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- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

TO: Sara Rosenbaum, Sallyanne Payton, and Jennifer Kline

* FROM: Margaret Farrell

RE: Section 1983 Actions and Adjudication of the Claims of Individuals
Arising Under Health Care Reform Legislation.

DATE: May 12, 1993

In our meeting with the Legal Audit Committee last week, you listed a number of claims that individuals might make against the federal government, the states, Alliances, Plans, non-Alliance plans and providers. You asked the general question -- how should such claims be adjudicated under the new system -- and the more specific question -- how should section 1983 claims asserting federal rights be treated under the new system, in light of the *Suter* and *Wilder* decisions.¹ This memorandum addresses both of those questions.

¹ *Suter v. Artist M*, 112 S. Ct. 1360 (1992) (Supreme Court in seven to two decision held that class of children beneficiaries of Adoption Assistance and Child Welfare Act did not have a cause of action under section 42 U.S.C. §1983 or an implied cause of action to enforce the federal acts requirement that states use "reasonable efforts" to prevent removal of children from their homes.); *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 1120S. Ct. 2510 (1990) (Supreme Court in five to four decision held that class of providers of services under the Medicaid Act did have a cause of action under section 42 U.S.C. §1983 to enforce the federal act's requirement that states reimburse providers at rates that are "reasonable and adequate" to meet the costs of efficiently and economically operated facilities.)

THE GENERAL QUESTION

Some Basic Principles

Adjudicatory mechanisms created for the new program should be designed to further its fundamental objectives. It is assumed that whatever configuration the Clinton managed competition proposal takes, it will seek to create a nationally uniform right for all Americans to purchase from private plans and insurers health insurance covering basic benefits of good quality at reasonable cost. Under the plan, the states and federal government will share responsibility for pursuing these objectives.

This memorandum is based on the understanding that the federal government will establish national standards and goals for the system, including budgetary goals, and that the states will assume the responsibility for implementing them. It also assumes that the states will be given maximum flexibility to devise procedures and regulatory strategies for doing so. The following analysis proceeds on several principles.

First, because the states will have the major role in implementing the system, individuals' claims against the system will often implicate legal responsibilities of the states to comply with federal requirements in administering the standards applicable to Alliances, Plans and providers. For this reason, it is important that claimants receive a hearing in a federal court at some point in an adjudicatory process. It would seem to be unrealistic to ask state courts to rigorously hold state governments to federal standards, particularly budgetary standards. That is, state courts would not seem to be sufficiently neutral forums within which to determine the responsibilities of the state to enforce standards that will have budgetary consequences for that state. This is particularly so in those states in which state court judges are political appointees or elected officials. In addition, the state courts in many jurisdictions have long been regarded as forums with fewer resources available to adjudicate claims efficiently and fairly.² If they are to be given large adjudicatory responsibilities, resources must be provided.

² See e.g. Newborn, *The Myth of Parity*, Har. L. Rev. (19).

Second, courts of law, whether federal or state, are not suitable forums in which to try facts necessary to the disposition of many of the individual health care claims you list. Formal litigation exacts an extra ordinary amount of time and money from litigants, witnesses, experts, and the judicial system . More expeditious, inexpensive, and user friendly procedures should be used, at least initially to mediate disputes, try facts and recommend conclusions of law.

Finally, a great number of disputes will be arise in the first years of the reform program. Nationally uniform standards will be developed in these years through adjudication as well as rulemaking. Therefore, unless there is federal administration at some level and/or federal judicial review, the diversity of decisions produced in state agencies and state courts may delay implementation and obstruct basic uniformity. Without federal control over adjudication as well as rulemaking, we would run the serious risk that the pieces of this system will simply not fit together.

Four Models

There are several ways in which to design an adjudicatory system based on these three principles necessary to a state implemented federal system - i. e. the principles of (1) a federal check on state responsibility for enforcement; (2) non-formal adjudication for individuals;³ and (3) national uniformity for basic rights.

- First, claims could be initiated and tried de novo before state agencies with federal administrative and judicial review. (the social security disability determination model).

- Second, claims could be made directly to a federal administrative body with judicial review under administrative procedure act (APA) (the social security insurance payment model).

³ This memorandum does not address claims of providers.

- Third, claims could be mediated by private bodies through various alternative dispute resolution mechanism (ADR) by Alliances and Plans, with a right to de novo hearing before a state or federal administrative body and federal judicial review under the APA. (cf. Medicare Part A claims). A variation on this model would be mandating final resolution through arbitration for some types or sizes of claims. (cf. the Medicare Part B claims)

- Fourth, claims could be brought de novo in the federal courts (section 42 U.S.C. § 1983 actions and implied causes of action or an express cause of action in the new legislation – Wilder and Suter claims).

The principles do not permit a model in which claims are brought de novo exclusively in state courts, (the Jones Act model) or in which claims are adjudicated by a state administrative agency, with judicial review under a state administrative procedure act only, and an appeal only to the United States Supreme Court. However, it could be that a mixture of the four models would be appropriate -- with different kinds of claims tried in different forums

Mixing The Models

1. Based on causes of action. In addition to conceiving of individual claims in terms of the party against whom they are made, individual claims can be grouped according to the causes of action they raise. Thus, persons seeking to purchase insurance through an Alliance would have statutory claims against the Alliance, the State and even the Federal government claiming that federal and state legislation gives them a right to enroll. In addition, such persons might claim they are third party beneficiaries to the contract between the state and Alliance that requires their enrollment. Further more, they may file a tort claim against the Alliance for negligently failing to enroll them. Finally, if Alliances can be characterized as engaged in state action, such individuals may claim they are constitutionally entitled to some kind of procedural due process before being denied enrollment. Similar causes of action can be imagined for persons who claim that Plans did not accept them properly, that they were improperly denied federal and state subsidies, favored tax treatment, and mandated benefits. Since it is likely that several causes of action will be claimed in a single dispute, cases cannot easily be allocated to various adjudicatory forums on the basis of cause of

action. Thus, if Congress only eliminated 1983 and implied causes of action, other causes of action might still be tried in the federal courts as contract or tort disputes based on diversity jurisdiction.

2. Based on identity of the parties. Nor can claims easily be allocated to different forums on the basis of the parties sued, because claimants will join claims against several defendants. Thus a claim that treatment has been improperly denied will be brought against the doctor who found it medically unnecessary, the Plan that supervised the doctor and conducted quality assurance, the Alliance that approved the Plan's inadequate benefits and the state that certified the derelict Alliance.⁴ Furthermore, a determination that one actor in the system is legally responsible will affect others, who may thus have standing to intervene. Finally it would seem inappropriate to require informal dispute resolution conducted by any one of the parties, for instance to require dispute resolution conducted by the Plan for claims against the Plan. (As discussed below, dispute resolution mechanisms would necessarily be conducted by a disinterested third party.)

3. Based on size of the claim. Claim size which has been used as a criteria for the allocation of disputes to small claims court, state courts, and federal courts, as well as within administrative agencies (Part A and Part B claims) such differentiation seems inappropriate where some claims Will be for injunctive relief and others will involve small amounts of money but large personal values -- RU486.

For these reasons, a unitary process should be considered for the adjudication of individual claims, that is, claims brought by persons as subscribers of Alliances, enrollees of plans and patients of providers. The system would not provide different process and forums for different parties, different causes of action or different size claims.

⁴ Presumably each would be sued for its own dereliction and not vicariously for the malfeasance of the parties it supervises.

THE SPECIFIC QUESTION: SECTION 1983 ACTIONS AND CLAIMS IN THE FEDERAL COURTS

This memorandum discusses only the extent to which § 1983 actions can and should be limited by Congress to prevent claims being tried de novo, in federal courts and constitutional limitations on the alternatives.

Assuming that the objectives are (1) to retain federal judicial control over adjudication of individual claims and (2) to avoid de novo trials in the federal courts, two questions need to be answered: first, can Congress create a federal statutory right to access and constitutionally limit its adjudication in federal courts (eliminating 1983 causes of action, etc.); and second, how can federal judicial review over state administrative, state judicial and federal administrative adjudications be assured?

A. Section 1983 causes of action.⁵

Unless expressly modified by new legislation, 42 U.S.C. § 1983 would permit individual subscribers, enrollees and patients to bring suit in the federal courts against individuals (for personal liability) who have, under color of state law, deprived them of a right secured by the laws of the United States, including the new health care reform laws. In each suit, the court would be required to determine (1) whether the defendant acted under color of state law; (2) whether the defendant could invoke good faith, qualified immunity; (3) whether the plaintiff is among the class of persons Congress meant to benefit directly by the

⁵ 42 U.S.C. § 1983 provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or any person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

legislation; and (4) whether there are sufficient standards provided in the legislation, in light of its history, to permit enforcement of the right.⁶

Not only does the section permit the recovery of damages for which offenders are personally liable, it permits the recovery of attorneys fees Civil Rights' Attorney's Fee Award Act of 1976.⁷

Private individuals as well as state public officials may be held personally liable under § 1983 so long as their actions are taken under color of state law.⁸ Actions "under color of state law" include more those that would constitute "state action" for purposes of the fourteenth amendment. Thus, the actions of private persons which do not constitute constitutionally defined state action⁹ may still be actionable under § 1983.¹⁰ Enforceable rights have been held to arise under the Hill-Burton Act,¹¹ the Medicaid Act,¹² the Education of the Handicapped Act,¹³ and the AFDC provisions of the Social Security Act.¹⁴ Section 1983 remedies have been held to be available despite adequate state remedies.¹⁵ And, exhaustion of state administrative remedies is not required

⁶ Maine v. Thiboutot, 448 U.S. 1 (1980); Wright v. Roanoke Redevelopment and Housing Authority, 479 U.S. 418 (1987) (§ 1983 action lies for violation of the Brooke Amendment to the Housing Act); Golden State Transit Corp. v. Los Angeles, 493 U.S. 103 (1989).

⁷ 42 U.S.C. 237.

⁸ Wyatt v. Cole, 112 S. Ct. 1827 (1992) (private parties enforcing pre-judgment remedies acted under color of state law)

⁹ See the test established in Blum v. Yaretsky, 457 U.S. 991, 1004-5 (1982)(state action requires a "close nexus with state law, by a person for whom the state is response

¹⁰ Lugar v. Edmondson Oil Co. 457 U.S. 922 (1982).

¹¹ Gadway v. Blum, 567 F. Supp. 772 (N.D.N.Y. 1983).

¹² Suter v. Artist M. supra.

¹³ Robinson v. Pinder-Hughes, 810 F. 2d 1270 (4th Cir. 1987).

¹⁴ Carelli v. Howser, 733 F. Supp. 271 (S.D. Ohio 1990). It has been held that the supremacy clause is not itself the source of rights enforceable through § 1983. Thus preemption alone does not require § 1983 vindication. See Golden State Transit Corp. v. City of Los Angeles, 58 U.S.L.W. 4033 (1989).

¹⁵ Monroe v. Pape, 365 U.S. 167 (1961) and see Swan v. Stoneman, 635 F.2d 97 (2d Cir. 1980).

before a § 1983 action will lie.¹⁶ Where administrative process is followed, there is debate as to whether administrative findings are conclusive in later § 1983 actions.¹⁷

The recent *Wilder* and *Suter* cases demonstrate the unpredictability of the requisite determinations. The opposite results reached in those cases can be reconciled on several basis – the change in composition of the Supreme Court, the provider/beneficiary distinction, the request for essentially monetary relief as opposed to judicial micromanagement of social services, etc. However, none provide a good basis for predicting which federal rights claimed under reform legislation could be vindicated through § 1983. Therefore, the new legislation should expressly limit its application.

It is recommended that the new legislation be predicated on the assumption that rights not expressly excluded from the operation of § 1983 be actionable under it. That is, where there is question whether individuals can bring an action under § 1983 in light of new exclusions, the presumption should be that they can.

Apart from causes of action provided by § 1983, persons claiming rights under the Constitution have an implied cause of action against federal agents under *Bivens v. Six Unknown Agents*,¹⁸ that would not be precluded by eliminating § 1983 causes of action. Presumably, Congress may not eliminate that implied cause of action completely without running into the Supreme Court's original jurisdiction, its Article III authority to exercise judicial power extending to all laws of the United States and constitutional judicial review.

¹⁶ *Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496 (1982). See also Civil Rights of Institutionalized Persons Act, 42 U.S.C. 1997e which requires administrative exhaustion in prisoner suits under the Act.) Neither is exhaustion of administrative remedies required in *Bivens* type actions.

¹⁷ See e.g. *Tennessee v. Elliott*, 474 U.S. 1004 (1986).

¹⁸ *Bivens v. Six Unknown Agents*, 403 U.S. 388 (1971) (federal officials could be sued for damages flowing from their violation of plaintiff's constitutional rights); *Davis v. Passman*, 442 U.S. 228 (1979) (congressional staff employee had an implied cause of action directly under the due process clause of the Fifth Amendment for gender discrimination); and *Halperin v. Kissinger*, 606 F. 2d 1192, 1207-08 (D.C. cir. 1979).

Thus, even if Congress exempts federal health care rights from those that may be enforced through § 1983, it may not eliminate federal judicial review (at least not in the Supreme Court) of the constitutionality of, for instance, the federal process used to adjudicate those rights elsewhere,

B. Constitutional limitations on Congressional powers to eliminate § 1983 causes of action.

There can be no question that Congress can eliminate implied causes of action to enforce new health care rights under *Cort v. Ash* precedents.¹⁹ Similarly, there would seem to be little question that Congress may also eliminate causes of action provided by § 1983. Nevertheless, some questions are presented by the due process clause, the seventh amendment, Article II and the separation of powers doctrine, if individual claimants are not provided certain alternatives.

1. Article III courts.

While Congress has power to limit the appellate jurisdiction of the Supreme Court through its power to establish inferior courts,²⁰ there is considerable debate about whether it can preclude such jurisdiction altogether, particularly where constitutional claims are made, for instance in abortion cases.²¹ Thus, an effort to preclude individuals from obtaining Supreme Court review of claims asserting constitutional rights, either by writ of certari or appellate review of state and federal court decisions, would be problematic. Furthermore, the elimination of § 1983 causes of action would not eliminate the federal courts' jurisdiction to try causes of action implied under the Constitution per *Bivens*.

¹⁹ *Cort v. Ash*, 422 U.A. 66 (1975).

²⁰ Article III, section 1.

²¹ See generally Geoffrey Stone, Louis Seidman, Cass Sunstein and Mark Tushnet, *Constitutional Law*, 65- 68, 70-75 (1986) and Ratner, *Constitutional Limitations on Congress' Authority to Regulate the Jurisdiction of the Federal Courts*, 95 Harv. L. Rev. 17 (1981) and Bator, *Congressional Power over the Jurisdiction of the Federal Courts*, 27 Villanova L. Rev. 1030 (1982).

2. Seventh amendment guarantees of trial by jury

If the new federal law were to preempt and replace state common tort law (for instance, by replacing common law provider negligence with enterprise liability or by requiring binding arbitration of some malpractice claims) and contract causes of action, the question might arise whether constitutional guarantees of trial by jury are abridged.²² Some courts have found such state laws did violate constitutional guarantees of trial by jury.²³ Constitutional challenges to the workman's compensation system on the ground that it precludes trial by jury of common law tort claims, have been unsuccessful because workers have been held to consent to a non-jury process when they accept employment.²⁴ It may be more difficult to make such an argument with regard to the compulsory purchase of health insurance which includes mandatory adjudication without juries.²⁵

3. Article II and separation of powers.

If Congress were to eliminate § 1983 causes of action and provide that individuals may submit to final arbitration claims made under the new federal law, challenges might be brought based on the argument that federal laws must be carried out by executive branch officials and such enforcement may not be delegated to non-executive branch officials such as private arbitrators. In testimony before Congress, the Office of Legal Counsel commented on proposed federal legislation that would have permitted private parties and executive

²² Thus, in *Boyd v. Bulala* state legislation capping malpractice awards was found by the District Court to violate the seventh amendment. 647 F. Supp. 781 (W.D.Va. 1986). The Fourth Circuit reversed, finding that the award of damages was not a jury function. 877 F.2d 1191 (4th Cir. 1989). See also *Tull v. United States*, 481 U.S. 412, 426, n. 9 (1987) (jury function does not extend to the remedy stage); but see *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980) (delays created by arbitration held to infringe on the right of trial by jury).

²³ See e.g. *Sofie v. Fibreboard Corp.* 771 P.2d 711 (Wash. 1989).

²⁴ See *New York Central Railroad Co., v. White*, 243 U.S. 188 (1917); *Beatty v. Akron City Hospital*, 424 N.E.2d 586 (Ohio 1981) and *Reynolds, Lockwood, Smart and Schiferi, A Constitutional Analysis of the AMA's Medical Liability Project Proposal*, 1 Courts, Health Science and the Law 58 (1990).

²⁵ See generally, Barry Furrow, Sandra Johnson, Timothy Jost, and Robert Schwartz, *Liability and Quality Issues in Health Care*, 413 - 414 (1991).

agencies to engage in voluntary binding arbitration before neutral arbitrators and avoid adjudication through an administrative ALJ process.²⁶

OLC opposed the legislation for several reasons: it was unnecessary because ALJ's already provided informal adjudication; it was unnecessary because the agency already provided expertise in the subject area of the dispute; it would not lead to the development of legal principles and precedents; and because arbitrators with powers to finally adjudicate disputes between claimants and the agency, could be viewed as officers of the united states engaged in execution of the laws, but not appointed in the manner required by the appointments clause and not accountable through the executive.²⁷ Such arguments should be further explored before a binding arbitration option is included in health care reform for the adjudication of individual claims against the federal government.

4. Due process.

Elimination of § 1983 causes of action to vindicate individual rights under new federal health care legislation would not preclude individuals from suing in the federal courts on implied causes of action under the fifth or fourteenth amendments claiming that they were deprived of their federal and/or state, constitutional, statutory or common law rights without due process of law.²⁸

In order to prevail, such claimants would have to show that they had a "positive" legal rights, i.e. ones grounded in state or federal constitutional

²⁶ Statement of William P. Barr, Assistant Attorney General, Office of Legal Counsel, Hearing Before the Subcommittee on Oversight of Government Management, Committee on Governmental Affairs, United States Senate, on S. 971, Sept. 19, 1989.

²⁷ Article II, section 2, clause 2. *Buckley v. Valeo*, 424 U.S. 1, 137 - 41(1976) (persons involved in functions necessary to ensure compliance with statutes and rules -- informal procedures, administrative determinations and hearings and civil suits, -- held officers of the United States.); *Bowsher v. Synar*, 478 U.S. 714, 733 (1986) ("interpreting law enacted by Congress to implement the legislative mandate" is a function that "plainly entails execution of the law in constitutional terms.")

²⁸ Such suits would be premised on a *Bivens* cause of action and federal question jurisdiction. See discussion at note 20 *supra*.

provisions, state or federal statutes or state common law.²⁹ Individuals asserting rights under the new legislation will claim that, like welfare and social security beneficiaries, they have statutory entitlements of which they cannot be deprived without due process. Under *Mathews v. Eldridge*, they will claim that they are entitled to due process procedures merited by the weighing of their interests, the efficacy of the procedures they invoke, against the government's interest in withholding relief and avoiding the administrative burden of the procedures.³⁰

Thus, the procedures required by the Fifth and Fourteenth Amendments due process clauses vary depending on the interests involved and the administrative burden of providing proposed procedures. Due process does not require adjudication of factual issues and federal claims de novo by Article III courts.³¹ Such determinations made by administrative agencies or Article I

²⁹ E.g. *Board of Regents v. Roth*, 408 U.S. 564 (1972); *Vitek v. Jones*, 445 U.S. 480 (1980); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (welfare beneficiaries held to have "new property" right to which they were entitled unless deprived of the right through due process of law); *Wisconsin v. Constantineau*, 400 U.S. 433 (1971) (posting of name of chronic drinker affected legal right to purchase liquor held a protected liberty interest); *Paul v. Davis*, 424 U.S. 693 (1976) (distribution by police of flyers identifying individual as known shoplifter held not a protected interest where no other interests protected by due process were implicated); *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980) (nursing home residents did not have a constitutionally protected interest to remain in the home entitled to due process procedures).

³⁰ *Mathews v. Eldridge*, 424 U.S. 319 (1976). The process that is due can be determined by weighing

first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

³¹ *Crowell v. Benson*, 285 U.S. 22 (1932) (federal Longshoremen's and Harbor Workers' Compensation Act which permitted federal agency official to make determinations of law and fact reviewable on a substantial evidence standard in the federal district court.). Cf. *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.* 458 U.S. 50 (1982) (Congress prohibited by Article III from giving jurisdiction over adjudication of private contract claims at issue to

courts have been held sufficient to meet due process requirements where judicial review by an Article III court is provided either by the terms of the organic act, the federal administrative procedure act or the Constitution.³²

While notice and the opportunity for some sort of hearing is required by due process,³³ the kind of notice, type of hearing and timing of the hearing depend on the interests involved.³⁴ Thus, each of the four administrative models proposed earlier would be subject to scrutiny under the due process clause to determine whether it provided sufficient protections for the adjudication of the interests at stake in each individual suit in which the

non-Article III bankruptcy court, distinguishing the adjudication of substantive federal rights created by Congress).

Apart from cases involving constitutional rights...there can be no doubt that the Act contemplates that, as to questions of facts, the findings of the deputy commissioner, supported by evidence and within the scope of his authority, shall be final. To hold otherwise would be to defeat the obvious purpose of the legislation to furnish a prompt, continuous, expert and inexpensive method for dealing with a class of questions of fact which are peculiarly suited to examination and determination by an administrative agency specially assigned to that task. ... The use of the administrative method for these purposes, assuming due notice, proper opportunity to be heard, and that findings are based upon evidence, falls easily within the principle of decisions sustaining similar procedure against objections under the due process clauses of the Fifth and Fourteenth Amendments.

³² For instance, in *Estep v. United States*, 327 U.S. 114 (1946) the Court decided that provisions of military draft legislation that made decisions of local draft boards "final" permitted only a narrow review of the board's jurisdiction and whether its decisions had no basis in fact (i.e. arbitrary). See § 10(b)(3) of the Military Selective Service Act of 1967. Constitutional determinations made by the Court of Military Appeals, an Article I court, are reviewable by the United States Supreme Court as a matter of due process.

³³ *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950); *Goldberg v. Kelly*, 397 U.S. 254 (1970).

³⁴ *Zinermon v. Burch*, 110 S. Ct. 975, 988 (1990) (noting that in certain circumstances post-deprivation hearing is sufficient for due process); *Ingraham v. Wright*, 430 U.S. 651 (1977) (possibility of subsequent tort suit held to sufficiently protect liberty interests of children subject to physical punishment in school); *Parratt v. Taylor*, 451 U.S. 527 (1981) (prisoner's post deprivation state tort remedies provided sufficient due process).

procedures were challenged. It can be safely said, however, that adjudication of such claims de novo in state courts, though not recommended, would meet such requirements, as would adjudication in a state or federal agency in accordance with conventional administrative adjudicative procedures.³⁵

Whether reform legislation could preclude judicial review of any kind for the determinations of arbitrators and/or administrative agencies is not clear.³⁶ If federal administrative adjudication were provided, judicial review could be invoked under § 701(a)(1) of the APA, except "to the extent that ...statutes preclude review."³⁷ Usually the courts have required more than congressional silence to indicate legislative preclusion of review.³⁸ The question of the extent to which Congress may constitutionally preclude judicial review is a complicated one.³⁹ Some have argued that as long as a claimant has some forum, for example a state court, in which to raise a claim under the federal constitution (to due process or free speech) federal due process requirements are met -- even though Congress may have withdrawn jurisdiction of the federal courts over these questions.⁴⁰ Others, contend that the constitutional right to judicial review as a

³⁵ See generally, Jerry Mashaw, *Due Process in the Administrative States* (1985) and *Bureaucratic Justice: Managing Social Security Disability Claims* 121 (1983); Koch and Koplow, *A Study of the Operation and Utility of the Social Security Administration's Appeals Council*, 1987 ACUS Reports and Recommendation 625 (1988); Searchinger, *The Procedural Due Process Approach to Administrative Discretion: The Courts' Inverted Analysis*, 95 Yale L. J. 657 (1988).

³⁶ Medicare claims below certain amounts were determined by private fiscal intermediaries, prior to 1986, without administrative or judicial review. *Schweiker v. McClure*, 456 U.S. 188 (1982). Cf. *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980), 716 F.2d (D.C. Cir. 1983) (claimants of less than \$100 entitled to oral hearing as a matter of due process)

³⁷ Until relatively recently, decisions of the Administrator of Veteran's Affairs were final and conclusive and no court of the United States had power or jurisdiction to review that decision. *Veterans Benefit Act*, 72 Stat. 1115 (1958).

³⁸ *Commonwealth of Virginia v. Marshall*, 599 F.2d 588, 593 (4th Cir. 1979); *Banzoff v. Smith*, 737 F.2d 1167 (D.C. Cir. 1984).

³⁹ See generally, Stephen Breyer and Richard Stewart, *Administrative Law and REgulatory Policy*, second edition, 1075 - 80 (1985).

⁴⁰ *Id.* citing Professor Hart.

matter of due process may turn on type of illegality asserted and the whether the right asserted is to a government benefit or freedom from government coercion.⁴¹

Provisions in the health care reform legislation for final arbitration of individual claims and final unreviewable state agency action as alternatives to § 1983 actions should be avoided because of the constitutional issues they pose and because they preclude policy formation through adjudication.

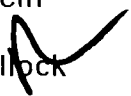
CONCLUSION

In order to afford individuals who claim federal rights under the new health care reform legislation an informal forum within which to settle disputes and to assure uniform policy formation through adjudication, this memorandum recommends that § 1983 be amended or its application be expressly precluded with regard to individual claims against persons acting under color of state law. Similarly, the new legislation should expressly preclude implied causes of action arising under the federal law against federal officials. Individuals should be permitted to invoke non-binding alternative dispute resolution mechanisms provided by contracts at the Alliance or plan level, and be given have a right to administrative review of such determinations by a state or federal agency, with judicial review in a federal court. Federal judicial review of constitutional claims of individual claimants probably cannot, and should not, be avoided.

⁴¹ Breyer and Stewart, *supra* at 1076.

STATE OF NEW YORK - DEPARTMENT OF HEALTH

INTEROFFICE MEMORANDUM

TO: Jennifer Klein
FROM: Peter J. Millock 
SUBJECT: Comments on Working Group Draft
DATE: July 13, 1993

Thank you for the opportunity to review the Working Group Draft (the Draft). It is a very cogent and persuasive document and you should be pleased that all the hard work has not been wasted.

My primary suggestion is that the section on State Responsibilities (7) be significantly expanded to include all of the powers the states retain. The Draft refers to state authority at several points, but there is no comprehensive description of what specific powers remain at the state level. For example, may a state set its own quality standards for hospitals? May a state require recredentialing of physicians and nurses? May a state add to the benefits in mandated comprehensive plan? I advocate state power, but even if that argument does not prevail, the extent of state powers should be better delineated. This also fits with the argument for explicit preemption stated in the Legal Audit Group paper.

By section, but not importance, here are the rest of my comments:

4. Benefits

The Draft (p.12) refers to hearing aids determined necessary by a "certified audiologist." Certified by whom? a state? What if a state does not certify audiologists?

The Draft (p.14) refer to medical personnel and institutions refusing to perform procedures for moral or religious reasons. Many state laws allow this but only upon some showing of the sincerity of belief (particularly for hospitals and nursing homes) and only if the provider gives prospective patients advance notice of beliefs and helps a patient transfer to another provider. Otherwise, the provider may be guilty of abandonment or dumping under state law.

The Draft (p.15) prohibits a state from imposing class practice restrictions except as justified by the skill or training of the class of professional. This prohibition should only refer to explicit state definitions of the scope of practice. Otherwise, limits imposed indirectly through, for example, a state's failure to mandate insurance coverage, may also be prohibited. If the prohibition is meant to encompass even indirect limitations, that should be made clear.

7. State Responsibilities

The Draft (p.33) limits balance billing to the allowable charge plus 10 percent. One of the greatest difficulties in federal and state enforcement of balance billing laws is the universal uncertainty about the allowable charge. The Draft will make that simpler, but it is crucial that any consumer bill clearly indicate the allowable charge, the derivation of that charge, and the balance bill sought.

8. Regional Health Alliances

The Draft (p.41) indicates that an alliance must use random selection to decide which new applicants may enroll in a plan near capacity. What happens to those applicants not enrolled? If they are enrolled in an inferior plan, do they have an equal protection argument? Similarly, do plans not chosen by alliances have some appeal right? The Draft does not include one.

10. ERISA

The Draft (p.52) allows states to impose taxes on health benefit plans if they are "non-discriminatory." A major issue in ERISA litigation in New York and elsewhere is whether Blue Cross plans are entitled to a differential (a reduction) in hospital payments. The proposal should address this question directly.

The Draft (p.54) states that plans must offer consumers the opportunity to make an advance directive or appoint a surrogate decisionmaker. The proposal should require all states to pass such laws (without precisely mandating the content of the state law). At least, in the spirit of portability, the proposal should require providers to honor directives and appointments made in other states.

16. Quality Management

The Draft (pp.81-82) refers to performance standards for plans, institutions, and practitioners. The relationship of these standards to outcome measures is unclear. The reference to morbidity and mortality conjures up images of the early discredited HHS comparison of hospital mortality rates. Since it is so difficult to identify meaningful outcome measures, it will be even more difficult to devise performance tests based on those outcomes. In addition, the performance goals for states are very vague. The implications of poor performance (e.g., rising death rates) are also unclear.

The Draft (pp.83-84) indicates that alliances and plans will prepare quality reports and comparisons for consumers. This sounds good but, particularly

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with regard to the intentionally inept alliances, seems impractical. Why aren't these comparisons standardized at the federal level from the start.

The Draft (p.84) indicates that Plans must disclose performance and quality measures. This raises at least two questions. First, is performance by individually names providers disclosed and, if so, when are disclosures made and may providers challenge the disclosure? Second, is the plan's information available upon request by consumers and, if so, by what mechanism?

The Draft (p.85) describes the data gathering process. It does not provide a mechanism and standards for private access to the data bank for research purposes.

The Draft (p.85) sketches plan obligations relating to utilization review. At the state level, providers and consumers want the right to appeal a tentative UR decision and some right to mediate a dispute with a final UR decision. These issues are not addressed in the Draft.

The Draft (p.87) suggests CLIA's personnel requirements be eliminated and its proficiency testing requirements deemphasized. New York's laboratory quality program antedates CLIA. It sets requirements for the laboratory director and stresses proficiency testing. Are New York's law and similar laws in other states preempted?

The Draft (pp.87-88) encourages the development of practice guidelines. The Draft does not indicate whether adherence to approved guidelines will be mandatory. Is this intentional? You should not follow the Maine law which makes guidelines a shield against liability for physicians who adhere but not a sword for patients of physicians who do not adhere to guidelines. I think the Maine law has equal protection problems.

18. Academic Health Centers

The Draft (p.97) authorizes Alliances to maintain quality at academic health centers. This seems like the proper role for the states and appears to contradict provisions for state authority over other providers.

19. Medical Research

The Draft (p.102) directs that outcomes research be disseminated through several publications. The Draft does not address consumer requests for unpublished information. This was at issue in the 1991 Newsday case in which the paper challenged the State's refusal to divulge provider specific data.

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20. Public Health Initiatives

The draft (p.104) implies that federal grants may go directly to localities. This is a sore point in New York where the state resents the City's direct access to federal funds (Mark will disagree, of course).

21. Information Systems

The Draft (p.111) refers to the Data Protection Panel. The powers of this body are not stated. In New York, a similar panel rules on requests by private and government entities for access to collected hospital discharge data.

22. Malpractice

The Draft is silent, but I offer one suggestion based on newspaper reports that the President will propose caps on pain and suffering. Caps deter victims' access to the courts and reduce their awards. Caps reduce premiums but do not redistribute benefits to a larger group of victims. In order to avoid a premium windfall to providers and a concomitant burden on victims, the caps should be introduced progressively as the broad benefits under the proposal are actually available to victims and others. That way, plaintiffs will at least secure their health benefits and one plaintiffs' argument against caps--pain and suffering is a cushion against underestimated medical costs--may be neutralized.

23. Antitrust Reform

The Draft (p.127) limits permissible hospital joint ventures to "high tech equipment and ancillary services." Why are joint ventures so limited? Closer cooperation in basic services is warranted under the proposal and should not be discouraged. Several state laws now allow broader joint ventures.

24. Fraud and Abuse

The Draft (p.129) requires that penalties and fines for fraud be deposited in a trust fund. In some states (e.g., New York), fines must be deposited in the state's general fund. Does the proposal intend to preempt such state laws?

The Draft (p.134) allows HHS to exclude a provider who has lost a license because of "professional competence, performance, or financial integrity." In state professional licensing laws, there is a much broader array of transgressions which justify loss of license (e.g., fraudulent practice of medicine). The proposal should not describe the predicate for exclusion too narrowly. The reverse is also true;

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exclusion for whatever reason should trigger a license action by the state against the excluded provider.

In addition, the authority to exclude should not be vested only in a federal government.

25. Long-Term Care

The Draft (p.138) refers to a consumer grievance process. Are these grievances against the provider only or may grievances be filed against the state and others?

PJM/dlm

MEMORANDUM

TO: Jennifer Kline
FROM: Margaret Farrell
RE: Legal Audit - Summary
DATE: April 27, 1993

The Clinton administration intends to submit to Congress a health care reform proposal that will provide all Americans access to basic health care services of good quality at a reasonable cost. The following is a summary of the options currently under consideration to accomplish that goal. Essentially, the health reform proposal requires all individuals and employers to purchase comprehensive private health insurance from qualified health plans through federally certified purchasing cooperatives. Low income individuals and impacted businesses would be assisted by government subsidies. Quality care would be promoted through malpractice reform as well as the collection and dissemination of information about service outcomes. This market oriented reform is expected to control prices through the operation of private market forces. To the extent that these are insufficient in the short term, or long run, to adequately contain the escalation of health care expenditures, the proposal presents several options global budget controls.

This summary is intended to provide a view of the landscape and a road map for exploring it. It necessarily omits features and options that may nevertheless be very important to the accomplishment of the reform's objectives. It is organized so that you can find materials in the accompanying notebooks that enlarge on its various sections. The first section provides an overview and sets out the public and private bodies that may carry out the new program. The second section suggests how existing health care programs could fit into the new program. The third section describes how universal access and basic services could be assured. Reform measures intended to assure that quality health care services and provided are discussed in the fourth section. Financing and cost control options are set out in the fifth section. Finally, the sixth section describes how responsibility for administration of the new program might be divided between the state and federal governments.

I. New structures.

A. Health Alliances

The proposed program would be initiated by federal legislation calling for the establishment of non-profit corporations, public corporations or government agencies that would broker the sale of health insurance. New health insurance purchasing cooperatives, called Health Alliances (Alliances) would be created and made responsible for enrolling all eligible individuals in their geographic areas in health insurance plans (Health Plans) that meet certain federal and state requirements and that offer at least federally established standard benefits.

These new Alliances would collect information from Health Plans about the coverage and services they offer and provide such information to consumers. At least once a year, Alliances would hold an "open enrollment" a period of time during which any individual could enroll in any Health Plan offered by the Alliance, without regard to their treatment history or health status. Alliances will collect premium payments from all eligible individuals and employers in their areas and purchase health insurance for them in from the Health Plans that such individuals and employers choose. Intended to aggregate purchasing power, the Alliance would bargain with each Health Plan for the lowest price package of standard benefits defined by federal law. Persons eligible to purchase health insurance through the Alliance would be given a choice among the Health Plans offered by the Alliance.

Only one Alliance would serve the residents of a given geographic area. The Alliance areas are expected to be states or parts of states, perhaps counties, containing socially, economically and ethnically diverse populations. Like the constituency they serve, the boards that govern Alliances would be composed of consumers and employers but not providers or insurers. The administrative cost of these Alliances would probably be met by a surcharge on premiums paid to them.

B. Health Plans

The new program is intended to encourage the development of organizations that integrate the provision of health insurance and health services, much as HMOs, PPOs, and IPAs do now. These organizations, called Health Plans, would have to offer at least standard benefits and meet certain legal requirements regarding such things as solvency, staffing, utilization review, accessibility, outreach, claims processing, data reporting, grievance resolution, advertising, etc. Different Health Plans in an area would be expected to compete in price, convenience and quality for the sale of the standard benefit coverage. It is expected that at least one traditional, indemnity or service benefit plan with an open panel of providers paid on a fee for service basis would be offered by the

Alliance in each area, though subscription may be discouraged by significant copayment requirements.

During open enrollment periods, any individual or employer could purchase standard coverage from any Health Plan offered by the Alliance for a community rated premium -- i.e. a premium reflecting the average cost to that Plan of providing standard benefits to all members of the community. Different Plans would have different community rated premiums. No individual could be denied coverage or be charged more for coverage because of pre-existing illness, health care history or present health status. Coverage would continue indefinitely; that is, it could not be terminated or canceled for any reason except the subscriber disenrolling and joining another Plan. Plans which have a greater portion of high risk individuals (defined by age, health status, treatment experience, income, etc) than the community at large, would be paid a higher "risk adjusted" premium by the Alliance. Plans which have fewer high risk individuals would be paid less. Plans with very high risk subscribers, such as HIV positive individuals, might receive an additional government stipend for each such enrollee. In this way, Plans would not have as great an incentive to "shop" or "skim" for low risk subscribers, as they do now, and would not be penalized if they attracted high risk enrollees.

It is expected that new federal laws governing the operation of health plans will preempt state laws governing health plans. Thus, state corporate practice laws, HMO laws, and anti-networking laws might be preempted partially or entirely, or enactment of new uniform laws in these areas might be required of the states. Similarly, antitrust, anti-fraud and abuse, state insurance and state employment laws need to be examined with regard to their effect on the new program.

C. The National Health Board.

The proposed system would be overseen by a new federal body charged with providing expert, independent, competent leadership. Such a body might be modeled on existing independent regulatory authorities, such as the SEC or Federal Reserve Board. These agencies are headed by a group of commissioners or governors appointed by the President and confirmed by the Senate, for fixed staggered terms, removable only for cause. Such a National Health Board could provide independent expert recommendations to Congress and the President on nationally uniform aspects of the proposed system, such as standard benefits, data collection, technology assessment, budget refinements, plan requirements, practice guidelines, etc. Or, it could be given rulemaking, regulatory authority in these areas.

Because this model is not well suited to the oversight of state administered programs, such as Medicaid, or large, federally operated programs, such as Social Security and Medicare, an executive agency could complement the Board

and provide operational administration. An existing executive agency might be used for this purpose, such as HCFA, modified to fulfill its new purposes, or a new agency could be created within an existing cabinet level agency or outside of one, like EPA.

D. State Flexibility.

While the objectives of universal access, quality care and reasonable cost are given, there are a number of ways that managed competition concepts can be used to achieve them. This flexibility permits the development by different states of programs addressing the significantly different conditions affecting access to health care in the fifty states. Thus, the reform proposal is intended to give states considerable latitude to adopt a health care plan that is suited to the conditions in each state. For example, states would be free to designate a single Alliance for the whole state or itself act as such an Alliance. Alternatively, a state could decide to be the single payor in a state, negotiating rates with providers as Canadian provincial governments currently do. Or, states could set rates for providers, as states such as Maryland have set all payor rates for hospitals.

It is expected that the federal legislation necessary to bring about reform will be enacted as an exercise of Congressional spending powers, so that state obligations to pay subsidies, monitor Alliances, license and regulate plans and collect and report data are exchanged for federal subsidies and funding of health related programs in each state.

II. Integration of Existing Programs.

A. National payment and insurance programs -- Medicaid and Medicare

Existing national health care programs serving special populations could be integrated into the new system in several ways. Nationwide insurance and payment programs such as Medicaid and Medicare might be incorporated through new government payment obligations. Medicaid, the state/federal assistance program that purchases health care for many (but not all) low income people may be replaced by the provision of subsidies described above. Medicare, the federal insurance program providing hospital and medical insurance to the elderly could remain separate at least until the new system is in place. After that time, elderly persons would purchase standard benefit coverage through Alliances with federally provided premium payments.

B. National service programs -- VA, DOD, FEHB, IHS.

National service programs that provide health care services directly to specified populations could be integrated into the new system by becoming qualified health plans and offering coverage to present eligibles through Alliances. Presently the Department of Defense provides health services directly

required to pay a specified percentage (say, 50 to 80%) of the cost of standard coverage for all its employees. Employees would be required to pay the remainder, (probably having payment withheld by their employer). Indeed, all individuals would be required to purchase standard health insurance coverage either as employees (sharing the cost with their employer) or as unemployed or self employed individuals.

Large exempt firms could be permitted to continue insuring or self-insuring their employees' health care benefits without purchasing through an Alliance. However, periodically, such firms would have the option of doing so (but not of opting out again). Firms that elected to join an Alliance would do so at a risk adjusted rate, to prevent large firms with high costs from opting in to take advantage of lower cost community rates. In addition to modified ERISA requirements relating to disclosure and fiduciary obligations, self insuring firms not purchasing through an Alliance would be regulated by the Labor Department or other federal agency. Such agency would assure that self insuring firms offer all employees standard benefits and are able to meet requirements for solvency, utilization management, enrollment without regard to demographic characteristics, pre-existing illness or health status, claims resolution, and reporting capability. Insurance companies that contract with large firms would have to meet the same requirements. Some worry that failure to include large firms will foster the development of a two track system in which employees of large firms have richer, cheaper benefits than others, because they are usually younger, healthier people than the community as a whole, leaving more low income and high risk people in Alliances.

In order to help individuals and employers purchase basic health insurance, the state and federal governments would provide certain financial assistance. This assistance could take two forms -- first, as described below, subsidies would be provided for low income individuals and for certain businesses, and second, favored tax treatment would be available for other individuals and businesses (with the probable exception of large self-insuring businesses). The amount of government assistance to be provided would depend on the price of the standard package of health care benefits in a given area, or "bench mark premium." The bench mark premium might be the lowest price at which any qualified Health Plan sells a standard package of benefits through the Alliance in an area or the average price for a portion of the population in that Alliance area.

Individuals and employers purchasing insurance through the Alliance will pay the Alliance an amount equal to the benchmark premium. If they choose a Plan that charges a higher premium, they will be required to pay the marginal difference to the Plan. Each Plan would be paid by the Alliance the risk adjusted bench mark premium for the number of Alliance subscribers who enroll in the Plan. Thus, it is expected that Plans will not compete for low risk individuals because the Alliance will compensate each Plan an amount reflecting

the greater or lesser number of high risk individuals who choose the Plan. Health Plans may or may not be permitted to compete by offering benefits in excess of those in the standard benefit package.

For individuals whose incomes are too high to qualify for subsidy assistance, the government could provide an indirect tax subsidy measured by the benchmark price in the relevant Alliance area. That is, all individuals would be permitted to deduct what they pay to purchase standard coverage up to the amount of the benchmark price. If the individual chose a Health Plan that offered a standard policy at a price greater than the benchmark price, the individual would pay the excess amount but would not be able to tax deduct the excess. Similarly, if an individual chose a plan that offered greater benefits at a higher price, they would not be able to deduct the additional cost.

In addition to the standard coverage they will be required to purchase through the Alliance, it is expected that individuals will be able purchase both insurance and services offered outside of the Alliance. Thus, if long term care were not part of the standard package of benefits, and were not offered as an additional benefit by any Health Plan selling through an Alliance, individuals would be able to purchase long term care insurance and services independently.

If an individual fails to enroll in a Health Plan through an Alliance and needs medical care, such a person must enroll at the point of service in accordance with state specified procedures that assure adequate compensation for providers and that will not encourage people to avoid timely mandated enrollment.

2. Low income individuals

No individual would be required to pay more than a certain percentage (say three or five percent) of his or her income to purchase standard health insurance. For an individual, the government (state and/or federal) would pay the Alliance a "subsidy" amounting to the difference between that percent of income and the benchmark premium, in order to permit the Alliance to purchase for a standard policy for that person. Depending on whether the benchmark premium is set at the premium charged by the lowest cost plan in the Alliance or an average premium charge, low income people will have a choice of health plans. Some recommend that the subsidy be based on the premium in the lowest priced plan plus a given percent (say, 20%) to assure low income individuals a choice of plans. It has been proposed that up to \$ 8 thousand dollars of annual income be exempted from the percentage cap in order to relieve the burden on the lowest income families by providing full subsidy (free health insurance) for families with less than \$8,000 annual income.

It is expected that eligibility for the subsidy will turn on earned and unearned gross family income, as those terms is defined for tax purposes, and

not on net worth. Calculations of in-kind income and net worth are among the most expensive and administratively burdensome determinations associated with some present means tested programs. It is thought that eliminating them in the new program will be cost effective, even if some individuals are "over subsidized."

3. Unemployed workers

When workers are separated from their jobs, they lose their employer's contribution to their health insurance premiums as well as their income. Under health care reform, all temporarily unemployed workers, regardless of income, would continue their health insurance coverage either through the state's unemployment compensation system or through a new federal program financed through a new payroll tax. Both systems permit unemployment health insurance to be "purchased" during employment periods either through contributions to the state system or the federal payroll tax. During unemployment, the former employer's contribution would be paid by the government, and the employee would continue to be required to pay the remainder. However, subsidies would be available for persons for whom such payments would amount to more than a given percent of their income.

The funds accumulating such payments are available in recessionary times to pay Health Plans to continue coverage of unemployed workers. That is, both a state unemployment based and national system are counter-cyclical. The state systems have experience in administering unemployment benefits. However, such a state system would make it difficult to administer a payroll deduction method of purchasing mandated coverage, discussed below. A federal system would relieve states of the administrative burden of determining eligibility for health care coverage and would redistribute wealth to states with high unemployment rates.

4. Impacted employers

No employer would be required to spend more than a certain percentage of gross payroll (perhaps seven percent) to purchase standard health insurance for its employees. The government (state and/or federal) would pay a subsidy to any employer for whom the cost of employee health insurance would be more than such percentage of payroll. The amount of the subsidy would be the difference between seven percent of the employer's payroll, (such sum to be paid by the employer), and cost of purchasing standard coverage at the benchmark price in the area.

For all other employers, a tax benefit would probably be available. Although some consideration has been given to eliminating the deduction for employer contributions all together, or limiting it with a national ceiling, it is probable that employers may be permitted to deduct their contribution for

standard coverage up to the percentage of the benchmark price they pay for all employees.

B. For Basic Services

1. The standard package of benefits.

Health care reform proceeds on the assumption that all people should have access to a comprehensive set of health services for several reasons. First, entitlement to a broad set of benefits reflects our social conscience and concern for equity. Second, many Americans have broad insurance coverage and expect it to be maintained under the new system. Third, a broad benefit package reduces the need to regulate and administer supplemental insurance. Fourth, coverage of an wide array of services permits the integration and the development of innovative approaches to service delivery. Finally, health care costs can be more effectively controlled if most services are provided through a single system of regulated competition such as the one discussed in this summary.

The basic benefits that could be included in the health care reform program include: in/outpatient hospital services, physicians care, emergency care, diagnostic and laboratory tests, preventative services, reproductive health services, substance abuse treatment, mental health services, prescription drugs, X-ray and chemotherapy, home infusion, durable medical equipment and prostheses, extended nursing care, hospice care, organ transplants, rehabilitative services (e.g. speech and occupational therapy) eye care, and dental care. It is expected that cosmetic treatment, eyeglasses, orthodontia, custodial care, private duty nurses, or investigational services will be included. Medically unnecessary services would, of course, not be covered.

Consumers would be expected to share the cost of receiving such benefits by sharing in the cost of the premium for the basic benefit package, and by paying a charge when services are received (co-payments or co-insurance), with limitations on total out of pocket expenditures. The cost sharing and deductibles charged low income individuals would be subsidized along with their premium payments. Because substantial balance billing by providers (charges in addition to those covered by insurance) would make care financially difficult or impossible for some people, it would be prohibited by Health Plans. If indemnity type, fee for services plans cannot remain solvent if they pay at a rate that most providers in the area will accept without balanced billing, they could be permitted to pay at rates mandated by the Alliance, the state or the federal government.

A broad package of basic benefits can be provided by a variety of health care professionals. The scope of services that may legally be provided by persons in different health care professions is largely determined by state

licensing and scope of practice laws. While national legislation might specify what professionals may be used to delivery basic benefits overall, the federal law ought not to replace state licensing and practice laws. Thus, national legislation could require Health Plans to provide insurance covering the services of many non-physician providers, including nurses, physician assistants, podiatrists, optometrists, chiropractors, dietitians, nutritionists, physical therapists, psychologist, clinical social workers, and other incensed mental health care professionals. It would not indicate what individual services each might perform. State licensing laws and Health Plans would make those determinations. Furthermore, Health Plans would not be prohibited from covering services lawfully provided by other health care workers.

2. Long Term Care

Long term care for poor elderly, disabled or AIDS populations could be left in a residual Medicaid program in states where it is now provided as a "waiver" service or adopted by other states. It has been proposed that states be permitted to offer different benefits to select populations and in different geographic locations and modify income and resource eligibility requirements, as long as total state expenditures for such care remain within federal requirements and a federally determined cap. It has also been recommended that present laws that permit the transfer of assets to obtain Medicaid eligibility be tightened to prohibit such transfers for five years prior to eligibility and impose stricter penalties. Finally, federal Medicare laws could be changed to encourage HMOs serving Medicare beneficiaries to provide more long term chronic care services.

A bolder long term care proposal would compliment Medicaid programs with the creation of a voluntary public insurance program under a new Medicare Part C for older individuals with moderate incomes.

3. Mental Health Services

There has been considerable debate about the extent to which mental health and substance abuse services should be included in the standard package of mandated benefits. On the one hand, when efficacious, such services are cost effective, keeping people in jobs, out of institutional care and in better physical health. On the other hand, such services can be overused and inappropriate. Health care reform would promote the appropriate use of mental health and substance abuse services by requiring plans offering such benefits to provide (1) screening by a specially training mental health professional; (2) 24 hour crisis intervention; (3) non-residential treatment (including drug, behavioral and somatic therapies) and coordinated social services ; (4) substance abuse counseling, home based treatment, partial hospitalization and day treatment programs; (5) residential and hospital inpatient services; and (6) clinical and social service case managers. These services would be provided by a variety of professional mental health workers.

Capitation and plan assumption of risk would discourage the inappropriate use of mental health services in many cases. However, capitation also creates incentives for health plans not to serve high cost, seriously mentally ill subscribers, often ineffective people without family support, encouraging them to disenroll or seek treatment in the public sector. Research needs to be done to determine how to risk adjust plan premiums to reflect enrollment of such persons in individual plans. Some have also recommended the use of a mixed payment system based on prospective capitation and retrospective cost reimbursement for mental health expenditures by plans.

4. Uncovered Services

As discussed above, all persons would be free to purchase insurance for uncovered services or uncovered services themselves outside the Alliances. Because such an uncontrolled market provides more health care to wealthier people it threatens the ethic of equity underlying the plan and it thwarts efforts to contain costs through a managed market. Thus, the standard benefit package will be made as inclusive as is fiscally possible.

C. Special Provisions to Enhance Access

1. For Underserved Populations.

Although the new system would provide universal access to basic benefits, there are vulnerable populations whose special needs must be addressed if they are actually to have access to necessary care. Currently, there are scores of federal programs providing funds directly to states and local governments (which sometimes match federal funds) to meet the special needs of mentally ill people, migrant workers, ethnic minorities, rural and low income residents in underserved areas, homeless people, children and adolescents, pregnant women and public housing residents.

One way to address the need of these populations for special health related services would be to create four new, consolidated fundings sources to gradually replace the present complex, administratively burdensome system of categorical federal assistance. A single fund could be established to provide for capital investment in physical facilities and the training and employment of needed health care workers in underserved areas, such as National Health Service Corps scholarships and loan programs. A separate funding stream would support the provision of a core set of "enabling services", such as transportation, individual case management, caregiver services, language translation, home visitors, health education, nutrition and parenting classes, mobile vans, and special child care services. These services would be provided to the greatest extent possible in conjunction with the Health Plans that provide basic benefits to these populations. Such plans could be monitored through

outcome data collection to determine whether vulnerable and low income enrollees are as well served as other enrollees. Funds for these services might be added to the funds received by Health Plans or might be provided directly by the federal government to state and local governments or providers.

2. For Community Disease and Injury Prevention Programs

The federal government has also helped fund general, population based preventive services and public health activities conducted by state, county and city governments. In the past, these programs have been chronically underfunded, fragmented and unresponsive to local needs. A third federal funding source could be established to provide a single stable source of funds (perhaps a given percentage of total health care expenditures) to lessen through prevention the need for covered services. The fund would cover such activities as public health data collection, TB prevention, detection and outreach, HIV education, seat belt enforcement programs, immunization, injury and violence prevention programs, infant mortality reduction efforts and substance abuse prevention.

3. For HIV and Certain Other Chronically Ill People.

A special funding source could be provided for persons with HIV or AIDS and others with certain chronic diseases that are also high-cost, relatively rare and require specialized medical expertise. Although like most chronically ill people, AIDS sufferers will get their medical care from the Health Plans they select, they need case management, home and institutional long term care, hospice care and respite services. In addition, AIDS victims are unevenly distributed, stigmatized, and infectious, and their illness is episodic and always fatal. For these reasons, they need special services such as legal counseling, housing assistance, nutritional support, day care for dementia and debilitation, and dental care. Alliances would be responsible for assuring coordinated quality care for these patients.

4. For Residents of Rural Communities

Rural communities present particular problems for residents seeking access to health care. Their disbursed populations do not support large investment in health care facilities and personnel, and they are often far from urban areas that do. For these reasons, some have urged that laws regulating the aggregation of capital for investment in health care facilities be relaxed as applied in rural communities. For example, it has been recommended that corporate practice laws be preempted, antitrust laws modified, and fraud and abuse laws clarified to permit needed investment in rural health care. Current barriers that discourage providers from locating and staying in rural areas also could be removed, such as restrictions on professional training sites. Training sites for physician and non-physician health care professionals could be expanded

beyond teaching hospitals to provide experience closer to that of a rural practice through consortiums of interested providers.

In addition, steps could be taken to promote the initial and continued education of practitioners for practice in rural communities, especially in mental health and long term care, and particularly for practitioners reflecting the ethnic and cultural make up of such communities. Programs for the training and education for non-professional health care workers could also be created and existing programs expanded, through loan guarantee and forgiveness programs, and the funding of education and training programs on a capitated basis.

Finally, rural state's could be permitted to adopt a single Alliance, single Health Plan system suited to providing care to scattered populations.

IV. Quality Care

The Clinton reform proposal would use four approaches to the promotion of quality health care: 1) outcome reporting and disclosure; 2) the establishment of practice guidelines and technology assessment, 3) malpractice reforms; and 4) work force improvement. An underlying premise is that these quality assuring devices should apply to all health plans and providers, not just those that operate through Alliances. Thus, large employers who do not purchase through the Alliances and providers who sell services not covered by Alliance brokered plans could not create a two-tiered system of care. Consumers would be provided with information about all providers and plans with which to make comparisons between different care arrangements.

It has been proposed that Medicare's and Medicaid's current quality assurance system based on the certification of health care facilities' compliance with federal conditions of participation should eventually be transformed into an outcome, performance-based, state licensure system meeting federal requirements. This proposal recognizes that states have the practical means and knowledge of local conditions necessary to apply quality assurance standards, but seeks to establish national outcome based standards for incorporation in state laws.

A. Data Collection, Reporting and Disclosure

A nationally uniform data collection system would be created to provide governments, consumers, providers and Alliances with information about the outcome and performance of health care services, including institutional and individual practitioner profiles. This information would be used by governments to assure that providers and plans meet applicable legal standards; by consumers to decide what Health Plan or provider to use; by providers to improve their services; and by Alliances to select and negotiate with Health

Plans. In addition, such information would be used as a basis for the development of patient care guidelines and technology assessment.

To minimize the need to generate new data, the system would build largely on patient care records, requiring providers to report certain federally specified information to their Health Plans or to the state. It is expected that the trend to computerize patient care data will continue, and that the information system will become increasingly capable of generating useful data. States would collect such information from the plans and conduct surveys of consumer satisfaction. States would also be responsible for analyzing the data and completing a report that describes plans, institutions and individual providers on federally prescribed measures. These report cards, patient service, outcome and consumer satisfaction data would be provided to the National Health Board and other federal agencies.

Such report cards and subscriber satisfaction data could be used to assure the equitable and adequate treatment of low income people. In the past, efforts have been made to include low income people in the governance of health care facilities and institutions such as health planning agencies, HMOs and hospitals so that they might protect their interest in receiving good care. Similarly, health plans providing services to Medicaid eligibles have been limited in the portion of their subscriber population that may be composed of such eligibles. These efforts have been problematic, and health care reform may place new emphasis on outcome measures rather than these process measures to assure quality care for low income people.

B. Practice Guidelines and Technology Assessment

Uncertainty about what medical practices are effective and what practices work best has contributed significantly to overall health care costs. In an effort to eliminate some of that uncertainty, it is expected that the National Board will support the development of national, non-binding, scientifically based practice guidelines and protocols for the appropriate management of health service utilization. These guidelines could be used by practitioners to improve their services and would form the basis for national performance measures for institutions and plans. In addition, the Board would seek to disseminate information on clinically ineffective uses of treatment, provide assessments of the cost and efficacy of new technologies, and set priorities for health care evaluation research.

C. Malpractice Reform

1. Alternative Dispute Resolution

State malpractice laws have been blamed for providing a much too expensive process for compensating the victims of medical negligence and for

creating incentives for the practice of costly defensive medicine. A health care reform proposal could address those deficiencies in two ways. First, less expensive, alternative dispute resolution (arbitration, mediation, settlement facilitation, etc.) could be promoted by requiring that Alliances to negotiate with Plans to make some alternative dispute resolution mechanisms available to enrollees of each Plan. Such alternatives might be mandatory or voluntary and could be made binding or non-binding (permitting judicial review).

2. Enterprise Liability

Second, Health Plans could be made legally responsible for medical injuries occasioned by affiliated providers. Because they know about the competence of their providers, the cost of care, the efficacy of treatments and the utilization of services, Plans may be the most appropriate entities to be held legally responsible for adverse events occurring within their treatment domain. Such liability would create strong incentives for Plans to use their authority over providers to require quality improvement system wide. Furthermore, Plans are in a position to weigh the cost of preventing future injuries against the cost of compensating them after they occur. Their determinations would significantly affect the practice of defensive medicine by practitioners. For these reasons, it has been proposed that only Health Plans and subsidiary institutions, such as hospitals (which can also control practice within their facilities) be solely responsible for medical negligence or adverse events. Individual practitioners would be immune from suit and Plans would be prohibited from obtaining indemnification from them. Steps would be taken to assure that state rather than federal courts retain jurisdiction over malpractice claims.

D. Work Force Reforms

Quality care can be provided by a variety of health care workers. It has been proposed that the supply of non-physician providers be increased, that consortiums for community based health education be developed to promote the education and training of health care personnel in non-academic settings, and that the training and utilization of a variety of health care personnel be increased in underserved areas and populations. (See discussion of rural communities and underserved populations).

V. Financing and cost controls

The aggregate cost of providing standard health insurance coverage for all people would be paid by individuals and private employers, the federal government and state governments. The contributions of each are discussed briefly below.

A. Federal Funds

The federal government presently pays for health insurance and health services in several ways: nationwide insurance programs, principally Medicaid and Medicare; national service programs such as the VA, DOD and CHAMPUS programs; categorical grants in aid to the states for particular purposes; federal technical assistance and regulatory programs such as the Center for Disease Control and the FDA; and "tax expenditures" i.e. foregoing the collection of taxes on income used to purchase health insurance or services through employee/employer contributions. As discussed above, all of these would be affected by the proposed reforms.

1. The subsidy - enlarged responsibilities

The subsidy to low income people would eventually replace Medicaid as a means of providing health care to the poor. It has been proposed that, as with Medicaid, the subsidy be the joint responsibility of the state and federal governments. Thus, the federal government might commit itself to pay a percentage (perhaps 50 to 80%) of the difference between say 3% of an individual's income and the benchmark premium in an area and that states would commit themselves to pay the remainder. Determinations of both employer and individual eligibility would be made by the states and would turn exclusively on personal income and payroll information. See the discussed below regarding federal action if a state terminates its participation.

The contributions of both the federal and state governments to help low income individuals and business will increase under the reform proposal because persons not now eligible for Medicaid and employers who do not now purchase health insurance for employees would become entitled to subsidies. Nevertheless, there will be some off-setting savings because uninsured persons do get some care now and these costs are often shifted by providers to private payors. Under the reform, such costs would go through the tax system rather than the private payment system.

Federal contributions to Medicaid are paid out of general revenues, collected largely through a progressive individual income tax and corporate tax system. Under the reform, funds necessary to support the federal government's replaced Medicaid obligations and its new, expanded obligation to pay subsidies could be met by an increase in these taxes or by new taxes, such as an ad velorum tax. New payroll taxes would also be possible but seemingly inappropriate for this purposes.

2. State grant in aid programs

As discussed above, the reform proposes a consolidation and simplification of present federal categorical programs into four funding streams, addressing the need for investment in facilities and enabling services in underserved areas, prevention and community public health activities and

special services to people with HIV/AIDS and some other chronic conditions. Although some of the services offered by these programs such as community health centers, and the maternal and child health program may be assumed by Health Plans under the new program, it is recognized that these funding streams will have to be continued and perhaps increased to provide meaningful access to certain populations. If additional funds are needed, they would most probably be appropriated annually out of general revenues.

3. Tax expenditures

Tax deductions allowed for the purchase of health insurance can be regarded as an indirect subsidy which results in the purchase of more insurance that people would buy if they were paying with after tax dollars. For this reason, some have argued that such tax deductions for employers and employees should be disallowed. The increase in tax revenues resulting from such an elimination is very large, estimated by some to be \$50 to 75 billion annually. Others argue that as a matter of public policy, the federal government should favor the purchase of health insurance over other goods and services and that a tax subsidy is an appropriate means of doing so. If favored tax status for contributions to the purchase of health insurance are continued as discussed above, it must be regarded as a federal contribution to the new system.

4. Medicare

It is expected that Medicare will continue as a separate federal insurance program for the elderly, financed out of payroll taxes paid into a special trust fund and general revenues, as it is now. Eventually, perhaps as Alliance enrollees age, Medicare beneficiaries would be eligible to purchase insurance through Alliances, from Health Plans that meet federal/state requirements replacing current Medicare quality assurance regulation. Payment of the benchmark premium would be made by the federal government and beneficiary on much the same basis as it is in the present program. The payroll taxes and general revenues that support the current Medicare program could be kept separate for this purpose.

5. New funding

There are three major options with regard to the funding of new federal responsibilities under health care reform. First, a single new federal tax, such as an ad valorem tax, could be enacted to pay the total costs of universal coverage, replacing the general revenues now devoted to Medicaid, categorical programs that would be affected and tax expenditures. However, it is more likely that new taxes -- additional income taxes, a payroll tax, taxes of hazardous activities such as a "sin tax" on cigarettes or a value added tax -- would be established to pay the incremental costs of the new program. Finally, a combination of new taxes could be used.

A payroll tax could be created to fund an insurance trust fund from which payments would be made to Alliances, to pay benchmark premiums in each Alliance area for all residents. Since purchasing health insurance will be mandatory for employers and employees and meant to move with employees from job to job, it is argued that financing for the purchase should be treated as what it is - a tax. If based on the Medicare and Social Security insurance model, these funds would not be available for the payment of other federal obligations, including block grants and regulatory activity such as technology assessment performed by agencies like the FDA. One advantage of a payroll system would be the administrative feasibility of including part-time workers and workers who are employed by several employers in the system, rather than collecting premiums from such workers outside their workplace. Such a tax would be a flat tax on payroll, unrelated to income but perhaps capped at certain income levels.

Alternatively, a value added or "national sales tax" might be imposed to defray the cost of providing coverage subsidies for newly eligible individuals and business, the administrative costs of moving to the new system, and the cost of categorical grant in aid programs to the states. A portion of these taxes might be dedicated exclusively for the payment of health insurance. Or, they might be added to general revenues out of which appropriations would be made for premium payments and other health funding. The imposition of "sin taxes" could be treated in much the same way.

If large firms are permitted to purchase health insurance outside Alliances or to self-insure, they might be taxed to provide funds with which to pay subsidies for sicker, unemployed, higher risk and low income people enrolled in Alliances.

B. State Funds

1. The subsidy - replacing Medicaid and programs for non-Medicaid eligible poor people.

The proposed reform is not intended to relieve state's of their historic, sometimes constitutional, obligation to provide medical care for the poor, nor to completely relieve them of their obligations under the Medicaid program. Rather, as discussed above, states would be expected to contribute to the cost of helping low income individuals and impacted businesses to purchase health insurance under managed competition. Just as Medicaid was intended to permit low income people to participate in the market for health services, managed competition reform seeks their participation in the market for health insurance. Much of the criticism of Medicaid has centered on its segregation of the poor into a separate health care system, where services can be rationed differently in accordance with available resources. Such identifiable programs are especially hard hit in recessionary times.

The proposed reform could seek to eliminate such affects by including low income people and vulnerable populations in Alliances that are required to purchase standard coverage at benchmark premiums from the plan of choice for all subscribers. However, if the benchmark premium is the lowest premium charged by any certified Health Plan in an Alliance area, low income people would have limited choice, and there is danger that benchmark plans will be perceived as poor people's plans, causing other subscribers to enroll elsewhere. Such a tendency to ward a two-tiered system of health care should be avoided.

Medicaid could be integrated into the new program as a whole or phased in over several years. One option would phase Medicaid eligible children into the new program first, with other eligible groups, the disabled and the elderly following sequentially.

2. Administrative costs

The administrative costs of the new system would be shared by the state and federal governments, with states receiving federal assistance where necessary, particularly for the cost of collecting and reporting performance data from providers and plans.

3. Public health expenditures

State and local governments presently make substantial contributions to the health care of their citizens by operating public hospitals, nursing homes, clinics and other health facilities. While persons with means are usually required to pay for care in such public facilities and Medicaid beneficiaries are reimbursed, poor people who are not eligible for Medicaid are provided much care free of charge. A few state and local programs provide Medicaid like reimbursement to private facilities that care for low income people who are not eligible for Medicaid because they are not aged, disabled or otherwise categorically qualified (i.e. the medically indigent population). When these individuals enroll in Health Plans through Alliances with the support of subsidies, these public facilities could serve more diverse populations. Like VA and DOD facilities, they could form provider groups or health plans and offer their services to the general Alliance population. However, some public institutions have very poor physical facilities and a stigma that would deter many people from enrolling in plans that use them. Special funding may be necessary to permit such public facilities to compete with other providers and plans.

State and local contributions to health care will continue to be made outside the Alliance system when these governments provide health education and training, disease screening, sanitation programs, health inspections, licensure enforcement and special services to vulnerable populations. These

activities will continue to be financed through state tax systems with some assistance from new federal funding streams replacing state grant in aid programs, discussed above.

C. Private Funds - Insurance reforms.

Unless a dedicated value added tax or payroll tax is enacted, the greatest portion of total health care costs will be borne by the private sector under health care reform. If employer contributions to health insurance are viewed as substitutes for wages, employed individuals bear the ultimate burden of paying for health insurance for themselves, their dependents and low income persons.

The market for health insurance could be regulated in three ways to assure that individuals, compelled under health care reform to purchase insurance, will be protected. First, the federal government would establish guidelines or requirements for Alliances, including requirements as to the composition of their boards, outreach, data collection and reporting, dissemination of information about plans to consumers. Second, it would set minimum standards for Health Plans that may be marketed through Alliances, including standards for board composition, open enrollment, community rating, risk adjustment, solvency, the inclusion of specialties, advertising, data collection, outreach, claims processing, utilization review, grievance procedures, and alternative dispute resolution.

State laws conflicting with the new federal standards would be preempted. Thus, it is anticipated that state corporate practice laws, HMO legislation, antitrust laws, laws prohibition fee splitting and professional network restriction would be affected. However, much state insurance regulation would remain in place, subject to the federal requirements. States may be asked to play a major role in establishing risk adjustment formulas and procedures be applied by Alliances in their states. In addition, states would continue to bear responsibility for regulating private health insurance sold outside the Alliances to large firms and individuals purchasing supplemental coverage. Finally, states would be allowed to serve as Alliances themselves or to create a single payor system in which the state assumes all underwriting risk and deal directly with providers..

D. A Global Budget

Although the fundamental premise underlying managed competition is that market forces can be used to keep prices at an acceptable level, budget controls have been proposed as a fall back measure or a temporary one, until the market is reformed and operating efficiently. A global budget could seek to control several things: (1) all health care expenditures, both public and private (made through Alliances and outside them); (2) all private expenditures made

only through Alliances, but including both benchmark premiums and other payments for higher cost plans and/or additional benefits; or (3) only benchmark premiums. Different considerations and enforcement mechanisms attach to each.

At least initially, it may be possible to control only benchmark premiums and to set targets for other budgets. That is, Congress or the National Board might set an allowable rate of increase for benchmark premiums in all Alliance areas, or a graduated allowable rate of increase over time (e.g. 8% the first year, 7% the second year, 6% the third year, etc.). Federal, state and Alliance sanctions could be used to enforce these budget caps. The federal government could withhold subsidy payments for any more than the allowable benchmark premium and prohibit tax deductions for employer and employee contributions for more than the allowable benchmark premium. In addition the federal government could put pressure on states to take steps by withholding other health funding from the state. State governments could use their authority to decertify Alliances to pressure Alliances to drive hard bargains with providers, and states could ultimately enact all payor rate systems to control provider prices that drive benchmark premiums up. Finally, Alliances could bargain hard with health plans for allowable increases. They could agree to pay only the allowable benchmark premium, leaving plans to collect the excess from subscribers or they could drop plans that are unable or unwilling to comply.

If all public and private spending were to be controlled, a national budget for health care expenditure could be established by setting allowable rates of increase for all health expenditures in each state. These state allocations would probably be made according to a Congressionally determined formula applied by the National Health Board or executive agency. They would be based on the current expenditures in states, demographic characteristics and the size of the presently insured population. States would be forced to take action to keep expenditures down within the state, using the methods described above or risk losing federal subsidies, health care funding and favorable tax treatment of health care premiums in their states. As mentioned, state set rates for providers is probably the most decisive action states could take in this regard. They could also use their regulatory authority over Alliances and insurers.

VI. State-Federal Administration Responsibilities

Administration of the new system could be divided between the state and federal governments. Those features of the program that require national uniformity would be set on the federal level, but could be implemented by the states. Those features that permit state variation could be both established and implemented by states. There are many functions that states historically have performed such as professional and institutional licensure, insurance regulation, identifying persons eligible for public assistance and public health activities upon which the new system can build.

A. Federal responsibilities

To the extent that they are not established by legislation, the National Health Board and executive agency could perform the following functions:

Set standards and state plan requirements for participating states requiring states to ensure universal access, benefits and quality care.

Review and approve state plans.

Monitor state compliance with federal regulations and state plan requirements.

Establish simplified, national, automated, secure information collection requirements for quality assessment, utilization review, claims processing, and coordination of benefits purposes.

Oversee and receive the collection of information regarding the utilization and outcome of health services from the states.

Establish voluntary practice guide lines.

Conduct and support technology assessment.

Establish procedures through which states may settle disputes with the federal agencies.

Set standards for Alliances

Set standards for Health Plans

Set standards for providers.

B. State responsibilities

States could be given responsibility for the following tasks in accordance with federal requirements:

Develop a state plan meeting federal requirements

Designate a state agency to coordinate and be ultimately responsible for administration of the program.

Designation of geographic areas to be served by each Alliance within the state.

Designate or certify Alliances that conform to federal and state requirements.

Collect and insure the confidentiality of federally designated health care data and report such data to the National

Determination which individuals and businesses are eligible for subsidies.

Monitor Alliances' compliance with applicable state and federal standards

License health care institutions and providers (eventually in accordance with federally established performance standards).

Regulate insurers and monitor Health Plans compliance with federal and state requirements.

Enforce Alliance and Plan procedures for the resolution of disputes with subscribers, providing state administrative remedies and judicial review of final agency action.

Establish and enforce procedures for the resolution of disputes between the state and Alliances and Plans, providing administrative remedies and judicial review.

C. Enforcement - federal defaults

As mentioned above, it is expected that Congress would exercise its spending authority when enacting the Clinton health plan. While Congressional authority to regulate interstate commerce is broad, it is constrained by the tenth amendment from directly requiring states to exercise state sovereign prerogatives with regard to such commerce. Thus, Congress might well enlist the participation of the states by conditioning receipt of federal subsidies, health related funding and favorable tax treatment for individuals and employees on the states' voluntarily agreeing to participate in the program. To the extent that such participation requires states to make financial commitments into the future, consideration should be given to the effect of state balanced budget provisions now part of many state constitutions.

If a state felt burdened by its responsibilities or overwhelmed by the cost of providing subsidies to low income individuals and business, it might decide to withdraw from the new program. Where a state either refuses or fails to participate in the new health care system according to federal requirements, the federal government could withdraw federal funds, take over state responsibilities and designate Alliances and apply standards directly. It could

also impose rate controls directly on individual and institutional providers in the state. Finally, the federal government could eliminate the tax favored treatment of health insurance premiums for individuals and employers who do not purchase policies through state approved Alliances to put political pressure on states to continue their participation and to increase revenues with which to pay the state share of subsidies in the state, if the federal government chooses to continue it and if maintenance of effort and other state commitments cannot be enforced.

to active military personnel and their dependents. In addition, it purchases through CHAMPUS private health care services for such personnel when they are needed. Similarly, the Department of Veterans Affairs provides health services directly to veterans with service connected disabilities and veterans with low incomes. The Federal Employees Health Benefit (FEHB) program operates much like the proposed Alliances and provides health insurance to federal workers.

One option is to let these separate national programs operate outside the new system, at least initially, to ease the transition from the present to a new managed competition system. Another would be to integrate beneficiaries and public providers into the new system as enrollees and qualified health plans. Providers (doctors, hospitals, health care professionals) working for each agency could form Special Health Plans that would offer standard coverage through the Alliances to individuals (military personnel, veterans, Indians, etc.) who are eligible to receive services from such sponsors. These Special Health Plans would compete with other Health Plans for the premiums of such eligible. Eligible individuals could enroll in a Special Health Plan or any other Plan offered by the Alliance. Beneficiaries would continue to be entitled to services or coverage not included in the standard package of benefits but presently offered by the relevant agency. Such services would be funded outside the new program.

The FEHB program could operate on a regional basis in areas with sufficient federal workers to support a separate Alliance for them. Alternatively, the FEHB program could be treated as a large employer operating outside an Alliance, possibly incorporating other federal populations such as CHAMPUS eligibles.

Finally, the Indian Health Service (IHS) provides health care and environmental health services more inclusive than the standard package of benefits to native American. IHS could affiliate with area Health Plans as a provider, or IHS could become a Special Health Plan for native Americans, like the Veterans plan described above. Uncovered services would continue to be offered by IHS under separate a federal budget.

III. Universal Access

A. For All People

1. Employed individuals

With the exception of large firms (perhaps those with at least 1,000 employees) all employers with more than a minimum number of employees would be required to help purchase standard health insurance benefits for their full time employees and their dependents. That is, each employer would be

SUMMARY OUTLINE

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FEDERAL JUDICIAL CENTER

TRANSMISSION OF FACSIMILE DOCUMENT

RESEARCH DIVISION

TO: Jennifer Kline

Health Policy Task Force FAX # (202) 456-7739

FROM: Margaret Farrelly

PHONE: (202) 273-4070 FAX: (202) 273-4021

DATE: 3/19/93 SUBJECT: Legal Audit

PAGES TO FOLLOW: 4

MESSAGE OR SPECIAL INSTRUCTIONS:

MEMORANDUM

TO: Jennifer Kline
FROM: Margaret Farrell
RE: Legal Audit
DATE: April 19, 1993

I was thinking over the weekend about plans for the legal audit and have the following suggestions:

1. If the auditors are not familiar with the thinking behind managed competition and a global budget approach, I would include the Enthoven and Starr and Zelman articles from Health Affairs for background reading. Perhaps there are other good background pieces.

2. Next I would give them, if they do not already have one, a clear statement of the several purposes of the audit -- I assume there are several. For instance, such a statement might say:

We are asking you to do this audit so that we may have your thoughts on whether the proposed new laws will be effective in bringing about the consequences intended, whether they are internally consistent and whether they can be improved.

More specifically, we would like to know:

whether the legal implementation of the reforms might bring about difference consequences than those expected because they can be evaded

whether we need to repeal or modify other laws in order for the reforms to work

how the reforms would affect behavior outside of the health care area

whether the proposed reforms raise any constitutional issues regarding use of Congress's enumerated powers to regulate interstate commerce, spend funds for the general welfare, and to enact legislation necessary and proper to the carrying out of its enumerated powers, tenth amendment issues; any issues regarding due process, equal protection or the taking clause, or any other constitutional questions you might see.

whether the proposed reforms conflict with existing federal or state laws that should be expressly addressed, such as tax laws, antitrust laws, insurance laws, HMO legislation, CON laws, malpractice and product liability laws, etc. *corp. practice of medicine laws*

Memorandum to Jennifer Kline re Legal Audit
From Professor Farrell,

April 19, 1993

*This is
spiritually
predicted* [whether, as a consequence of its legal form, the proposal would have different consequences than those intended. For instance, if the reform includes an elimination of malpractice liability for providers, providers might be asked by HMOs to assume such liability through contract as a condition of employment, unless that question is expressly addressed.

Whether there are more effective legal measures than the ones proposed that might be used to accomplish the reforms goals

whether the administrative structures proposed have been properly conceived to carry out the functions they will be assigned.

whether the allocation of responsibilities to the states and the federal government creates unanticipated legal problems.

3. The materials should also provide a summary of the overall proposal (10 pages) in as concrete a form as is possible at this stage of the process.

4. An outline of the summary should be prepared and a notebook of materials provided under the topics in the outline. Most of the materials would be drawn from the tollgate papers of groups concerned with different topics. Not all tollgate papers would be included, and not all topics would have materials provided. There may also be good materials on some subjects that we could find where the tollgate papers are weak (for instance tax exemptions). Thus, if the outline were divided into the traditional policy areas of access, cost and quality, it might look something like this:

I. New structures

- A. A National Health Board
- B. Health Insurance Purchasing Cooperatives (HIPCs)
- C. Federal and state agencies
- D. Health plans

II. Integration of existing programs

- A. Medicaid
- B. Medicare
- C. Veterans programs
- D. CHAMPUS — Defense
- E. FEHBA — IHS
- D. State grant in aid programs

III. Universal access to care

A. For all people

1. Employees/Employers
2. Unemployed
3. Low income people
4. Aliens

B. For basic services

Memorandum to Jennifer Klinc re Legal Audit
From Professor Farrell,

April 19, 1993

1. The standard benefit package
2. Long term care
3. Mental health services
4. Other included services
5. The purchase of uncovered services

C. Special provisions to enhance access for special groups

1. Rural communities
2. The underserved
3. Children
4. The disabled

IV. Quality care

- A. Data collection
- B. Malpractice and tort reform
- C. Professional/work force reforms
- D. Technological assessment

V. Financing and cost controls

A. Federal funds

1. The subsidy for low income people and marginal businesses
2. Categorical payments - state grant in aid programs
3. Tax expenditures
4. Medicare
5. Other programs

B. State funds

1. The subsidy for low income people and marginal businesses
2. Administrative costs
3. Public health expenditures

C. Private funds

1. Employer contributions
2. Insurance reforms.

D. A global budget -- state and federal enforcement

V. State - federal administrative responsibilities

VI. Development

- A. New system development
- B. Interim cost containment
- C. Phasing in the program

We might provide summaries of the tollgate papers in those sections where full presentations are not necessary.

Memorandum to Jennifer Kline re Legal Audit
From Professor Farrell,

April 19,1993

5. A last section of the materials for auditors could suggest several methods of analysis that they might want to consider in their review. For instance, one can analyze each legal change with regard to the purpose it is intended to accomplish. Or, one can conceive of the various legal relationships involved -- subscriber/ HIPC; subscriber/plan; subscriber/provider; subscriber/government; HIPC/plan; HIPC/provider, etc. -- and think about how those relationships are affected by the reforms. What private rights of action will be reforms retain, create, eliminate? Finally, one can think about various sources of law -- constitutions, federal statutes, state statutes and common law -- and how they affect each of the behaviors to be governed by the new reforms. For instance, how are provider pricing, provider treatment decisions and patient selection affected by each of these? We would need to give this more thought if it is to be useful.

Let me know what you think of these suggestions and what it would be helpful to do next.

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

**FEDERAL JUDICIAL CENTER**

TRANSMISSION OF FACSIMILE DOCUMENT

RESEARCH DIVISION

[001]

TO: Jennifer KlineHealth Care Task ForceFAX # (202) 456-7739FROM: Margaret FarvellPHONE: (202) 273-4070FAX: (202) 273-4021DATE: 4/22/93SUBJECT: Legal AuditPAGES TO FOLLOW: 25

MESSAGE OR SPECIAL INSTRUCTIONS:

I couldn't get in the building Sunday, so this is unfinished. I would like to come in tonight at 6:00 (b)(6) and wrap it up. Let me know what you think about the attached draft.

MEMORANDUM

DRAFT

TO: Jennifer Kline
FROM: Margaret Farrell
RE: Legal Audit - Summary
DATE: April 25, 1993

The Clinton administration intends to submit to Congress a health care reform proposal that will provide all Americans access to basic health care services of good quality at a reasonable cost. The following is a summary of the options currently under consideration to accomplish that goal. Essentially, the health reform proposal requires all individuals and employers to purchase comprehensive private health insurance from qualified health plans through federally certified purchasing cooperatives. Low income individuals and impacted businesses would be assisted by government subsidies. Quality care would be promoted through malpractice reform as well as the collection and dissemination of information about service outcomes. This market oriented reform is expected to control prices through the operation of private market forces. To the extent that these are insufficient in the short term, or long run, to adequately contain the escalation of health care expenditures, the proposal presents several options global budget controls.

This summary is intended to provide a view of the landscape and a road map for exploring it. It necessarily omits features and options that may nevertheless be very important to the accomplishment of the reform's objectives. It is organized so that you can find materials in the accompanying notebooks that enlarge on its various sections. The first section provides an overview and sets out the public and private bodies that may carry out the new program. The second section suggests how existing health care programs could fit into the new program. The third section describes how universal access and basic services could be assured. Reform measures intended to assure that quality health care services and provided are discussed in the fourth section. Financing and cost control options are set out in the fifth section. Finally, the sixth section describes how responsibility for administration of the new program might be divided between the state and federal governments and how the new system could be developed.

I. New structures.

A. Health Alliances

The proposed program would be initiated by federal legislation calling for the establishment of non-profit corporations, public corporations or government agencies that would broker the sale of health insurance. New health insurance purchasing cooperatives, called Health Alliances (Alliances) would be created and made responsible for enrolling all eligible individuals in their geographic areas in health insurance plans (Health Plans) that meet certain federal and state requirements and that offer at least federally established standard benefits.

These new Alliances would collect information from Health Plans about the coverage and services they offer and provide such information to consumers. At least once a year, Alliances would hold an "open enrollment" a period of time during which any individual could enroll in any Health Plan offered by the Alliance, without regard to their treatment history or health status. Alliances will collect premium payments from all eligible individuals and employers in their areas and purchase health insurance for them in from the Health Plans that such individuals and employers choose. Intended to aggregate purchasing power, the Alliance would bargain with each Health Plan for the lowest price package of standard benefits defined by federal law. Persons eligible to purchase health insurance through the Alliance would be given a choice among the Health Plans offered by the Alliance.

Only one Alliance would serve the residents of a given geographic area. The Alliance areas are expected to be states or parts of states, perhaps counties, containing socially, economically and ethnically diverse populations. Like the constituency they serve, the boards that govern Alliances would be composed of consumers and employers but not providers or insurers. ~~The administrative cost of these Alliances would probably be met by a surcharge on premiums paid to them.~~

B. Health Plans

~~The new program is intended to encourage the development of organizations that integrate the provision of health insurance and health services, much as HMOs, PPOs, and IPAs do now.~~ These organizations, called Health Plans, would have to offer at least standard benefits and meet certain legal requirements regarding such things as solvency, staffing, utilization review, accessibility, outreach, claims processing, data reporting, grievance resolution, advertising, etc. Different Health Plans in an area would be expected to compete in price, convenience and quality for the sale of the standard benefit coverage. It is expected that at least one traditional, indemnity or service benefit plan with an open panel of providers paid on a fee for service basis would be offered by the

Alliance in each area, though subscription may be discouraged by significant copayment requirements.

During open enrollment periods, any individual or employer could purchase standard coverage from any Health Plan offered by the Alliance for a community rated premium -- i.e. a premium reflecting the average cost to that Plan of providing standard benefits to all members of the community. Different Plans would have different community rated premiums. No individual could be denied coverage or be charged more for coverage because of pre-existing illness, health care history or present health status. Coverage would continue indefinitely; that is, it could not be terminated or canceled for any reason except the subscriber disenrolling and joining another Plan. Plans which have a greater portion of high risk individuals (defined by age, health status, treatment experience, income, etc) than the community at large, would be paid a higher "risk adjusted" premium by the Alliance. Plans which have fewer high risk individuals would be paid less. Plans with very high risk subscribers, such as HIV positive individuals, might receive an additional government stipend for each such enrollee. In this way, Plans would not have as great an incentive to "shop" or "skim" for low risk subscribers, as they do now, and would not be penalized if they attracted high risk enrollees.

It is expected that new federal laws governing the operation of health plans will preempt state laws governing health plans. Thus, state corporate practice laws, HMO laws, and anti-networking laws might be preempted partially or entirely, or enactment of new uniform laws in these areas might be required of the states. Similarly, antitrust, anti-fraud and abuse, state insurance and state employment laws need to be examined with regard to their effect on the new program.

C. The National Health Board.

The proposed system would be overseen by a new federal body charged with providing expert, independent, competent leadership. Such a body might be modeled on existing independent regulatory authorities, such as the SEC or Federal Reserve Board. These agencies are headed by a group of commissioners or governors appointed by the President and confirmed by the Senate, for fixed staggered terms, removable only for cause. Such a National Health Board could provide independent expert recommendations to Congress and the President on nationally uniform aspects of the proposed system, such as standard benefits, data collection, technology assessment, budget refinements, plan requirements, practice guidelines, etc. Or, it could be given rulemaking, regulatory authority in these areas.

Because this model is not well suited to the oversight of state administered programs, such as Medicaid, or large, federally operated programs, such as Social Security and Medicare, an executive agency could complement the Board

and provide operational administration. An existing executive agency might be used for this purpose, such as HCFA, modified to fulfill its new purposes, or a new agency could be created within an existing cabinet level agency or outside of one, like EPA.

D. State Flexibility.

While the objectives of universal access, quality care and reasonable cost are given, there are a number of ways that managed competition concepts can be used to achieve them. This flexibility permits the development by different states of programs addressing the significantly different conditions affecting access to health care in the fifty states. Thus, the reform proposal is intended to give states considerable latitude to adopt a health care plan that is suited to the conditions in each state. For example, states would be free to designate a single Alliance for the whole state or itself act as such an Alliance. Alternatively, a state could decide to be the single payor in a state, negotiating rates with providers as Canadian provincial governments currently do. Or, states could set rates for providers, as states such as Maryland have set all payor rates for hospitals.

It is expected that the federal legislation necessary to bring about reform will be enacted as an exercise of Congressional spending powers, so that state obligations to pay subsidies, monitor Alliances, license and regulate plans and collect and report data are exchanged for federal subsidies and funding of health related programs in each state.

II. Integration of Existing Programs.

A. National payment and insurance programs -- Medicaid and Medicare

Existing national health care programs serving special populations could be integrated into the new system in several ways. Nationwide insurance and payment programs such as Medicaid and Medicare might be incorporated through new government payment obligations. Medicaid, the state/federal assistance program that purchases health care for many (but not all) low income people may be replaced by the provision of subsidies described above. Medicare, the federal insurance program providing hospital and medical insurance to the elderly could remain separate at least until the new system is in place. After that time, elderly persons would purchase standard benefit coverage through Alliances with federally provided premium payments.

B. National service programs -- VA, DOD, FEHB, IHS.

National service programs that provide health care services directly to specified populations could be integrated into the new system by becoming qualified health plans and offering coverage to present eligibles through Alliances. Presently the Department of Defense provides health services directly

to active military personnel and their dependents. In addition, it purchases through CHAMPUS private health care services for such personnel when they are needed. Similarly, the Department of Veterans Affairs provides health services directly to veterans with service connected disabilities and veterans with low incomes. The Federal Employees Health Benefit (FEHB) program operates much like the proposed Alliances and provides health insurance to federal workers.

One option is to let these separate national programs operate outside the new system, at least initially, to ease the transition from the present to a new managed competition system. Another would be to integrate beneficiaries and public providers into the new system as enrollees and qualified health plans. Providers (doctors, hospitals, health care professionals) working for each agency could form Special Health Plans that would offer standard coverage through the Alliances to individuals (military personnel, veterans, Indians, etc.) who are eligible to receive services from such sponsors. These Special Health Plans would compete with other Health Plans for the premiums of such eligibles. Eligible individuals could enroll in a Special Health Plan or any other Plan offered by the Alliance. Beneficiaries would continue to be entitled to services or coverage not included in the standard package of benefits but presently offered by the relevant agency. Such services would be funded outside the new program.

The FEHB program could operate on a regional basis in areas with sufficient federal workers to support a separate Alliance for them. Alternatively, the FEHB program could be treated as a large employer operating outside an Alliance, possibly incorporating other federal populations such as CHAMPUS eligibles.

Finally, the Indian Health Service (IHS) provides health care and environmental health services more inclusive than the standard package of benefits to native American. IHS could affiliate with area Health Plans as a provider, or IHS could become a Special Health Plan for native Americans, like the Veterans plan described above. Uncovered services would continue to be offered by IHS under separate a federal budget.

III. Universal Access

A. For All People

1. Employed individuals

With the exception of large firms (perhaps those with at least 1,000 employees) all employers with more than a minimum number of employees would be required to help purchase standard health insurance benefits for their full time employees and their dependents. That is, each employer would be

required to pay a specified percentage (say, 50 to 80%) of the cost of standard coverage for all its employees. Employees would be required to pay the remainder, (probably having payment withheld by their employer). Indeed, all individuals would be required to purchase standard health insurance coverage either as employees (sharing the cost with their employer) or as unemployed or self employed individuals.

Large exempt firms could be permitted to continue insuring or self-insuring their employees' health care benefits without purchasing through an Alliance. However, periodically, such firms would have the option of doing so (but not of opting out again). Firms that elected to join an Alliance would do so at a risk adjusted rate, to prevent large firms with high costs from opting in to take advantage of lower cost community rates. In addition to modified ERISA requirements relating to disclosure and fiduciary obligations, self insuring firms not purchasing through an Alliance would be regulated by the Labor Department or other federal agency. Such agency would assure that self insuring firms offer all employees standard benefits and are able to meet requirements for solvency, utilization management, enrollment without regard to demographic characteristics, pre-existing illness or health status, claims resolution, and reporting capability. Insurance companies that contract with large firms would have to meet the same requirements. Some worry that failure to include large firms will foster the development of a two track system in which employees of large firms have richer, cheaper benefits than others, because they are usually younger, healthier people than the community as a whole, leaving more low income and high risk people in Alliances.

In order to help individuals and employers purchase basic health insurance, the state and federal governments would provide certain financial assistance. This assistance could take two forms -- first, as described below, subsidies would be provided for low income individuals and for certain businesses, and second, favored tax treatment would be available for other individuals and businesses (with the probable exception of large self-insuring businesses). The amount of government assistance to be provided would depend on the price of the standard package of health care benefits in a given area, or "bench mark premium." The bench mark premium might be the lowest price at which any qualified Health Plan sells a standard package of benefits through the Alliance in an area or the average price for a portion of the population in that Alliance area.

Individuals and employers purchasing insurance through the Alliance will pay the Alliance an amount equal to the benchmark premium. If they choose a Plan that charges a higher premium, they will be required to pay the marginal difference to the Plan. Each Plan would be paid by the Alliance the risk adjusted bench mark premium for the number of Alliance subscribers who enroll in the Plan. Thus, it is expected that Plans will not compete for low risk individuals because the Alliance will compensate each Plan an amount reflecting

the greater or lesser number of high risk individuals who choose the Plan. Health Plans may or may not be permitted to compete by offering benefits in excess of those in the standard benefit package.

For individuals whose incomes are too high to qualify for subsidy assistance, the government could provide an indirect tax subsidy measured by the benchmark price in the relevant Alliance area. That is, all individuals would be permitted to deduct what they pay to purchase standard coverage up to the amount of the benchmark price. If the individual chose a Health Plan that offered a standard policy at a price greater than the benchmark price, the individual would pay the excess amount but would not be able to tax deduct the excess. Similarly, if an individual chose a plan that offered greater benefits at a higher price, they would not be able to deduct the additional cost.

In addition to the standard coverage they will be required to purchase through the Alliance, it is expected that individuals will be able purchase both insurance and services offered outside of the Alliance. Thus, if long term care were not part of the standard package of benefits, and were not offered as an additional benefit by any Health Plan selling through an Alliance, individuals would be able to purchase long term care insurance and services independently.

If an individual fails to enroll in a Health Plan through an Alliance and needs medical care, such a person must enroll at the point of service in accordance with state specified procedures that assure adequate compensation for providers and that will not encourage people to avoid timely mandated enrollment.

2. Low income individuals

No individual would be required to pay more than a certain percentage (say three or five percent) of his or her income to purchase standard health insurance. For an individual, the government (state and/or federal) would pay the Alliance a "subsidy" amounting to the difference between that percent of income and the benchmark premium, in order to permit the Alliance to purchase for a standard policy for that person. Depending on whether the benchmark premium is set at the premium charged by the lowest cost plan in the Alliance or an average premium charge, low income people will have a choice of health plans. Some recommend that the subsidy be based on the premium in the lowest priced plan plus a given percent (say, 20%) to assure low income individuals a choice of plans. It has been proposed that up to \$ 8 thousand dollars of annual income be exempted from the percentage cap in order to relieve the burden on the lowest income families by providing full subsidy (free health insurance) for families with less than \$8,000 annual income.

It is expected that eligibility for the subsidy will turn on earned and unearned gross family income, as those terms is defined for tax purposes, and

not on net worth. Calculations of in-kind income and net worth are among the most expensive and administratively burdensome determinations associated with some present means tested programs. It is thought that eliminating them in the new program will be cost effective, even if some individuals are "over subsidized."

3. Unemployed workers

When workers are separated from their jobs, they lose their employer's contribution to their health insurance premiums as well as their income. Under health care reform, all temporarily unemployed workers, regardless of income, would continue their health insurance coverage either through the state's unemployment compensation system or through a new federal program financed through a new payroll tax. Both systems permit unemployment health insurance to be "purchased" during employment periods either through contributions to the state system or the federal payroll tax. During unemployment, the former employer's contribution would be paid by the government, and the employee would continue to be required to pay the remainder. However, subsidies would be available for persons for whom such payments would amount to more than a given percent of their income.

The funds accumulating such payments are available in recessionary times to pay Health Plans to continue coverage of unemployed workers. That is, both a state unemployment based and national system are counter-cyclical. The state systems have experience in administering unemployment benefits. However, such a state system would make it difficult to administer a payroll deduction method of purchasing mandated coverage, discussed below. A federal system would relieve states of the administrative burden of determining eligibility for health care coverage and would redistribute wealth to states with high unemployment rates.

4. Impacted employers

No employer would be required to spend more than a certain percentage of gross payroll (perhaps seven percent) to purchase standard health insurance for its employees. The government (state and/or federal) would pay a subsidy to any employer for whom the cost of employee health insurance would be more than such percentage of payroll. The amount of the subsidy would be the difference between seven percent of the employer's payroll, (such sum to be paid by the employer), and cost of purchasing standard coverage at the benchmark price in the area.

For all other employers, a tax benefit would probably be available. Although some consideration has been given to eliminating the deduction for employer contributions all together, or limiting it with a national ceiling, it is probable that employers may be permitted to deduct their contribution for

standard coverage up to the percentage of the benchmark price they pay for all employees.

B. For Basic Services

1. The standard package of benefits.

Health care reform proceeds on the assumption that all people should have access to a comprehensive set of health services for several reasons. First, entitlement to a broad set of benefits reflects our social conscience and concern for equity. Second, many Americans have broad insurance coverage and expect it to be maintained under the new system. Third, a broad benefit package reduces the need to regulate and administer supplemental insurance. Fourth, coverage of an wide array of services permits the integration and the development of innovative approaches to service delivery. Finally, health care costs can be more effectively controlled if most services are provided through a single system of regulated competition such as the one discussed in this summary.

The basic benefits that could be included in the health care reform program include: in/outpatient hospital services, physicians care, emergency care, diagnostic and laboratory tests, preventative services, reproductive health services, substance abuse treatment, mental health services, prescription drugs, X-ray and chemotherapy, home infusion, durable medical equipment and prostheses, extended nursing care, hospice care, organ transplants, rehabilitative services (e.g. speech and occupational therapy) eye care, and dental care. It is expected that cosmetic treatment, eyeglasses, orthodontia, custodial care, private duty nurses, or investigational services will be included. ~~Medically unnecessary services would, of course, not be covered.~~

Consumers would be expected to share the cost of receiving such benefits by sharing in the cost of the premium for the basic benefit package, and by paying a charge when services are received (co-payments or co-insurance), with limitations on total out of pocket expenditures. The cost sharing and deductibles charged low income individuals would be subsidized along with their premium payments. Because substantial balance billing by providers (charges in addition to those covered by insurance) would make care financially difficult or impossible for some people, it would be prohibited by Health Plans. If indemnity type, fee for services plans cannot remain solvent if they pay at a rate that most providers in the area will accept without balanced billing, they could be permitted to pay at rates mandated by the Alliance, the state or the federal government.

A broad package of basic benefits can be provided by a variety of health care professionals. The scope of services that may legally be provided by persons in different health care professions is largely determined by state

licensing and scope of practice laws. While national legislation might specify what professionals may be used to delivery basic benefits overall, the federal law ought not to replace state licensing and practice laws. Thus, national legislation could require Health Plans to provide insurance covering the services of many non-physician providers, including nurses, physician assistants, podiatrists, optometrists, chiropractors, dietitians, nutritionists, physical therapists, psychologist, clinical social workers, and other incensed mental health care professionals. It would not indicate what individual services each might perform. State licensing laws and Health Plans would make those determinations. Furthermore, Health Plans would not be prohibited from covering services lawfully provided by other health care workers.

2. Long Term Care

3. Mental Health Services

4. Uncovered Services

C. Special Provisions to Enhance Access

1. For Underserved Populations.

Although the new system would provide universal access to basic benefits, there are vulnerable populations whose special needs must be addressed if they are actually to have access to necessary care. Currently, there are scores of federal programs providing funds directly to states and local governments (which sometimes match federal funds) to meet the special needs of mentally ill people, migrant workers, ethnic minorities, rural and low income residents in underserved areas, homeless people, children and adolescents, pregnant women and public housing residents.

One way to address the need of these populations for special health related services would be to create four new, consolidated fundings sources to gradually replace the present complex, administratively burdensome system of categorical federal assistance. A single fund could be established to provide for capital investment in physical facilities and the training and employment of needed health care workers in underserved areas, such as National Health Service Corps scholarships and loan programs. A separate funding stream would support the provision of a core set of "enabling services", such as transportation, individual case management, caregiver services, language translation, home visitors, health education, nutrition and parenting classes, mobile vans, and special child care services. These services would be provided to the greatest extent possible in conjunction with the Health Plans that provide basic benefits to these populations. Such plans could be monitored through outcome data collection to determine whether vulnerable and low income enrollees are as well served as other enrollees. Funds for these services might be

added to the funds received by Health Plans or might be provided directly by the federal government to state and local governments or providers.

2. For Community Disease and Injury Prevention Programs

The federal government has also helped fund general, population based preventive services and public health activities conducted by state, county and city governments. In the past, these programs have been chronically underfunded, fragmented and unresponsive to local needs. A third federal funding source could be established to provide a single stable source of funds (perhaps a given percentage of total health care expenditures) to lessen through prevention the need for covered services. The fund would cover such activities as public health data collection, TB prevention, detection and outreach, HIV education, seat belt enforcement programs, immunization, injury and violence prevention programs, infant mortality reduction efforts and substance abuse prevention.

3. For HIV and Certain Other Chronically Ill People.

A special funding source could be provided for persons with HIV or AIDS and others with certain chronic diseases that are also high-cost, relatively rare and require specialized medical expertise. Although like most chronically ill people, AIDS sufferers will get their medical care from the Health Plans they select, they need case management, home and institutional long term care, hospice care and respite services. In addition, AIDS victims are unevenly distributed, stigmatized, and infectious, and their illness is episodic and always fatal. For these reasons, they need special services such as legal counseling, housing assistance, nutritional support, day care for dementia and debilitation, and dental care. Alliances would be responsible for assuring coordinated quality care for these patients.

4. For Residents of Rural Communities

Rural communities present particular problems for residents seeking access to health care. Their disbursed populations do not support large investment in health care facilities and personnel, and they are often far from urban areas that do. For these reasons, some have urged that laws regulating the aggregation of capital for investment in health care facilities be relaxed as applied in rural communities. For example, it has been recommended that corporate practice laws be preempted, antitrust laws modified, and fraud and abuse laws clarified to permit needed investment in rural health care. Current barriers that discourage providers from locating and staying in rural areas also could be removed, such as restrictions on professional training sites. Training sites for physician and non-physician health care professionals could be expanded beyond teaching hospitals to provide experience closer to that of a rural practice through consortiums of interested providers.

In addition, steps could be taken to promote the initial and continued education of practitioners for practice in rural communities, especially in mental health and long term care, and particularly for practitioners reflecting the ethnic and cultural make up of such communities. Programs for the training and education for non-professional health care workers could also be created and existing programs expanded, through loan guarantee and forgiveness programs, and the funding of education and training programs on a capitated basis.

Finally, rural state's could be permitted to adopt a single Alliance, single Health Plan system suited to providing care to scattered populations.

IV. Quality Care

The Clinton reform proposal would use four approaches to the promotion of quality health care: 1) outcome reporting and disclosure; 2) the establishment of practice guidelines and technology assessment, 3) malpractice reforms; and 4) work force improvement. An underlying premise is that these quality assuring devices should apply to all health plans and providers, not just those that operate through Alliances. Thus, large employers who do not purchase through the Alliances and providers who sell services not covered by Alliance brokered plans could not create a two-tiered system of care. Consumers would be provided with information about all providers and plans with which to make comparisons between different care arrangements.

It has been proposed that Medicare's and Medicaid's current quality assurance system based on the certification of health care facilities' compliance with federal conditions of participation should eventually be transformed into an outcome, performance-based, state licensure system meeting federal requirements. This proposal recognizes that states have the practical means and knowledge of local conditions necessary to apply qualify assurance standards, but seeks to establish national outcome based standards for incorporation in state laws.

A. Data Collection, Reporting and Disclosure

A nationally uniform data collection system would be created to provide governments, consumers, providers and Alliances with information about the outcome and performance of health care services, including institutional and individual practitioner profiles. This information would be used by governments to assure that providers and plans meet applicable legal standards; by consumers to decide what Health Plan or provider to use; by providers to improve their services; and by Alliances to select and negotiate with Health Plans. In addition, such information would be used as a basis for the development of patient care guidelines and technology assessment.

To minimize the need to generate new data, the system would build largely on patient care records, requiring providers to report certain federally specified information to their Health Plans or to the state. It is expected that the trend to computerize patient care data will continue, and that the information system will become increasingly capable of generating useful data. States would collect such information from the plans and conduct surveys of consumer satisfaction. States would also be responsible for analyzing the data and completing a report that describes plans, institutions and individual providers on federally prescribed measures. These report cards, patient service, outcome and consumer satisfaction data would be provided to the National Health Board and other federal agencies.

Such report cards and subscriber satisfaction data could be used to assure the equitable and adequate treatment of low income people. In the past, efforts have been made to include low income people in the governance of health care facilities and institutions such as health planning agencies, HMOs and hospitals so that they might protect their interest in receiving good care. Similarly, health plans providing services to Medicaid eligibles have been limited in the portion of their subscriber population that may be composed of such eligibles. These efforts have been problematic, and health care reform may place new emphasis on outcome measures rather than these process measures to assure quality care for low income people.

B. Practice Guidelines and Technology Assessment

Uncertainty about what medical practices are effective and what practices work best has contributed significantly to overall health care costs. In an effort to eliminate some of that uncertainty, it is expected that the National Board will support the development of national, non-binding, scientifically based practice guidelines and protocols for the appropriate management of health service utilization. These guidelines could be used by practitioners to improve their services and would form the basis for national performance measures for institutions and plans. In addition, the Board would seek to disseminate information on clinically ineffective uses of treatment, provide assessments of the cost and efficacy of new technologies, and set priorities for health care evaluation research.

C. Malpractice Reform

1. Alternative Dispute Resolution

State malpractice laws have been blamed for providing a much too expensive process for compensating the victims of medical negligence and for creating incentives for the practice of costly defensive medicine. A health care reform proposal could address those deficiencies in two ways. First, less expensive, alternative dispute resolution (arbitration, mediation, settlement

facilitation, etc.) could be promoted by requiring that Alliances to negotiate with Plans to make some alternative dispute resolution mechanisms available to enrollees of each Plan. Such alternatives might be mandatory or voluntary and could be made binding or non-binding (thus permitting judicial review).

2. Enterprise Liability

Second, Health Plans could be made legally responsible for medical injuries occasioned by affiliated providers. Because they know about the competence of their providers, the cost of care, the efficacy of treatments and the utilization of services, Plans may be the most appropriate entities to be held legally responsible for adverse events occurring within their treatment domain. Such liability would create strong incentives for Plans to use their authority over providers to require quality improvement system wide. Furthermore, Plans are in a position to weigh the cost of preventing future injuries against the cost of compensating them after they occur. Their determinations would significantly affect the practice of defensive medicine by practitioners. For these reasons, it has been proposed that only Health Plans and subsidiary institutions, such as hospitals (which can also control practice within their facilities) be solely responsible for medical negligence or adverse events. Individual practitioners would be immune from suit and Plans would be prohibited from obtaining indemnification from them. Steps would be taken to assure that state rather than federal courts retain jurisdiction over malpractice claims.

D. Work Force Reforms

IV. Financing and cost controls

The aggregate cost of providing standard health insurance coverage erage for all people would be paid by individuals and private employers, the federal government and state governments. The contributions of each are discussed briefly below.

A. Federal Funds

The federal government presently pays for health insurance and health services in several ways: nationwide insurance programs, principally Medicaid and Medicare; national service programs such the VA, DOD and CHAMPUS programs; categorical grants in aid to the states for particular purposes; federal technical assistance and regulatory programs such as the Center for Disease Control and the FDA; and "tax expenditures" i.e. foregoing the collection of taxes on income used to purchase health insurance or services through employee/employer contributions. As discussed above, all of these would be affected by the proposed reforms.

1. The subsidy - enlarged responsibilities

The subsidy to low income people would eventually replace Medicaid as a means of providing health care to the poor. It has been proposed that, as with Medicaid, the subsidy be the joint responsibility of the state and federal governments. Thus, the federal government might commit itself to pay a percentage (perhaps 50 to 80%) of the difference between say 3% of an individual's income and the benchmark premium in an area and that states would commit themselves to pay the remainder. Determinations of both employer and individual eligibility would be made by the states and would turn exclusively on personal income and payroll information. See the discussed below regarding federal action if a state terminates its participation.

The contributions of both the federal and state governments to help low income individuals and business will increase under the reform proposal because persons not now eligible for Medicaid and employers who do not now purchase health insurance for employees would become entitled to subsidies. Nevertheless, there will be some off-setting savings because uninsured persons do get some care now and these costs are often shifted by providers to private payors. Under the reform, such costs would go through the tax system rather than the private payment system.

Federal contributions to Medicaid are paid out of general revenues, collected largely through a progressive individual income tax and corporate tax system. Under the reform, funds necessary to support the federal government's replaced Medicaid obligations and its new, expanded obligation to pay subsidies could be met by an increase in these taxes or by new taxes, such as an ad velorum tax. New payroll taxes would also be possible but seemingly inappropriate for this purposes.

2. State grant in aid programs

As discussed above, the reform proposes a consolidation and simplification of present federal categorical programs into four funding streams, addressing the need for investment in facilities and enabling services in underserved areas, prevention and community public health activities and special services to people with HIV/AIDS and some other chronic conditions. Although some of the services offered by these programs such as community health centers, and the maternal and child health program may be assumed by Health Plans under the new program, it is recognized that these fundings streams will have to be continued and perhaps increased to provide meaningful assess to certain populations. If additional funds are needed, they would most probably be appropriated annually out of general revenues.

3. Tax expenditures

Tax deductions allowed for the purchase of health insurance can be regarded as an indirect subsidy which results in the purchase of more insurance that people would buy if they were paying with after tax dollars. For this reason, some have argued that such tax deductions for employers and employees should be disallowed. The increase in tax revenues resulting from such an elimination is very large, estimated by some to be \$50 to 75 billion annually. Others argue that as a matter of public policy, the federal government should favor the purchase of health insurance over other goods and services and that a tax subsidy is an appropriate means of doing so. If favored tax status for contributions to the purchase of health insurance are continued as discussed above, it must be regarded as a federal contribution to the new system.

4. Medicare

It is expected that Medicare will continue as a separate federal insurance program for the elderly, financed out of payroll taxes paid into a special trust fund and general revenues, as it is now. Eventually, perhaps as Alliance enrollees age, Medicare beneficiaries would be eligible to purchase insurance through Alliances, from Health Plans that meet federal/state requirements replacing current Medicare quality assurance regulation. Payment of the benchmark premium would be made by the federal government and beneficiary on much the same basis as it is in the present program. The payroll taxes and general revenues that support the current Medicare program could be kept separate for this purpose.

5. New funding

There are three major options with regard to the funding of new federal responsibilities under health care reform. A single new federal tax, such as an ad velorum tax, could be enacted to pay the total costs of universal coverage, replacing the general revenues now devoted to Medicaid, categorical programs that would be affected and tax expenditures. However, it is more likely that new taxes -- additional income taxes, a payroll tax, taxes of hazardous activities such as a sin tax on cigarettes or a value added tax -- would be established to pay the incremental costs of the new program. Finally, a combination of new taxes could be used.

A payroll tax could be created to fund an insurance trust fund from which payments would be made to Alliances, to pay benchmark premiums in each Alliance area for all residents. Since purchasing health insurance will be mandatory for employers and employees and meant to move with employees from job to job, it is argued that financing for the purchase should be treated as what it is - a tax. If based on the Medicare and Social Security insurance model, these funds would not be available for the payment of other federal obligations, including block grants and regulatory activity such as technology assessment

performed by agencies like the FDA. One advantage of a payroll system would be the administrative feasibility of including part-time workers and workers who are employed by several employers in the system, rather than collecting premiums from such workers outside their workplace. Such a tax would be a flat tax on payroll, unrelated to income but perhaps capped at certain income levels.

Alternatively, a value added or "national sales tax" might be imposed to defray the cost of providing coverage subsidies for newly eligible individuals and business and the administrative costs of moving to the new system, as well as the cost of categorical grant in aid programs to the states. These taxes might be dedicated exclusively for the payment of health insurance or might be added to general revenues out of which appropriations would be made for premium payments and other health funding. The imposition of "sin taxes" could be treated in much the same way.

If large firms are permitted to purchase health insurance outside Alliances or to self-insure, they might be taxed to provide funds with which to pay subsidies for sicker, unemployed, higher risk and low income people enrolled in Alliances.

B. State Funds

1. The subsidy - replacing Medicaid and programs for non-Medicaid eligible poor people.

The proposed reform is not intended to relieve state's of their historic, sometimes constitutional, obligation to provide medical care for the poor, nor to completely relieve them of their obligations under the Medicaid program. Rather, as discussed above, states would be expected to contribute to the cost of helping low income individuals and impacted businesses to purchase health insurance under managed competition. Just as Medicaid was intended to permit the low income people to participate in the market for health services, managed competition reform seeks their participation in the market for health insurance. Much of the criticism of Medicaid has centered on its segregation of the poor into a separate health care system, where services can be rationed differently in accordance with available resources. Such identifiable programs are especially hard hit in recessionary times.

The proposed reform could seek to eliminate such affects by including low income people and vulnerable populations in Alliances that are required to purchase standard coverage at benchmark premiums from the plan of choice for all subscribers. However, if the benchmark premium is the lowest premium charged by any certified Health Plan in an Alliance area, low income people would have limited choice, and there is danger that benchmark plans will be perceived as poor people's plans, causing other subscribers to enroll elsewhere. Such a tendency to ward a two-tiered system of health care should be avoided.

Medicaid could be integrated into the new program as a whole or phased in over several years. One option would phase Medicaid eligible children into the new program first, with other eligible groups, the disabled and the elderly following sequentially.

2. Administrative costs

The administrative costs of the new system would be shared by the state and federal governments, with states receiving federal assistance where necessary, particularly for the cost of collecting and reporting performance data from providers and plans.

3. Public health expenditures

State and local governments presently make substantial contributions to the health care of their citizens by operating public hospitals, nursing homes, clinics and other health facilities. While persons with means are usually required to pay for care in such public facilities and Medicaid beneficiaries are reimbursed, poor people who are not eligible for Medicaid are provided much care free of charge. A few state and local programs provide Medicaid like reimbursement to private facilities that care for low income people who are not eligible for Medicaid because they are not aged, disabled or otherwise categorically qualified (i.e. the medically indigent population). When these individuals enroll in Health Plans through Alliances with the support of subsidies, these public facilities could serve more diverse populations. Like VA and DOD facilities, they could form provider groups or health plans and offer their services to the general Alliance population. However, some public institutions have very poor physical facilities and a stigma that would deter many people from enrolling in plans that use them. Special funding may be necessary to permit such public facilities to compete with other providers and plans.

State and local contributions to health care will continue to be made outside the Alliance system when these governments provide health education and training, disease screening, sanitation programs, health inspections, licensure enforcement and special services to vulnerable populations. These activities will continue to be financed through state tax systems with some assistance from new federal funding streams replacing state grant in aid programs, discussed above.

C. Private Funds - Insurance reforms.

Unless a dedicated value added tax or payroll tax is enacted, the greatest portion of total health care costs will be borne by the private sector under health care reform. If employer contributions to health insurance are

viewed as substitutes for wages, employed individuals bear the ultimate burden of paying for health insurance for themselves, ~~their dependents and low income~~ persons.

The market for health insurance could be regulated in three ways to assure that individuals, compelled under health care reform to purchase insurance, will be protected. First, the federal government would establish guidelines or requirements for Alliances, including requirements as to the composition of their boards, outreach, data collection and reporting, dissemination of information about plans to consumers. Second, it would set minimum standards for Health Plans that may be marketed through Alliances, including standards for board composition, open enrollment, community rating, risk adjustment, solvency, the inclusion of specialties, advertising, data collection, outreach, claims processing, utilization review, grievance procedures, and alternative dispute resolution.

State laws conflicting with the new federal standards would be preempted. Thus, it is anticipated that state corporate practice laws, HMO legislation, antitrust laws, laws prohibition fee splitting and professional network restriction would be affected. However, much state insurance regulation would remain in place, subject to the federal requirements. States may be asked to play a major role in establishing risk adjustment formulas and procedures be applied by Alliances in their states. In addition, states would continue to bear responsibility for regulating private health insurance sold outside the Alliances to large firms and individuals purchasing supplemental coverage. Finally, states would be allowed to serve as Alliances themselves or to create a single payor system in which the state assumes all underwriting risk and deal directly with providers..

D. A Global Budget

Although the fundamental premise underlying managed competition is that market forces can be used to keep prices at an acceptable level, budget controls have been proposed as a fall back measure or a temporary one, until the market is reformed and operating efficiently. A global budget could seek to control several things: (1) all health care expenditures, both public and all private expenditures made through Alliances and outside them; (2) all private expenditures made only through Alliances, but including both benchmark premiums and other payments for higher cost plans and additional benefits; or (3) only benchmark premiums. Different considerations and enforcement mechanisms attach to each.

At least initially, it may be possible to control only benchmark premiums and to set targets for other budgets. That is, Congress or the National Board might set an allowable rate of increase for benchmark premiums in all Alliance areas, or a graduated allowable rate of increase over time (e.g. 8% the first year,

7% the second year, 6% the third year, etc.). Federal, state and Alliance sanctions could be used to enforce these budget caps. The federal government could withhold subsidy payments for any more than the allowable benchmark premium and prohibit tax deductions for employer and employee contributions for more than the allowable benchmark premium. In addition the federal government could put pressure on states to take steps by withholding other health funding from the state. State governments could use their authority to decertify Alliances to pressure Alliances to drive hard bargains with providers, and states could ultimately enact all payor rate systems to control provider prices that drive benchmark premiums up. Finally, Alliances could bargain hard with health plans for allowable increases. They could agree to pay only the allowable benchmark premium, leaving plans to collect the excess from subscribers or they could drop plans that are unable or unwilling to comply. 7

If efforts were made to control all public and private spending, a national budget for health care expenditure could be established by setting allowable rates of increase for all health expenditures in each state. These state allocations would probably be made according to a Congressionally determined formula applied by the National Health Board or executive agency. They would be based on the current expenditures in states, demographic characteristics and the size of the presently insured population. States would be forced to take action to keep expenditures down within the state, using the methods described above or risk losing federal subsidies, health care funding and favorable tax treatment of health care premiums in their states. As mentioned, state set rates for providers is probably the most decisive action states could take in this regard. They could also use their regulatory authority over Alliances and insurers.

V. State-Federal Administration Responsibilities

Administration of the new system could be divided between the state and federal governments. Those features of the program that require national uniformity would be set on the federal level, but could be implemented by the states. Those features that permit state variation could be both established and implemented by states. There are many functions that states historically have performed such as professional and institutional licensure, insurance regulation and public health activities that the new system can build upon.

A. Federal responsibilities

To the extent that they are not established by legislation the National Health Board and executive agency could perform the following functions:

Set uniform standards for the collection of health data.

Set standards and state plan requirements for participating states requiring states to ensure universal access, benefits and quality care.

Review and approve state plans.

Monitor state compliance with federal regulations and state plans.

Oversee and receive the collection of information regarding the utilization and outcome of health services from the states.

Establish voluntary practice guide lines.

Conduct and support technology assessment.

Establish procedures through which states may settle disputes with the federal agencies.

Set standards for Alliances

Set standards for Health Plans

Set standards for providers.

B. State responsibilities

States could be given responsibility for the following tasks in accordance with federal requirements:

Develop a state plan meeting federal requirements

Designate a state agency to coordinate and be ultimately responsible for administration of the program.

Designation of geographic areas to be served by each Alliance within the state.

Designate or certify Alliances that conform to federal and state requirements.

Collect and insure the confidentiality of federally designated health care data and report such data to the National

Determination which individuals and businesses are eligible for subsidies.

Monitor Alliances' compliance with applicable state and federal standards

License health care institutions and providers (eventually in accordance with federally established performance standards).

Regulate insurers and monitor Health Plans compliance with federal and state requirements.

Enforce Alliance and Plan procedures for the resolution of disputes with subscribers, providing state administrative remedies and judicial review of final agency action.

Establish and enforce procedures for the resolution of disputes between the state and Alliances and Plans, providing administrative remedies and judicial review.

C. Enforcement - federal defaults

As mentioned above, it is expected that Congress would exercise its spending authority when enacting the Clinton health plan. While Congressional authority to regulate interstate commerce is broad, it is constrained by the tenth amendment from directly requiring states to exercise state sovereign prerogatives with regard to such commerce. Thus, Congress might well enlist the participation of the states by conditioning receipt of federal subsidies, health related funding and favorable tax treatment for individuals and employees on the states' voluntarily agreeing to participate in the program. To the extent that such participation requires states to make financial commitments into the future, consideration should be given to the effect of state balanced budget provisions now part of many state constitutions.

If a state felt burdened by its responsibilities or overwhelmed by the cost of providing subsidies to low income individuals and business, it might decide to withdraw from the new program. Where a state either refuses or fails to participate in the new health care system according to federal requirements, the federal government could withdraw federal funds, take over state responsibilities and designate Alliances and apply standards directly. It could also impose rate controls directly on individual and institutional providers in the state. Finally, the federal government could eliminate the tax favored treatment of health insurance premiums for individuals and employers who do not purchase policies through state approved Alliances to put political pressure on states to continue their participation and to increase revenues with which to pay the state share of subsidies in the state, if the federal government chooses to continue it and if maintenance of effort and other state commitments cannot be enforced.

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