MAINSTREAM COALITION PROPOSED AGREEMENT JUNE 24, 1994

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6/24/94
8:00 a.m.

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I. COVERAGE

A. Expanded Tax Deductibility

The health insurance deduction for self-employed persons is extended permanently and phased in to cover 100% of the cost of qualified health plans.

A medical expense deduction for health insurance premiums for individuals is added and phased in to permit the deduction of 100% of the taxpayer's cost for a qualified health plan.

B. Low Income Assistance

Low-income individuals will receive subsidies to purchase health insurance. By 1997, individuals and families with incomes below 90% of the federal poverty level (who are not eligible for Medicaid) will receive a subsidy to purchase health care insurance through accountable health plans.

By 2002 the subsidy will be phased-in for those with incomes up to 240% of poverty. At 100%, the subsidy covers the full premium, up to the "applicable dollar limit". Federal assistance phases out at 240% of poverty.

Federal Subsidies for low-income families and individuals will be based on the standard benefit package. For individuals and families with incomes above 200% of the federal poverty level, subsidies could be used for the purchase of the standard benefit package, or the basic benefit package.

C. Mechanism to Assure Full Coverage

The Health Commission will report to Congress every 2 years on the demographics of the uninsured, and its findings on why those individuals are uninsured.

In the event 95% of all Americans do not have health insurance by 2002, the

The package will be reported to Congress. Any legislation resulting from the package must be considered within a limited time period and will be fully amendable on the floor.

Commission will develop a package of recommendations to Congress designed to reach universal coverage.

~~At the end of six months, if Congress fails to act on the Health Commission recommendations or defeats their recommendations without enacting an alternative, a requirement that individuals have insurance coverage is automatically imposed and can be satisfied by coverage under either a standard package or a basic package.~~

~~Those residing in Health Care Coverage Areas where coverage is at or above 95% will be exempt from this requirement.~~

II. EXPANDED ACCESS TO HEALTH COVERAGE

A. Insurance Market Reforms and Standards for Accountable Health Plans

The Secretary shall, in consultation with private expert entities, develop standards for health plans within six months of enactment. Whenever a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or health plan sponsor.

States will enforce the standards set forth in this Act pursuant to regulations issued by the Secretary.

These requirements apply to all certified health plans. Special rules regarding the application of these requirements to large employers and the self-insured are in the sections relating to employers.

- Guarantee availability throughout the entire HCCA in which the plan is offered;
- Guarantee eligibility to all applicants;
- Guarantee renewal to all enrollees, except in instances of non-payment of premiums, fraud or misrepresentation, or relocation outside the area.
- No denial, limitation, or condition of coverage based on health status, claims experience, or medical history during the annual open enrollment period.

- Individuals enrolling in a plan for the first time or after a long gap in coverage may be subject to a pre-existing condition limitation of no more than six months.

- Comply with all rating requirements, including age adjustment and family class, established within the coverage area. Special rules apply to large employers not eligible for the HCCA pool.

- Comply with open enrollment process established by the state and establish enrollment processes consistent with the requirements of this act;

- Comply with financial solvency requirements, premium and collection criteria.

- Participate in a risk adjustment program designed by the Secretary and administered by the states, in accordance with the factors and rules set forth in this act; States may apply for a waiver from the Secretary to establish alternative risk adjustment mechanisms;

- Collect and provide standardized data collection and reporting requirements, and comply with confidentiality standards;

- Establish dispute resolution processes in accordance with this act;

- Provide written information to all enrollees regarding a patient's right to
self-determination in health care services;

- Meet requirements for designated underserved areas.

The following state laws relating to health plans are preempted.

- State laws that have the effect of prohibiting or restricting plans from.

  - limiting the number and type of providers who participate in the plan;
  - requiring enrollees to obtain health services from participating providers;
  - requiring enrollees to obtain referral for treatment by a specialist

or health institution;
- establishing different payment rates for participating providers;
- creating incentives to encourage the use of participating providers;

- State corporate practice acts;

- State mandated benefit acts.

B. Other Qualified Health Plans

Employer Sponsored and Group Health Plans

Employer-sponsored health plans (risk-bearing) and group health plans (a combination of risk-bearing and commercial insurance) must meet the same insurance reform requirements as other accountable health plans, including no pre-existing conditions, open enrollment, guaranteed issue, guaranteed renewal, etc. They must offer the standard and basic benefit packages. They also must meet solvency requirements for risk-bearing plans that will be developed by the Department of Labor.

Qualified Association Health Plans

The bill grandfathers existing association health plans that have been in existence for three years prior to the date of enactment. These include trade and professional associations, religious organizations, public entity associations, and Chambers of Commerce. Association health plans must meet solvency requirements developed by DOL and take all comers in their designated association. Otherwise, all qualified health plan insurance reform requirements apply.

"Qualified Association Plans" must be organized and maintained in good faith, with appropriate by-laws that specifically state the purpose, as a trade association, industry association, professional association, Chamber of Commerce, a religious organization, or a public entity association and that the entity has been established and maintained for substantial purposes other than to provide the health care required under this section; and the sponsoring entity is and has been in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years and receives the active support of its membership.

Any arrangement that, as of June 1, 1994, has been in effect for not less than 18 months and with respect to which there is pending application with the State insurance commissioner for a certificate of operation as a health plan, shall be treated for purposes of this subtitle as a qualified health plan (if such a plan otherwise meets standards under this subtitle) unless the State can demonstrate that –

(1) fraudulent or material misrepresentations have been made in the application which are hazardous to the State;

(2) a disqualification of the sponsor of the applicant entity has occurred;

(3) the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

(4) a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

Rural Cooperatives and Multi-Employer Plans (Taft-Hartley)

Existing Rural Cooperatives must meet the same rules as qualified association plans. They must meet solvency requirements developed by DOL and take all comers in their cooperative. Otherwise, all accountable health plan insurance reform requirements apply.

Multi-Employer (Taft-Hartley) plans must meet the same rules as large employers. They must meet the same insurance reform requirements as other health plans, including no pre-existing condition, open enrollment, guaranteed issue, guaranteed renewal, portability, etc. They also must offer the standard benefit package. They also must meet solvency requirements for risk-bearing plans that will be developed by the Department of Labor.

C State Responsibilities

Within one year of the promulgation of this act, states must carry out the following responsibilities:

establish the HCCAs, including interstate HCCAs, consistent with the requirements of this act; states may submit waiver applications,

according to HHS criteria, in the drawing of boundaries for HCCAs.

provide procedures for the establishment and operation of individual and small business purchasing groups, rules governing sales by agents or direct sales of health plans, rules for the annual open enrollment period, and other oversight responsibilities;

oversee standardization of information about health plan performance consistent with the requirements of this act;

implement a ~~establish a~~ risk adjustment program developed by the federal government to ensure the ~~fair~~ allocation of risks among health plans operating with each coverage area;

certify that health plans comply with the requirements of this act, and provide monitoring of health plan standards;

establish (monitor) dispute resolution processes consistent with the health plan standards.

The bill divides employers into two classes, based on employer size.

Small Employers: 100 full-time employees or less. May purchase an accountable health plan at the adjusted community rate through either independent brokers or insurance agents, cooperatives or private, non-profit purchasing groups or public enrollment sights.

Large Employer Group Purchasers: More than 100 full-time employees. Large employer group purchasers may offer either accountable health plans for which the employer negotiates the rate (experience-rated), employer-sponsored health plans (risk-bearing plan) or a combination of the two as a group health plan. Large employers may group together to negotiate and purchase accountable health plans or to offer employer-sponsored plans. Large employers are not part of the community-rated pool.

All employers must provide their employees with information regarding their health plan options. If the employee requests, employers must enroll them in their choice of health plan and deduct the amount of the premium from wages, minus any employer contribution. Employers are neither required, nor precluded from contributing to the cost of employee health coverage.

Nondiscrimination provisions that apply to all employers:

Employers cannot discriminate in the provision of health insurance to either full- or part-time employees based on their eligibility for low-income subsidies.

Employers who contribute to the purchase of any full-time employee's health insurance must make an equal contribution on behalf of all full-time employees. Employers who contribute to the purchase of any part-time employee's health insurance must make the same dollar contribution for all part-time employees.

A full-time employee is defined as an individual who is employed for 30 or more hours per week. A part-time employee is defined as an individual who is employed for at least 10 but less than 30 hours per week.

For purposes of the nondiscrimination rules, an individual does not qualify as a full-time or part-time employee if the individual is a seasonal employee and/or until the individual has been employed for six months.

An employer who contributes to the purchase of an employee's health insurance must make the same dollar contribution regardless of the health plan chosen by the employee.

Accomodation for collectively-bargained plans will be considered.

~~In order to prevent employers from "dumping" employees into the community-rated pool, employers must offer—but not pay for—health coverage for all full-time employees, part-time employees, and pre-medicare retirees. Large employers are also prohibited from creating subsidiaries or otherwise segmenting their workforce based on health status, health risk, or anticipated need of health care services.~~

Small employers will pay any qualified health plan selected by the employee an amount equal to the contribution they would make on the employee's behalf to the employer-selected health plan. A point of service option plan will be offered in the small group market if available. Large employers must offer their employees (including part-time and seasonal workers) a choice of at least three health plans—one of which is a point of service option plan, if available in the area. Employers may meet

additional provisions on rural working group should be expected.

Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas

Physicians practicing in rural, frontier, or underserved urban areas are allowed a tax credit equal to $1,000 a month, up to a total of $36,000. Nurse practitioners and physician assistants would also be eligible for a similar credit equal to $500 per month.

Loan repayments under the National Health Service Corps Loan Repayment Program are excluded from taxable income.

The cost of medical equipment, limited to $32,500 annually, used by a physician in a rural health professional shortage area can be immediately expensed.

Interest, up to $5,000 annually, paid on education loans of a physician, registered nurse, nurse practitioner, or physician's assistant is allowed as an itemized deduction if the individual agrees to practice in a rural community.

Development of Networks of Care in Rural and Frontier Areas

The HHS Secretary is authorized to waive certain Medicare and Medicaid requirements for demonstration projects to operate rural health networks. Public and private entities may apply for such waivers. The Secretary may award grants to assist organizations in rural networks planning;

The Secretary will conduct a study on the benefits of developing a supplemental benefit package and making available premiums that will improve access to health services in rural areas.

Rural and Frontier Emergency Care

A rural emergency medical services program is established to improve emergency medical services (EMS) operating in rural and frontier communities.

Rural community hospitals meeting eligibility criteria may qualify as Rural Emergency Access Community Hospitals (REACHs). This program will permit existing rural community hospitals participating in the Medicare program to maintain their current status if they meet standards of eligibility

as a rural emergency access facility. Current special reimbursement to small rural Medicare-dependent hospitals enacted in Omnibus Budget Reconciliation Act of 1989 will be extended.

H. Long Term Care

Tax Provisions

Expenditures for qualified long-term care (QLTC) services are deductible as medical expenses. Such services include diagnostic, preventive, therapeutic, rehabilitative, maintenance and personal care. Provision of such services must be contingent upon certification of impairment in three or more activities of daily living by a licensed health care practitioner.

Employer provided long-term care coverage which meets certain consumer protection standards promulgated by the NAIC, is excluded from an employee's taxable income. Premiums paid by an individual for qualified long-term care are deductible as a medical expense;

NAIC is directed to promulgate standards for the use of uniform language and definitions in long-term care insurance policies, with permissible variations to take into account differences in state licensing requirements for long-term care providers.

A structure will be provided for home and community-based care.

Accelerated Death Benefits

Clarifies the income tax treatment of accelerated death benefits paid to terminally ill persons. Payments made under a qualified terminal illness rider can be received tax-free as if they were paid after the insured's death.

III. FISCAL RESPONSIBILITY

A. Financing (Estimated Over 5 years; $ in Billions)

Medicare Savings (must be increased to accomodate for decrease in tobacco tax	~~$54~~
Medicaid Savings	$55.8
Postal Service Retirement	$13.0
SUBTOTAL SPENDING REDUCTIONS	$154.7

Revenues	
High Cost Plan Premium Assessment	$30.0
Tobacco Tax (5¢ increase)	~~$86.0~~
HI State/Local	$ 7.6
SUBTOTAL REVENUES	$131.1
TOTAL FINANCING	$245.8

B. Fail-Safe Mechanism

A current baseline for federal health expenditures (CBO projected Medicare and Medicaid and tax spending) is established in the bill.

Under this act, it is anticipated overall federal health spending will decrease. However, in order to guarantee the act will not lead to deficit spending, a second baseline, called the health care reform baseline, is created. This second baseline includes existing and new spending.

In any year that the Director of OMB notifies Congress that health care reform spending, Medicare, Medicaid, Low-Income Vouchers, and Tax Spending will exceed the federal health expenditure baseline, the following automatic actions will occur to prevent deficit spending:

1. the voucher phase-in is delayed
2. the assessment on high cost insurance plans is ~~implemented~~ increased
3. the expanded tax deduction phase-in is slowed down
4. out-of-pocket limits in the standard and basic benefit packages are increased
5. starting in the year 2004, a tax cap is placed on supplemental benefits provided to employees and contributed to by employers.

Congress may act on alternative recommendations by the Health Commission to avoid the actions listed above.

IV. COST CONTAINMENT & CONSUMER PROTECTION

A. Benefits Package

The Commission will establish two benefit packages based on the categories of

benefits listed below.

1. A standard benefit package the value of which can not exceed the actuarial value equivalent of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

2. A basic benefit package which will contain higher cost sharing and/or fewer benefits. This package must be designed to prevent adverse risk selection when combined with the risk adjustments called for in the bill.

Provision will be included which will require individuals to show they can pay cost-sharing

Congressional priorities: within the constraints of the actuarial limits, Congress directs the Commission to adhere to the following priorities.

a) parity for mental health and substance abuse services (parity to be defined), which shall consist of a broad array of mental health and rehabilitation services managed to ensure access to medically necessary and psychologically necessary treatment and encourage the use of outpatient treatments to the greatest extent feasible.

b) consideration for needs of children and vulnerable populations, including rural and underserved persons.

c) improving the health of Americans through prevention.

Categories of Benefits:

Inpatient and outpatient care
Emergency, including appropriate transport services
Clinical preventive services, including services for high risk populations, immunizations, tests or clinician visits
Mental Illness and Substance Abuse
Family planning and services for pregnant women
Prescription drugs and biologicals
Hospice Care
Home health care
Outpatient laboratory, radiology and diagnostic
Outpatient rehabilitation services
Vision care, hearing aids and dental care for individuals under 22 years of age
Investigational treatments

For each package, the Commission will develop recommendations to clarify covered benefits; establish multiple cost sharing schedules that vary depending on the delivery system; and develop interim coverage decisions in limited circumstances. In making these determinations, the Commission will consult with expert groups for appropriate schedules for covered services. The Commission will have the authority to propose modifications to the benefits package that would not go into effect unless approved by Congress under base-closing procedures.

A qualified health plan shall provide for coverage of the categories of benefits described in this section for treatment and diagnostic procedures that are medically necessary or appropriate.

B. High Cost Plan Assessment

In each year beginning in 1996, an assessment will be imposed on the top 40 percent of all plans in an area. The assessment is equal to 25 percent of the difference between a target premium and the actual premium charged by an accountable health plan or self-insured plan for the standard benefit package in a community-rated area. The target premium is defined as the higher of the following:

1. the average premium of all qualified health plans offered to individuals and employees of small businesses in the HCCA

or

2. the geographically adjusted premium value at the 25th percentile of all accountable health plans in the United States.

The geographically adjusted premium value is calculated by adjusting each accountable health plan's premiums for regional variations. Such adjustments shall include but not be limited to variations in the cost of living and demographics.

For self-insured plans, the excise tax will apply to the difference between the target premium and the actuarial estimate used for meeting the COBRA requirements. The Department of Treasury will be given authority to develop regulations in this area.

C. Medical Liability Reform

There shall be a disincentive placed in the law to deter the continuation of lawsuits beyond the ADR process.

- No health care malpractice action may be brought in court until the final resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

~~If the party initiating the court action receives a worse result, with respect to liability or the level of damages, from the court than in the state ADR method, such party shall pay the costs and attorneys fees of all parties to the litigation.~~

- Non-economic damages awarded to a plaintiff in a health care malpractice claim or action may not exceed $250,000, indexed for inflation.

- The liability of each defendant to a health care malpractice action for non economic and punitive damages will be based on each defendant's proportion of responsibility for the claimant's harm.

- Seventy-five percent of punitive damage awards will be paid to the state in which the action is brought and such funds will be used for provider licensing, disciplinary activities and quality assurance programs.

- A twenty year statute of repose will be applied to medical malpractice actions.

- Lawyers may not charge contingency fees greater than 33 1/3% of the first $150,00 of the award in a health care malpractice action and 25% of amounts in excess of $150,000, using after tax amounts.

- State laws that limit malpractice awards and fees to a greater extent are not preempted.

~~Defendants shall be permitted to make payments on awards in excess of $100,000 on a periodic basis.~~

D. Administrative Simplification

This section streamlines administrative processes in the health care system by establishing standards for a health care electronic data interchange (EDI) system to reduce administrative waste in the health care system; provide the information on cost and quality needed to make competition work; create the tools needed to conduct outcomes research to improve the quality of care;

and, to make it possible to track down fraud. This subtitle also sets requirements to protect the privacy and confidentiality of health care information, and establishes a National Health Information Commission of private-sector experts.

E. Quality Standards

The Secretary, in consultation with relevant private entities, will develop standards to assess the quality of health plans. In addition, the Secretary may:

- set priorities for strengthening the medical research base;
- support research and evaluation on medical effectiveness through technology assessment, consensus development, outcomes research and the use of practice guidelines;
- conduct effectiveness trials in collaboration with medical specialty societies, medical educators and qualified health plans;
- maintain a clearinghouse and other registries on clinical trials and outcomes research data;
- assure the systematic evaluation of existing and new treatments, and diagnostic technologies in an effort to upgrade the knowledge base for clinical decision making and policy choice;
- design an interactive, computerized dissemination system of information on outcomes research, practice guidelines, and other information for providers.

F. Anti-Fraud and Abuse

This subtitle establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. It also expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices.

G. Patent Self-Determination Act + extension

V. PUBLIC PROGRAM REFORM

A. Medicaid Reform

INTEGRATION OF MEDICAID INTO PRIVATE INSURANCE

The Secretary shall study the impact on private health insurance premiums and make recommendations on the integration of AFDC and non-cash recipients into the community-rated private insurance pool. In general, the objective will be to treat both of these groups like other low-income families and individuals for the purposes of enrollment in health plans and subsidies. Services not covered in the standard benefit package will be retained and provided through the current Medicaid program for mandatory and optional eligibility groups.

OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

- At state option, the Medicaid program will permit AFDC recipients and SSI recipients to receive medical assistance through enrollment in a qualified health plan offered in a local HCCA. The state may not restrict an individual's choice of plan and is not required to pay more than the applicable dollar limit for the HCCA area (as determined under section 2001 of the Act). The number of individuals electing to enroll in a qualified health plan is limited to a fifteen percent of the eligible population in each of the first three years, and ten percent in each year there after.

LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS

- Federal financial participation for acute medical services, including expenditures for payments to qualified health plans, is subject to an annual federal payment cap. The cap is determined by multiplying the per-capita limit times the average number of Medicaid categorical individuals entitled to receive medical assistance in the state plan.

- The per-capita limit for fiscal year 1996 is equal to 118% of the base per capita funding amount. This amount is determined by dividing the total expenditures made for medical assistance furnished in 1994 by the average total number of medicaid categorical individuals for that year. Expenditures for which no federal financial participation was provided and disproportionate share payments are excluded from this calculation.

- In years after 1996, the per-capita limit is equal to the per capita funding amount determined for the previous fiscal year increased by 6 percent for fiscal years 1997 through 2000, and 5 percent for fiscal year 2001 and beyond.

- States are required to continue to make eligible for medical assistance any class or category of individuals that were eligible for assistance in fiscal year 1994.

STATE FLEXIBILITY CONTRACT FOR COORDINATED CARE SERVICES

- At state option, the Act establishes a risk contract program within the Medicaid program which allow states to enter into contracts with at-risk primary care case management providers. An at-risk primary care case management provider must be a physician, group of physicians, a federally qualified health center, a rural health clinic or other entity having other arrangements with physicians operating under contract with a state to provide services under a primary care case management program.

- Risk contracting entities must meet federal organizational requirements, guarantee enrollee access and have a written contract with the state agency that includes: an experienced-based payment methodology; premiums that do not discriminate among eligible individuals based on health status; requirements for health care services; and, detailed specification of the responsibilities of the contracting entity and the state for providing for or arranging for health care services.

- Standards are established for internal quality assurance and state options regarding enrollment and disenrollment are specified. State and federal monitoring of quality and access standards are also established.

- In addition, each risk contracting entity providing Medicaid services shall also enter into written provider participation agreements with an essential community provider; or at the election of an essential community provider, each risk contracting entity will enter into an agreement to make payments to the essential community provider for services. Essential community providers include: Migrant Health Centers, Community Health Centers, Homeless program providers, Public Housing Providers, Family Planning Clinics, Indian Health Programs, AIDS providers under the Ryan White Act, Maternal and Child Health Providers, Federally Qualified Health Centers, and Rural Health Clinics.

OTHER PROVISIONS

- The Act phases out Medicaid Hospital Disproportionate share adjustment

payments by fiscal year 2000.

Medicare Reform

Maintain Medicare as a separate program.

Medicare remains a separate program and continues to be federally administered. Beneficiaries enrolled in part B continue to pay a monthly premium. The statutorily defined Medicare benefits continue to be the Medicare benefit package in both fee-for-service and managed care.

A. Individuals could maintain coverage through private health plans when they become eligible for Medicare.

Individuals have the option to remain in an accountable health plan (AHP) when they become eligible for Medicare. If they remain, they continue to receive the standard benefit package with the full range of options available to the non-Medicare population.

Plans may offer a separate rate for the Medicare-eligible population. The Board is required to prescribe methods for risk adjustment.

For individuals choosing an AHP, Medicare will pay the federal contribution calculated for Medicare risk contracts. Individuals are responsible for paying the difference between the premium charged and the federal contribution.

During the annual enrollment period, Medicare-eligibles may choose a new plan through their employer/purchasing cooperative or they may return to the traditional Medicare program.

B. Medicare Select would become a permanent option in all States.

Medicare Select is a demonstration program limited to 15 states (including North Dakota, Missouri and Minnesota) established in OBRA 1990 to allow managed care organizations to deliver supplemental benefit packages to Medicare beneficiaries. An individual buying a Medicare Select policy is buying one of the 10 standard Medigap plans. The only difference is that

Medicare Select policies deliver care through preferred providers. The program is scheduled to expire in 1995.

Medicare Select would be a permanent option in all States. Medicare Select policies will be offered during Medicare's coordinated open enrollment period. Plans may not discriminate based on pre-existing conditions.

C Medicare risk contracts would be improved. (Medicare Choice Act)

GRADUATE MEDICAL EDUCATION

This subtitle features mechanisms to increase the number of primary care physicians.

Medicare GME Demonstration Project

- The Secretary will allow up to seven states to experiment with Medicare direct graduate medical education (DME) payments to increase the number of primary care physicians. Under this program, qualifying states may use different weighting factors, or a community-based health care training consortia, to direct a greater share of its DME funds for primary care medical education. A consortia will be composed of teaching hospitals, medical schools, and ambulatory training sites, with the goal of increasing the number of primary care providers;

- Up to seven training consortia nationwide will be eligible to receive Medicare DME waivers directly from the Secretary. Each such consortium will be permitted to determine the most appropriate mechanism to use its DME resources to increase the number of primary care providers, including distributing funding to medical schools.

Community-Based Physician Training

- Medical resident training time in non-hospital-owned community-based settings will begin to be counted in the determination of full-time-equivalent residents for the purpose of making Medicare DME payments with the goal of

moving more residency training out of hospitals and into the community;

- For the purpose of Medicare indirect graduate medical education payments (IME), training time in non-hospital-owned ambulatory settings will be counted in the determination of full-time-equivalent residents with the goal of providing equal incentives for hospitals to train primary care residents and sub-specialty residents. In addition, per-institution IME payments are adjusted to assure budget neutrality.

Expansion of National Health Service Corps

- Increases funding for the National Health Service Corps scholarship and the State Loan Repayment programs.

Increased Resources for Primary Care Health Professions Training

Enhances resources for Public Health Service programs which support training of primary care providers as follows:

- Increases funding for programs under Title VII of the Public Health Service Act for the training of family physicians, general internists, and general pediatricians;

- Creates a new scholarship program and increases Title VII Public Health Service Act funding for physician assistants;

- Increases Title VII Public Health Service Act funding for nurse practitioner training and scholarship programs.

State Programs for Non-Physician Providers

- A demonstration program is created for states and non-profit organizations to experiment with changes in state scope-of-practice laws for nurse practitioners and physician assistants, the retraining of subspecialists to deliver primary care, and other mechanisms to increase the supply of primary care providers.

How much does this cost?

The effect on the deficit will be zero (Fail-Safe)
We raise $250 billion over five years
These funds will be used to provide direct subsidies to individuals at 240% of poverty and below, and to expand the deductibility of health insurance premiums for individuals and the self-insured.
We expect additional savings from system reforms.

We expect the combination of these elements to lead to insurance coverage for at least 93% of all Americans by 2002, and coverage of about 98% of all health care costs in the