMO. If a HIPC not available in community-rated area, then FEHBP is required to sponsor HIPCs in that area.
Independent Contractor	Treasury Department would issue prospective regulations for worker classification.	Treasury Department submits a legislative proposal providing statutory standards for the classification of workers as independent contractors to the Congressional tax writing committees by January 1, 1996.	Same as in House Democratic version.
Subchapter S Corporations	Anyone owning over 2% of stock and materially participate in a service business would be treated as having net earnings from self-employment.	Net earnings from self-employment would include 80% of a shareholder's 2% pro-rata share of taxable income from a service related business.	The self-employment tax base will be modified to 1) include 80 percent of an owner-service provider's service related provider's share of an S corporation's income derived from service-related businesses in the case of shareholders owning more than 2 percent of the stock of the corporation; 2) provide similar rules for limited partners who provide significant services to partnerships; and 3) provide special exclusion for 40 percent of income derived from inventory for all taxpayers.

Mitchell

collecting premiums, paying plans -- that most small businesses and individuals must do on their own today.

- To give consumers choices among purchasing cooperatives as well as among plans, there may be more than one purchasing cooperative formed in the same area may to compete for business on the basis of choice, quality, and price.

Section 1323 -- Ensuring The Maximum Choice Of Health Plans And Doctors

- In order to guarantee consumers a choice of plans, each purchasing cooperative must offer at least three types of plans: a fee-for-serice plan, in which consumers may choose any doctor, a managed care plan, and a combination plan -- which has higher cost sharing for doctors outside of the network. Purchasing cooperatives are not limited to offering only three plans and may contract with any number of plans that meet the quality requirements.

- In rural areas which may not have enough people to support three plans, there must be at least a fee-for-service plan -- allowing rural residents to choose any doctor they want.

Section 1341-- Guarantee Individuals and Small Businesses the Same Choices as Federal Employees and Members of Congress

- Individuals and employees of businesses with 500 or fewer employees may join any health plan offered under the Federal Employees Health Benefit Program -- which currently offers more than 300 plans nationwide. Over time, private purchasers and Federal employees will all be charged the same (community-rated) premium.

- In order to ensure that this will be an option for all Americans, the Office of Personnel Management -- which currently administers the Federal Employee program -- must contract with a purchasing cooperative in every area or, if one does not exist, must establish a purchasing cooperative through which consumers would have access to the choices offered through the FEHBP. Employers who make contributions on behalf of their employees would have to continue to make this contribution to any plans their employees choose through the FEHBP.

Sections 1461 - 1468 -- Essential Community Providers

- In some areas of the country, health care services are harder to access and providers typically serve low income and/or uninsured populations. In order to guarantee choice and continuity to patients and access in underserved areas, these providers are designated as "essential" to the communities they serve, and all area plans must reimburse them for services they provide.

- Sec. 1462 - Providers in underserved areas, including Rural Health Clinics (RHC) are protected as Essential Community Providers. Health plans will either negotiate a provider agreement with them or pay them their cost-based rate. Health plans will also contract with at least one Medicare-dependent small rural hospital (those which have 60% Medicare admissions) in their service area. Other health professionals or institutional providers may be certified as Essential Community Providers if they offer essential services to underserved areas or populations.

Sections 2111 -- Developing Links with Hospitals for Ongoing Care in the Home and Community

- New grants will help hospitals develop programs aimed at discharging patients back to the community rather than to nursing homes or hospitals. (Today, patients are often discharged to long-term care facilities simply because there was no family member available to help with post-hospital care, and no one to arrange professional services or supervision for a patient returning home alone.) With better information and assistance, hospitals can implement programs aimed specifically at helping disabled patients organize and arrange post-hospital care in the home and community.

Sections 2201 -2218 -- Strengthening Consumer Protections in Long-Term Care Insurance Policies

- Enhances protection for consumers of long-term care insurance by setting new standards that must be met by all private long-term care policies. New standards will include clearly defined inflation protection, uniform eligibility determination, and standards for other aspects of insurance.

- Proposed premium increases for long-term care policies will have to go through an approval process, and no unjustified increases will be approved. All policies will have to be sold in "good faith and fair dealing" -- unfair or discriminatory sales practices known as twisting, high pressure tactics, and cold lead advertising will be prohibited.

- And long-term care policies must be renewed -- no long-term care policy can be canceled or nonrenewable for any reason other than nonpayment of premiums or fraud. Benefits will be clearly and uniformly defined and described, so that terms of insurance coverage are clear and understandable to individuals buying policies. Individuals cannot be denied coverage due to history of illness, and pre-existing condition exclusions are limited. (It also clarifies tax rules so that long term care services and insurance premiums can be deducted from taxable income -- see Sections 7401-7402).

Section 2701 -- Life Care: a Public Insurance Program for Nursing Home Care

- The Mitchell bill also establishes a federal long term care insurance program to cover the costs of extended nursing home stays. People will have the option to purchase coverage when they reach age 35, 45, 55, or 65.

TITLE III --HEALTH PROFESSIONS WORKFORCE AND PUBLIC HEALTH INITIATIVES

Section 3001 -- Broad-Based Advisory Council on Workforce Training:

- Creates National Council on Graduate Medical Education, made up of a panel of consumers, primary care M.D.s, specialists, and representatives from health plans and purchasing cooperatives. The purpose of the panel is to assist and advise the Secretary on ways to increase number of primary care physicians.

Section 3013 – Increase in Primary Care Physicians:

- Increases the number of physicians being trained in primary care from 39 percent to 55 percent between 1998 and 2001. Sec. 3014 allows for some modification (by the Council) of the percentage of primary care vs. specialty physicians beginning in 2001. [Section 3061 builds in a guarantee of substantial emphasis on primary health care education for physicians.]

- Outlines how reducing the numbers of specialists can be done voluntarily, by the training programs.

Section 3031 -3033 – Funding of Graduate Medical Education

- Provides for long-term, sufficient and stable funding for GME. (Arnie will add)

Section 3051-3055 – Funding for Academic Health Centers

- Provides for long-term, sufficient, and stable funding for these centers, both to support the costs of training and transitional costs for training that reduce the number of trainees. Recognizes unique needs and contributions of these centers, including research, teaching costs, high-tech high-cost specialized care.

Section 3061 - Funding for Medical Schools

- Provides funding for medical schools. Three quarters of the funding is directed for the support of primary care education and research.

Section 3071 - Funding for Graduate Nurse Training

- Provides grant support for graduate nurse training programs includes those for nurse midwives, clinical nurse specialists, nurse anesthetists and nurse practitioners.

Sections 3081-2 – Funding for Special Programs

- Provides funding to train additional primary care physicians and physician assistants; retrain mid-career specialists; expand the supply of physicians in rural and inner-city areas; and delivers primary care to those with mental, physical, developmental disabilities.

- Provides funding to increase the number of minorities and disadvantaged persons in medical professions and encourages the retention of health professionals in rural underserved areas.

- The Mitchell bill contains new initiatives to increase the number of rural area residents accepted into training programs, and it incorporates other programs to improve the retention of rural doctors through telemedicine systems, inter-disciplinary team building, and providing temporary practice coverage while doctors are away for vacations and continuing medical education.

Section 3082 -- Retraining and Workforce Adjustment:

- Establishes a program for health care industry job banks and one-stop career centers to assist displaced health care industry workers. Establishes a program for skills upgrading and occupational retraining.

Section 3101 -- Support for Rural Hospitals

- The Mitchell bill contains a new initiative to link academic health centers with rural providers and health plans. This provision will help establish and operate information and referral systems necessary to assure rural access to specialized services at academic health centers.

Sections 3201-2 -- Stable Funding for Health Services Research

- Provides that 0.25% of private insurance premiums (in addition to current funding) be directed to biomedical and behavioral research --including prevention, quality of care, consumer choice, administrative simplification, and improving access to health care for vulnerable populations.

Sections 3341, 3411, 3471 -- New Grants for Rural Networks

- Rural hospitals and other public and private providers are eligible for new grants to expand access to health care services though the use of telecommunications technology. New programs will build community-based health plans and networks and provide funding for supportive services like transportation, outreach, and translation services.

- Sec. 3471 - Over $1 billion in new funding is made available to expand the National Health Service Corps. Currently, rural areas receive about 60 percent of the doctors, nurses, and other health professionals placed by the Corps. This provision would result in 4,000 new doctors in the Corps by the year 2000.

Sections 3681 and 3902 -- Special Programs to Enhance Community-based Health Care

- Rural communities are eligible for funding to develop and operate school-based or school-linked health service programs targeted to the needs of rural communities through partnerships between schools and health care providers.

- New funds are provided for the community scholarship program, under which State may contract with community-based organization to provide scholarships in the health professions for local residents.

TITLE IV -- MEDICARE AND MEDICAID

Sections 4105 - 4111 -- Special Assistance for Rural Hospitals

- The Act updates and extends the special payment treatment for Medicare-dependent small rural hospitals through September 1999. These protections were scheduled to expire this year.

- The Rural Health Transition Grant Program -- which provides transitional assistance to rural hospitals --is extended through 1999. Rural Primary Care Hospitals are made eligible for funding.

- The Act greatly expands programs to help small rural hospitals convert from acute care to more primary care services. The new limited-service hospital program in the bill will provide new resources to support alternative rural health care models. Two programs specifically tailored for rural hospitals -- Rural Primary Care Hospitals and Medical Assistance Facilities -- will be authorized to expand to all States wishing to participate. Many technical and payment amendments are included to make the programs more useful for rural communities.

Sections 4204, 4212 - Bonus Payments to Rural Providers

- Medicare bonus payments for rural doctors in underserved areas are doubled from 10 percent to 20 percent for primary care services, and they are retained at 10 percent for non-primary care services.

- Payments for physician assistants and nurse practitioners are expanded to include services provided in a hospital setting.

TITLE VII -- REVENUE PROVISIONS

Sections 7101-7103 – Tobacco Tax

Raises revenues to fund subsidies by gradually increasing the tax on tobacco products from 25 to 45 cents a pack by 1999.

Section 7111 – Supports Workforce Training And Research

- Revenues from this assessment are dedicated to funding workforce training, academic health centers and research.

Sections 7112 – Penalizes High Cost Health Plans.

- For community rated plans tax is based primarily on cost of the plan relative to a federally defined baseline or "reference premium". For experience rated plans the tax is based more on the rate of growth in the premium of the plan relative to the federally-defined target rate of growth (4511).

Section 7131 – Raises Funds for Subsidies By Taxing Handgun Ammunition.

Section 7203 - Increased Deduction for the Self-Employed

- Under the Mitchell bill, self-employed individuals can deduct up to 50% of the cost of a certified standard health plan[3], up from the 25% allowed the self-employed today.

Sections 7401-2 – Tax Deductibility for Long-Term Care

- Increases tax deductibility of long-term care expenditures and insurance. Long-term care expenditures would be treated as medical expenditures for tax purposes, qualifying them as tax deductible expenses. Does the same for long term care insurance; gives it the same tax treatment as health insurance.

Sections 7511-2 – Tax Incentives for Rural Providers

- The Mitchell bill offers tax credits of up to $1,000 per month for doctors and $500 per month for nonphysician providers who begin practice in designated underserved areas for up to 3 years. Physicians already practicing in these areas may receive tax credits of $500 per month.

- The Act raises by $10,000 the amount that rural primary care doctors may claim on their taxes for medical equipment.

TITLE VIII - OTHER FEDERAL PROGRAMS

Sections 8101 to 8142 – Improving the Health of American Indians and Alaska Natives

- The Mitchell bill recognizes the unique trust responsibility of the federal government to Indian people. All health services will continue to be provided at no cost to the individual,

[3] The 50% deductibility is consistent with the level of employer contribution if Title X becomes effective, and with the minimum contribution for eligibility for employer-based subsidies.

and federal officials are required to maintain active and ongoing consultation with Indian people about Indian health programs.

- Tribes, tribal organizations and the Indian Health Service are given the authority and flexibility to form health plans.

- New funding sources -- including an Indian Health Care Investment Fund that provides $133,330,000 each fiscal year between 1996 and 2004 in addition to other appropriations -- can be used to expand and improve Indian health care facilities and should enable the Indian Health Service to provide the broad range of services in the standard benefit package.

- The bill also preserves the wide range of supplemental services -- including education, outreach and public health services -- that are provided today.

Section 8202 -- Maintaining Our Commitment to Our Nation's Veterans

- The Mitchell bill maintains our commitment to our nation's veterans by preparing the Department of Veterans Affairs for health care reform while preserving the right of veterans to receive supplemental services that meet their special needs at no charge. The bill relieves the Department from burdensome regulations and gives the VA the authority and flexibility necessary to form health plans to compete to serve veterans.

- New funding sources should make it possible for VA facilities to serve all veterans who wish to enroll, ending today's arbitrary eligibility requirements.

  - The VA may receive premium payments from employers and some veterans.

  - For the first time, VA facilities can receive Medicare reimbursement for all Medicare-eligible veterans who enroll in a VA health plan.

  - A Veterans Health Care Investment Fund provides approximately $3.5 billion over a three year period to expand and improve facilities and to help VA health plans become competitive.

- All veterans remain eligible to receive supplemental benefits -- such as treatment for post-traumatic stress syndrome and long-term care services -- that are provided today at no cost to the individual.

Gephardt

The House plan includes six initiatives to eliminate these barriers and to make access to health care a reality for people in inner-city and rural areas.

- o Grants will be available to all fifty states to help them develop health care networks in underserved areas.

- o A new grant program will be made available to local governments and health care facilities to help them expand or establish primary and acute care networks in underserved areas.

- o Financial assistance will be provided through a new federal trust fund to inner city and rural medical facilities to help them meet their capital financing needs.

- o The resources available to primary care doctors practicing in rural areas will be increased by doubling Medicare bonus payments, and by providing tax incentives to primary care doctors, nurse practitioners, and others who locate in rural and urban underserved areas.

- o Substantial new federal funding would be provided to support the operation of community and migrant health centers.

- o Additional funding for the National Health Service Corps would be provided.

Question: ***Will the tax treatment of health benefits be changed?***

Answer: For most people, the way their health coverage is treated for tax purposes will remain the same. Just like now, employer contributions to health insurance will not be counted as taxable income for individuals, and employers will be able to deduct the full cost of contributions made to their workers' coverage.

For those people who are self-employed, however, the tax treatment of health insurance will be changed: whereas these individuals are currently able to deduct only 25 percent of the cost of their health coverage, under the House proposal, self-employed people will be able to deduct the full cost of the employer share of their coverage.

Question: ***How will doctors and hospitals be affected by the plan?***

Answer:

- o Hospitals that are currently overburdened by indigent care and other unreimbursed costs will see a dramatic reduction in these costs.

- o Those hospitals that are already making innovative changes in the delivery system will be able to continue pursuing these innovations.

- o Doctors who want to continue practicing in a fee-for-service setting will be able to, and opportunities for those who prefer to practice in high-quality managed care settings will be increased.

- Burdensome billing and administrative procedures will be eliminated for both doctors and hospitals by the use of uniform electronic claims, medical records, and entitlement verification systems.

- Doctors and hospitals who currently serve Medicaid patients will see a significant increase in reimbursement for care provided to these patients as they are brought into private plans and the new Medicare Part C program.

- Hospitals that serve the vital function of training our nation's doctors will receive needed assistance in meeting the costs associated with providing this service

- New national health plan standards will ensure that no qualified doctor willing to meet a health plans terms and conditions can be denied participation in the plan.

Question: ***How will small employers be able to afford to pay?***

Answer: More than half of all employers with fewer than 100 employees already contribute to the cost of health coverage for their workers. Among small employers who do help pay, the average contribution in 1992 was about $2,300 (EBRI, *Sources of Health Insurance and Characteristics of the Uninsured,* 1994). For these firms, and particularly for those that currently offer this level of coverage to all their employees, providing coverage under the House plan will result in minimal if any additional payments.

Those small businesses which are currently least likely to help pay for their employees health coverage are low-wage businesses with fewer than 50 employees. The House plan will help low-wage small businesses who would otherwise have a difficult time making their required contributions in several ways.

Subsidies will be provided to small, low-wage businesses to reduce the amount they must contribute toward their workers' premiums: firms with 25 or fewer employees would be eligible for a maximum subsidy of 50 percent, and firms with 26-50 employees would be eligible for a maximum subsidy of 37.5 percent. For companies with 25 or fewer employees, the subsidy will reduce the employer obligation for an individual premium from about $.85 per hour to about $.42 per hour. For companies with 26-50 employees, the subsidy will reduce the obligation to about $.53 per hour.

The new Medicare Part C plan and the expanded Federal Employee Health Benefits Program will offer small employers two simple and affordable ways of providing high quality coverage for their employees.

Question: ***How will states be affected by the plan?***

Answer: Under the House plan, states will have broad flexibility to create the kind of

system meets the national goals of universal coverage and cost containment. Those states who have already started reforming their systems will be able to continue with these reforms, and those who would like to establish their own system -- including single payer, managed competition, or employer mandate systems -- will be able to.

States may also see a significant reduction in their health care spending under the proposal. As their uninsured residents are brought into the health care system, the increasingly large share of state and county resources being consumed by uncompensated hospital care and indigent health care programs should be reduced.

Question: ***What does the plan do about long-term care?***

Answer: Meeting the long-term care needs of disabled and elderly individuals is one of the most important challenges we face. This requires both ensuring the well-being of existing long-term care programs, and creating new programs to serve those who don't qualify for these programs.

The House plan will significantly expand the availability of long-term care for disabled individuals. Under the plan, a new federal program will provide home and community based services -- including personal assistance services, home modifications, and home health services -- to people with severe disabilities, regardless of their age or income. The plan will also preserve Medicaid's existing long-term care program for low-income Americans.

Question: ***How will the plan be paid for? And how will it affect the deficit?***

Answer: Most of the cost of the program will be covered by contributions from employers and individuals. Additional funds will be required to pay for improvements to the current Medicare program, the new long-term care program, subsidies for low income individuals and small, low-wage companies, and assistance to academic medical centers. Funds to cover these costs will be raised in four sensible and fair ways: savings from slowing the rate of growth in Medicare and Medicaid costs; a gradual increase in the tax on tobacco products; eliminating the tax subsidy for health benefits provided through cafeteria plans; and a 2-percent tax on private health insurance plans.

As proposed by the House, the plan will reduce the deficit by about $2 billion in the first five years of the program, and will provide additional long term savings as costs are held below current projections.

Question:	*Are fee schedules for medical services "price controls" and don't they have the same problems as price controls ?*

Answer: No! Fee schedules for medical services and supplies are not price controls, and the four common concerns raised about price controls do not apply to limits on medical fees.

The first concern is that price controls require a large bureaucracy in order to communicate prices to millions of buyers and sellers, and to make sure everyone is charging and paying the right amounts. Fee schedules for medical services, however, do not require any "bureaucracy" beyond the few payers -- public and private insurers -- themselves. Each of these payers has a strong incentive to know and pay only the right price, and each of the sellers -- doctors and hospitals -- has a strong incentive not to jeopardize a relationship that pays the bills for hundreds of patients. In fact, the vast majority of private insurers already use some form of fee schedule to establish the amounts they will pay for each service

The second concern is that price controls make the buying and selling of goods more complicated. Fee schedules, however, actually *simplify* the administrative aspects of "selling" and "purchasing" health care. In a system without maximum payment rates, doctors and hospitals have to figure out what different insurers will pay for their services, insurers have to figure out providers' "charges", and disagreements have to be fought over and resolved. With fee schedules, everyone knows what they can charge and what they will be expected to pay.

The third concern is that price controls only hold costs down temporarily, and that when the controls are removed, inflation comes back at even higher levels than before. Fee schedules for medical services, however -- although updated and revised -- would not be removed. As a result, there is no danger of a bout of post-control inflation.

The fourth concern is that price controls lead to "waiting lists" or "shortages". Fee schedules for doctors and hospitals, however, do not impose any kind of constraint or arbitrary limit on a medical system's capacity to provide needed care. There are no cut-off points after which doctors and hospitals will not be paid, and there are no incentives to not provide needed care. Under the House plan, if spending exceeds the "expenditure target" in a particular year, the fees paid to providers the next year will simply be allowed to rise less.

Question:	*Will fee schedules work to control costs ?*

Answer: Some argue that fee schedules will not provide an effective means of controlling costs because providers will increase the number of services they provide to make up for lost revenues.

Evidence from this country's Medicare program -- and from the five other countries

increase some, fee schedules provide an extremely effective way of controlling costs. There are two reasons why this is the case.

The first is that there are several factors that "naturally" limit how much the volume of services and goods will increase. While physicians may well be able to tell a patient to come back in for an "extra office visit", other providers who do not "prescribe what they provide" -- like hospitals and drug companies -- are not so easily able to create extra demand for their services. Even among those providers who can "induce demand" though, *the majority* would not choose, for financial reasons, to do unnecessary procedures and tests.

The second is that most fee schedule systems -- like the system in the House proposal -- have a mechanism built in to adjust fees to volume so that the total cost stays within the target. Under the House plan, as in other effective fee schedule systems, if the volume of services rises more than expected in a particular year, increases in the fees paid for these services will be allowed to rise less.

September 9, 1994

Robert A. Koshnick, M.D.
1017 Summit Avenue
Detroit Lakes, MN 56501

Dear Dr. Koshnick:

Congressman Collin Peterson forwarded to me the testimony that you prepared for the Great Plains Health Care Summit. I found your comments interesting and thought provoking.

You mentioned in your testimony that changes to the malpractice system should be a central part of health care reform. Senator Mitchell and Congressman Gephardt have introduced health reform bills with malpractice provisions that will minimize frivolous lawsuits while compensating deserving individuals. Both bills establish an alternative dispute resolution process to resolve malpractice claims in a fair, efficient and timely way. An individual may bring a case to court only after participating in the process. In addition, before filing a lawsuit, a lawyer must obtain a "certificate of merit" verifying that there is reasonable cause for filing an action. Both bills also limit attorneys' contingency fees. Congressman Gephardt's plan limits contingency fees to one-third of an award, and Senator Mitchell's plan limits contingency fees to one-third of the first $150,000 and 25 percent of any additional award. In addition, the plans permit damage awards to be paid by a defendant over a period of time.

Finally, as you well know, practice guidelines produced by professional societies are essential tools for physicians in making treatment decisions. To make guidelines more available, both the Gephardt and Mitchell bills provide for coordination of the development and dissemination of clinical guidelines at the federal level. Evidence that a physician has followed appropriate practice guidelines will be a complete defense in malpractice actions.

You also stated that this nation overutilizes expensive medical services because many people do not get preventive care. As I have listened to physicians and other health professionals share their views about the current health care system, I have heard again and again that too many Americans are unable to get primary and preventive health care. I have also learned that too many physicians and hospitals are forced to absorb the costs of

providing emergency care to uninsured individuals who wait until their illnesses are serious and costly before seeking care. The Gephardt and Mitchell bills include a broad range of preventive services -- such as immunizations, tests and regular check-ups -- at no cost to the individual.

Thank you again for your testimony on health care reform. Members in both the House and Senate have made great progress in proposing a less bureaucratic and less governmental approach to health care reform, while preserving the President's fundamental goal of guaranteeing private health insurance to American families. The President and I look forward to continuing to work with Congress to pass real health reform legislation.

Sincerely yours,

Hillary Rodham Clinton

cc: The Honorable Collin C. Peterson

September 7, 1994

Mr. Richard Gross
Chief Executive Officer
Gross Electric Inc.
2807 North Reynolds Road
Toledo, Ohio 43635-2377

Dear Mr. Gross:

Thank you for participating in the event at the White House for small business owners and for your letter on health care reform.

I appreciated learning that you support the President's fundamental goal of guaranteeing private health insurance coverage for all Americans. I was also pleased that you welcome many of the changes that are so important to the President -- including ending cost shifting, requiring shared responsibility between employers and employees, and reforming the insurance market to eliminate unfair practices.

To reach his goal of health security, the President supports shared responsibility for health care costs between employers and employees. Because nine out of ten Americans with private health insurance get it through their employers, the President believes that reform should build on that tradition by asking employers to help pay for their workers' health insurance premiums. Further, by requiring that all employers offer health insurance to their employees, cost shifting will cease between those employers who provide health care and those that do not. The State of Hawaii has successfully brought health care coverage to 98 percent of its population primarily through a mandated employer benefits plan that includes cost sharing between employers and employees. Hawaii's employer mandate, combined with programs to serve the unemployed, has resulted in virtual universal access to health care coverage and possibly the lowest health care costs in the nation.

As you noted in your letter, health insurers today often charge small businesses higher prices than large companies or deny them coverage altogether. Congressman Gephardt and Senator Mitchell have introduced health reform bills that will prevent these discriminatory practices. First, both bills eliminate preexisting condition exclusions, lifetime limits and other

practices that prevent those who need health care the most from getting it. Second, the bills will make insurance more affordable for individuals and small businesses by including subsidies for small, low-wage businesses to limit their premium contributions. Under Senator Mitchell's bill, firms paying 50 percent or more of their employees' premiums will receive a subsidy of up to 50 percent of the premium. Under the Gephardt bill, employers with 50 or fewer workers and average payroll of less than $26,000 will be eligible for a tax credit and a subsidy of up to 50 percent of the employer's share to reduce the amount they must contribute toward their workers' premiums. Further, both bills give individuals and small businesses the opportunity to bargain for and purchase health insurance on the same basis as large employers by allowing them to join voluntary, non-governmental purchasing cooperatives.

Again, I appreciate your support for the President's effort to reform the health care system. As you stated so well in your letter, small businesses stand to gain the most and lose the least from health care reform -- they gain affordable, quality health care for themselves and for their employees and lose the discriminatory insurance practices that make health care in-accessible today. The President and I look forward to continuing to work with Congress to pass real health security for all Americans.

Sincerely yours,

Hillary Rodham Clinton

June 22, 1994

To: Jennifer Klein

From: Stephanie Cutter

Subject: Florida Hospital Merger

As you requested, below is a brief summation of the settlement between the U.S. Department of Justice, the Florida Attorney General's office, Morton Plant Hospital and Mease Health Care regarding the merger of the two Florida hospitals. This is the first settlement of a case in the health care industry since last fall's release of the Statements of Antitrust Enforcement Policy in the Health Care Arena.

On June 17, the Justice Department and the Florida Attorney General's Office filed a proposed Final Consent Judgment barring the merger of Morton Plant and Mease, which account for nearly 60 percent of the market in the area. The Judgment, however, permits the two hospitals to form a "Partnership", allowing the consolidation and joint operation of certain administrative and patient care services. The "Partnership" will own and operate such services, independent from Morton Plant and Mease, and will sell each service to the two hospitals on the same terms and conditions. A listing of eligible joint services appear on pages two through four of the Judgment.

Further, Morton Plant and Mease may appoint members of their respective boards to a "Partnership" board. Independent services, managed care contracting for Morton Plant or Mease, or the marketing or pricing of any services, including "Partnership" services, may not be discussed by the "Partnership" board and its executives. The "Partnership" board may request Morton Plant and Mease to contribute capital, but each hospital is to determine independently the amount of capital to contribute.

In return for this "Partnership", the proposed Final Consent Judgment decree requires Morton Plant, Mease and the "Partnership" to undertake certain measures to preserve competition in the market. The "Partnership" must establish adequate protections, including employee confidentiality agreements, to keep information regarding pricing, managed care contracts, negotiations with managed care plans, and marketing and planning of the two hospitals separate. Further, Morton

Plant and Mease will continue as separate and competing entities, and will maintain an antitrust compliance program to formally inform their officers, directors, trustees and administrators about the Final Consent Judgment, and to educate them on the meaning of the Judgment and antitrust laws. Finally, to monitor compliance with the Final Consent Judgment, representatives from the Justice Department or the Florida Attorney General's Office are permitted access to Morton Plant and Mease during regular business hours.

Sixty-days after the Justice Department files a Competitive Impact Statement and gives sufficient public notice regarding the Judgment and the Statement, a Final Consent Judgment may be entered by the Court. The Judgment expires five years from the date of entry. However, before the expiration date, the Justice Department or the Florida Attorney General's Office may extend the Judgment at their own discretion for an additional five years.