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MEDICAL COLLEGES

Avenues to Access: A Resource Guide to Health Care Reform

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Avenues to Access: A Resource Guide to Health Care Reform

An AAMC Staff Report

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FOREWORD

No one needs to see more statistics to know that there is a health care crisis in this country. At least 37 million Americans--the majority of whom work--are without health insurance, and as the economy worsens and lay-offs increase, that number is likely to grow. The late 1980s saw the beginning of the latest national debate on health care reform. But it was in Pennsylvania this past November, when Democrat Harris Wofford overcame a 40-point deficit in the polls to win a seat in the U.S. Senate, that the debate moved to the forefront in the eyes of policy makers as well as the public. Mr. Wofford's major campaign issue? A call for national health insurance.

While it seems that health care reform is being discussed everywhere, there is yet to be one plan that can be labelled as the leading contender for adoption. Agreement has not even been reached about whether an incremental approach that tackles parts of the problem--such as reforming the insurance market or the tort system--can succeed, or whether a comprehensive approach is required. Among the few areas of consensus are that any viable reform plan must include a credible financing mechanism and cost containment measures.

Currently, the AAMC is in the process of determining ways in which academic medicine can contribute to reform efforts. One of the issues that is of great interest to AAMC members, and that is essential to any successful reform effort, is how to increase the number of primary care physicians. To that end, I have recently appointed an association Task Force on the Generalist Physician.

Additionally, with the publication of *Avenues to Access: A Resource Guide to Health Care Reform*, the Association of American Medical Colleges is providing a document that is a compendium of current information on health care reform. The AAMC hopes that if adequate information is readily available, health care reform finally may be transformed from an issue for debate to a problem that can be solved.

Robert G. Petersdorf, M.D.
President

Association of American Medical Colleges

PART I



THE HEALTH CARE REFORM PLANS: SUMMARIES

About Part I . . .

A *Quick Guide to Health Care Reform Plans* (page 5) is an at-a-glance comparison of the plans on the basis of a few major provisions: a pay or play mandate for employers, help for small employers to provide their employees with health care coverage, tax credits for individuals, limitations on provider reimbursement through fee schedules or negotiated rates, a federal or state program. Although a plan may emphasize one approach, such as pay or play, it nonetheless may include other approaches as well, such as tax incentives to reward individuals who make economic health insurance decisions.

Readers of this document may notice that there is no mention of a reform plan developed by President George Bush. The reason is that as we go to press, the president has not yet announced the details of a plan. The Bush administration's first attempt to address health care reform came in the president's January 1992 State of the Union address. He advocated for health care reform as follows:

We must make basic health insurance affordable for all low-income people not now covered. And we do it by providing a health insurance tax credit of up to \$3,750 for each low-income family.

The president also called for reforming the health insurance market. He concluded his remarks by saying that we "must bring costs under control, preserve quality, preserve choice and reduce people's nagging daily worry about health insurance." Details of the plan are to be announced soon.

In the meantime, further insights into the administration's thinking may be gleaned from the plan developed by Alain Enthoven and Richard Kronick on Page 21, the recommendations of the "Steelman Commission" (formally known as the Advisory Council on Social Security) on page 35, and a summary of remarks made by Richard Darman, Director of the Office of Management and Budget, on pages 38-39.

Summaries of 26 plans appear in alphabetical order by sponsor on pages 6 through 37. It was not possible to include every plan that has been proposed. Those chosen represent many, though not all, of the organizations or individuals that are expected to play a significant role in the reform debate.

No attempt was made to evaluate the plans. Rather, the following provisions of each plan are described:

- coverage--does the plan call for universal access, or does it target certain populations, such as women and children?
- benefits package--are benefits to be mandated and, if so, is a minimum benefits package described?
- financing--where will money be found to pay for the plan?

- insurance/small business--will the insurance market be reformed; for instance by the elimination of pre-existing condition limitations? Are there provisions to help small employers obtain affordable health insurance for their employees?
- beneficiary cost sharing--will beneficiaries be required to pay any out-of-pocket costs, such as deductibles or co-payments?
- provider reimbursement--what type of reimbursement can providers expect; for instance, fee schedules or rates that are derived from a free market approach?
- administrative costs--will there be a reduction in the paperwork that currently is required by payers (including private insurers and the federal government)?
- manpower development--are there provisions related to the training of physicians and other health care professionals? Are incentives provided for physicians and other health care professionals to locate in the areas that are underserved?

- research--will research be supported?
- quality assurance/practice guidelines--does the plan incorporate measures of quality, including practice guidelines and technology assessment?
- other major provisions--does the plan include malpractice reform, disease prevention or health promotion, or have other important provisions that do not fit in the above categories?

The variation in detail from summary to summary generally reflects the level of detail provided by each plan's sponsor. In those instances when there is additional helpful information, it is provided in the *Comments* section following the summary. For anyone wishing to obtain more information, or a copy of the plan, the address and phone number of the plan sponsors may be found on pages 40 and 41.

QUICK GUIDE TO HEALTH CARE REFORM PLANS

PLAN SPONSOR	<i>For Employers: Mandatory Employee Coverage (Pay or Play)</i>	<i>For Small Employers: Insurance and/ or Tax Reforms</i>	<i>For Individuals: Tax Incentives</i>	<i>For Providers: Fee Schedules/ Negotiated Payment Rates</i>	<i>For Those Not Otherwise Covered: A Federal or State Plan</i>
American Academy of Pediatrics	✓	✓			✓
American College of Physicians	✓				✓
AFL-CIO	✓	✓		✓	✓
American Hospital Association	✓	✓	✓		✓
American Medical Association	✓	✓	✓	✓	✓
American Nurses Association	✓				✓
American Society of Internal Medicine	✓	✓	✓	✓	✓
Blue Cross/Blue Shield		✓			✓
Business Roundtable		✓	✓		✓
Catholic Health Association ^o					
Sen. Chafee (S. 1936)		✓	✓		✓
Committee for National Health Insurance				✓	✓
Enthoven and Kronick	✓	✓			✓
Heritage Foundation			✓		
Health Insurance Association of America		✓	✓		✓
Sen. Kerrey (S. 1446)				✓	✓
Sen. Mitchell (S. 1227)	✓	✓		✓	✓
National Association of Children's Hospitals and Related Institutions ^o					
National Leadership Coalition for Health Care Reform	✓	✓		✓	✓
National Governors' Association		✓			✓
Pepper Commission	✓	✓		✓	✓
Rep. Rostenkowski (H.R. 3626)		✓		✓	
Rep. Russo (H.R. 1300)				✓	✓
Rep. Stark (H.R. 650)				✓	✓
Steelman Commission		✓			
U.S. Chamber of Commerce		✓			✓

✓ Indicates that the reform plan contains this provision.

^oNot a formal proposal; refer to summary for details.

SPONSOR: American Academy of Pediatrics

PLAN: Children first . . . , 1990

GOAL: To ensure access to affordable comprehensive health care for all children through age 21 and all pregnant women.

Provision	Description
Coverage	◆ Private health insurance coverage for all children up through age 21 and all pregnant women.
Benefits Package	◆ Federally specified benefits. ◆ Preventive care benefit basket: Routine office visits, immunizations, laboratory tests and preventive dental care; prenatal care; care of newborn infants; child abuse assessment; Primary/major medical benefit basket: hospital services; inpatient and outpatient physician services; diagnostic services; acute dental care; medical and surgical supplies; corrective eyeglasses or lenses; hearing aids; medical equipment; prescription drugs; Extended/major medical benefit basket: care coordination for chronically ill and other "at-risk children"; orthodontia (other than cosmetic); treatment of developmental and learning disabilities; mental health services; substance abuse; speech therapy; occupational therapy; physical therapy; hospice care; respite care; recuperative stays in long-term care facilities; nutritional assessment and counseling.
Financing	◆ Require employers to provide an insurance package with specified benefits, or pay a 3.17 percent tax on the wage of all employees, up to the social security wage base. ◆ Finance a state administered insurance fund from three sources: federal and state Medicaid funds currently allocated to children and pregnant women; employer payroll taxes; and premiums. ◆ Require states to contract with multiple insurers for private insurance for all children and pregnant women who do not receive employer-based insurance. ◆ Provide funds to states on the basis of the projected number and age of the beneficiaries enrolled in the state plan.
Insurance/ Small Business	◆ No exclusion of coverage of any pre-existing conditions. ◆ States will enact rules for insurance companies based on federal regulations. ◆ Make insurance available to small groups at equitable premium rates; tax deductions and tax credits are viable options.
Beneficiary Cost Sharing	◆ No cost sharing for preventive care, regardless of income. ◆ Base premiums for the state insurance program on income level. ◆ Cost sharing will be 20 percent for the primary/major medical benefit basket and 30 percent for the extended/major medical benefits baskets. ◆ Total family out-of-pocket expenditures not to exceed 10 percent of income, up to a maximum of \$1,000 for an individual and \$3,000 for a family per year.
Provider Reimbursement	◆ Determine physician reimbursement through the free market system.
Administrative Costs	◆ Require insurers to develop simple, standardized forms and systems.
Manpower Development	
Research	
Quality Assurance/Practice Guidelines	
Other Major Provisions	◆ Require states to develop mechanisms to overcome geographic, language, educational, cultural and other roadblocks to health care. ◆ Case management of children with special health care needs.

Comments: In September 1991, Congressman Robert T. Matsui (D-Calif.) introduced The Children and Pregnant Women's Health Insurance Act of 1991 (H.R. 3393) in Congress. The bill incorporates the major provisions of the AAP's plan. Rep. Matsui stated that, "I adopted this approach because it is realistic My bill is but a part of the solution to an enormous problem, but it is at least a start."

SPONSOR: American College of Physicians

PLAN: Access to Health Care, May 1990

GOAL: A comprehensive and coordinated program to assure access to health care for all Americans.

Provisions	Description
Coverage	◆ Health insurance coverage for all persons.
Benefits Package	◆ A mechanism for determining scope of benefits. ◆ Uniform, minimum benefits. ◆ Base coverage decisions on clinical effectiveness. ◆ Coverage and benefits to be continuous and independent of place of residence or employment.
Financing	◆ Financing adequate to eliminate financial barriers to obtaining needed care. ◆ Incorporate existing sources of revenue into any new financing system. ◆ Mandate employer coverage. ◆ Extend Medicaid eligibility. ◆ Expand charity care.
Insurance/ Small Business	◆ Encourage individuals and employers to purchase private insurance. ◆ Create health insurance risk pools.
Beneficiary Cost Sharing	
Provider Re- imbursement	
Administrative Costs	◆ Minimize administrative costs and procedures.
Manpower Development	◆ There should be sufficient infrastructure in terms of both facilities and manpower to deliver health care services efficiently and effectively.
Research	◆ Foster innovation and improvement.
Quality Assur- ance/Practice Guidelines	◆ Mechanisms to assure quality. ◆ Patients should be satisfied.
Other Major Provisions	◆ Mechanisms for controlling costs. ◆ The system should be flexible. ◆ Physicians and other health care professionals should be satisfied. ◆ Minimize professional liability. ◆ Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.

Comments: ACP considers "Access to Health" to be a position paper. The College is working on a proposal for comprehensive health care reform, that is expected to be issued in 1992.

SPONSOR: AFL-CIO

PLAN: No name; Summary from a February 1991 Statement on Health Care Reform and testimony before the Senate Finance Committee, April 1991

GOAL: A national system that makes quality health care available to everyone at a price that is reasonable and shared fairly by all Americans.

Provision	Description
Coverage	◆ Make health care a right for all Americans regardless of age, sex, race, health status, employment or income.
Benefits Package	◆ Assure all Americans a federally mandated set of comprehensive health care benefits; develop a national program to provide access to services for long term and chronic health conditions. ◆ Guarantee all Americans, regardless of where they live, access to the same mandated package of benefits.
Financing	◆ Require all employers to contribute to the cost of health care benefits for employees, including part time workers and their dependents; rechannel federal and state revenue sources and, to the extent necessary, explore other sources of revenue, including tax-based financing; link employee contributions with ability to pay. ◆ Establish a national social insurance program for workers, the unemployed and others not in the labor force, and incorporate Medicare and Medicaid. ◆ Reduce employment-based retiree health costs by lowering Medicare eligibility to age 60.
Insurance/ Small Business	◆ Establish national standards for the program at the federal level; make pooled funds available at the federal, state or regional level for the purchase of affordable, community-rated coverage administered through insurers or other third parties.
Beneficiary Cost Sharing	◆ Require that health care be provided in a manner which assures that services are affordable and out of pocket charges do not limit access.
Provider Reimbursement	◆ Require the development of mechanisms to contain rising health care costs for all payers; establish guidelines that prohibit physicians and other providers from charging patients more than they are paid under the program. ◆ Uniform reimbursement rates for all payers to be negotiated by a federal authority.
Administrative Costs	◆ Establish the requirements for administrative intermediaries to standardize claims forms, restrict the number of entities participating in the system, improve quality of care and assure that no individual is denied coverage. ◆ Assure that the program is administered by an independent entity; provide opportunity for the participation of labor, management, consumers and the health care community in the development and implementation of the national health care program.
Manpower Development	
Research	◆ Better coordinate existing medical research and commit the resources necessary to achieve the nation's health care objectives.
Quality Assurance/Practice Guidelines	◆ Develop appropriate mechanisms to encourage the delivery of high quality services and an equitable and cost-effective system for handling medical malpractice. ◆ Widespread dissemination of information to physicians through practice guidelines. ◆ Build a national data base on the cost and quality of care. ◆ Encourage physicians to avoid unnecessary tests and medical procedures. ◆ Create a national system for technology assessment.
Other Major Provisions	◆ Include a cap on health expenditures as part of a national cost containment program. ◆ Manage the now-uncontrolled duplication of technology and improve the allocation of resources through a capital budget. ◆ Develop a better system for handling malpractice disputes.

Comments: In November 1991 the delegates to the AFL-CIO's national convention overwhelmingly approved a resolution to establish a program of national health care reform. Any new system would include universal access and cost containment and emphasize wellness, prevention and primary care.

SPONSOR: American Hospital Association

PLAN: A Starting Point for Debate

GOAL: Improvement in the health status of all Americans and greater economic discipline in the use of health care resources.

Provisions	Description
Coverage	◆ Essential services available to all--All individuals should have access to at least basic health care services.
Benefits Package	◆ Basic benefits to include: effective preventive care, such as immunizations, prenatal and well-baby care and mammography; outpatient care; and inpatient care, including medical rehabilitation, psychiatric and substance abuse. Also to be included are: skilled nursing; intermediate and residential long-term care; prescription drugs; home health care; hospice care; and ambulance services. Apply a rigorous standard of medical necessity and reasonableness to help contain costs. ◆ Establish a public/private commission to: (1) provide Congress the information and advice it needs to set the budget targets for the public program; and (2) define basic benefits.
Financing	◆ Phase-in of mandatory employment based coverage. ◆ Employers expected to pay at least 50 percent of health coverage costs for full-time permanent employees and their dependents, and a prorated amount for permanent part-time workers and their families; strong incentives for employees to accept employer-sponsored coverage. Tax incentives for low income employees to cover their share of the premium. ◆ For those eligible for employment-based health insurance: provide the same tax advantages to self-employed individuals and unincorporated businesses for the purchase of health benefits that currently are enjoyed by large employers. For those receiving coverage through public programs: broadly based federal tax revenues dedicated to an off-budget trust fund and premium contributions by those covered who can afford them. States would be phased out of financial responsibilities for Medicaid, although there would be an offsetting federal-state realignment of financial responsibility for other domestic programs. ◆ The delivery and financing system arrangements must: (1) ensure the effective management of medical conditions, including the coordination of care among providers and over time and (2) promote continuous improvement in the quality of care. <i>See Benefits Package.</i>
Insurance/ Small Business	<i>See Financing.</i>
Beneficiary Cost Sharing	◆ Apply cost sharing to all services except preventive care through deductibles and co-payments. Eliminate or reduce cost sharing to nominal levels for those with limited financial resources under the public program.
Provider Reimbursement	◆ New integrated payment approaches that will cause providers and purchasers of care to work toward common objectives.
Administrative Costs	◆ Permit patients, providers and purchasers to obtain, deliver and pay for needed care with minimum uncertainty and confusion. Enable patients to know: how to obtain care; what care will be covered; and how much care will cost. Provide for timely settlement of claims and no excessive administrative burdens or costs on providers.
Manpower Development	◆ A more coherent and comprehensive approach to ensuring the availability of the number and types of physicians and other health care professionals needed to provide adequate access to health care services for everyone. The national goals should be an adequate supply, efficient use of health care professionals and appropriate geographic distribution of needed health manpower. ◆ For an adequate supply: direct funding priorities to those programs that train more practitioners than educators and researchers; reduce financial barriers to entry into health care professions; develop alternative competency measures to recognize and credit the knowledge and skills attained outside the formal education system through experience and on-the-job training; require public and private purchasers of care to pay for the costs incurred by hospitals and other types of providers in training various types of health care professionals; continue to finance graduate medical education primarily with patient care revenues; make manpower training more efficient by coordinating health occupations education programs; develop national standards for both vertical and horizontal articulation among health care training programs; institutions sponsoring graduate medical education programs should affiliate with ambulatory and extended care facilities and with health care delivery networks; health care providers should make a commitment to address basic skill and education deficiencies in the community's manpower pool.

Continued . . .

Manpower Development (cont'd)	<ul style="list-style-type: none"> ◆ For efficient use of health care professionals: consolidate core instruction in basic sciences courses; establish career ladders; develop national standards and guidelines for the evaluation of professional and occupational credentialing alternatives; revise provider licensure, certification and accreditation program standards regarding the numbers and qualifications of personnel; eliminate unnecessary and duplicative paperwork. ◆ For geographic distribution: financial support to educational programs which provide outreach programs in remote and underserved areas; funding to help poorer communities recruit primary care physicians nurses and allied health practitioners; remove federal regulatory barriers to the recruitment and retention of personnel, particularly in underserved areas.
Research	◆ There must be a sustained level of governmental and private support for innovation and the evaluation of new approaches.
Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Provider accountability through the use of practice parameters; the availability of information on individual practitioner and provider cost and quality outcomes; wide dissemination of guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services; incentives which reward the effective collaboration between hospitals and physicians in the management of care, assurance of quality and utilization of resources. Establish roles and responsibilities of providers and practitioners for managing care to patients within enrolled groups when contracting with purchasers. <i>See Financing.</i>
Other Major Provisions	◆ The affordability of services will be advanced by: reform of the medical liability tort system to obviate the need for defensive medicine; the widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care; and changes to anti-trust and other legislative and regulatory barriers to effective cost containment.

Comments: As the name suggests, this plan is intended to focus the debate. Many revisions can be anticipated. In November 1991, the AHA outlined three steps toward advancing its health reform strategy: (1) achieve short-term fixes in the current Medicare payment system; (2) flesh out the details of the AHA reform strategy, including longer term payment reform strategies; and (3) develop intermediate action steps. By January 1992 the AHA began advocating the following interim steps: medical liability reform, antitrust reform, medical practice parameters, insurance reforms, incentives for enrollment in coordinated care programs, administrative cost reduction, demonstration projects to test community-based innovative methods for assuring access and value, and living wills and other advance patient directives.

SPONSOR: American Medical Association

PLAN: Health Access America, February 1990 (refined December 1991)

GOAL: Strengthen and reform the American health care system by improving access to affordable, quality health care services.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Universal access through a private sector/public sector partnership.
Benefits Package	<ul style="list-style-type: none"> ◆ Minimum benefits package to include: maternal and child care; inpatient and outpatient physician services, including up to 20 office visits per year; limited dental services; outpatient services, including emergency treatment and outpatient X-rays and lab tests; up to 45 inpatient days per year; home health services; ambulance and skilled nursing facilities. ◆ Repeal or override state mandated benefit laws to help reduce the costs of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs. ◆ Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level. ◆ Reform Medicare to include catastrophic benefits.
Financing	<ul style="list-style-type: none"> ◆ Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage. ◆ Enact Medicare reform by creating an actuarially sound, pre-funded program to assure the aging population continued access to quality health care. ◆ Place all Medicare funds in trust funds administered by a federal reserve board type of agency that would be independent of the Congressional budgetary process. ◆ Cap employer tax-deductible premium costs. ◆ Alter the tax treatment of employee health care benefits to reward people for making economic health care insurance choices. ◆ Endorse the concept of individual "health IRA"/flexible benefit accounts that would use pre-tax dollars, tax-free accumulations and non-penalized withdrawals, with an emphasis on using the funds during retirement or disability. ◆ Require employers to offer the minimum benefits package in three versions: indemnity, UCR and pre-paid, with the employee being entitled to select his or her choice. ◆ Expand long term care financing through expansion of private-sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable. ◆ Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured plans as to state regulated health insurance policies. ◆ Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance. ◆ Community rating of premiums charged to small firms. ◆ Make insurance available to small businesses, with limitations on the amount that can be charged. ◆ Eliminate exclusions for pre-existing conditions from employee health insurance. ◆ Require insurers to make available to consumers information on the amount of payment provided toward each type of service in the required minimum benefits package. ◆ Guarantee employees the minimum benefits coverage, with no waiting period or pre-existing condition limitation, at a new employer without a rate increase. <i>See Financing.</i>
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ A basic deductible of \$350 per individual and \$750 per family. ◆ No deductible or co-payments on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8. ◆ Co-payments of 20 percent except as follows: 30 percent for the first \$1,000 of services, after deductible; 30 percent for inpatient room and board; 30 percent for outpatient facility services; \$25 emergency room visit after deductible. ◆ Out-of-pocket limits of \$1,500 per individual and \$3,000 per family. ◆ Lifetime benefit limit per person of \$1 million.

Continued . . .

Provider Reimbursement	<ul style="list-style-type: none"> ◆ Require physicians, hospitals, pharmacies, durable medical equipment suppliers and other providers to make information available to consumers on fees/prices charged for frequently provided services, procedures and products. ◆ For people below 200 percent of the state-adjusted poverty level, the applicable payment amount would constitute payment in full. A nominal point-of-service payment would be allowed. ◆ Require the Medicare program to negotiate the payment schedule conversion factor with the AMA.
Administrative Costs	<ul style="list-style-type: none"> ◆ Mandate use of a uniform claim form and standardized format for electronic claims through federal law. ◆ Support federal and state legislation regulating the conduct of utilization and managed care programs by all payers.
Manpower Development	<ul style="list-style-type: none"> ◆ Expand federal support for medical education, research and NIH.
Research	<i>See Manpower Development.</i>
Quality Assurance Practice Guidelines	<ul style="list-style-type: none"> ◆ Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.
Other Major Provisions	<ul style="list-style-type: none"> ◆ Enact professional liability reform. ◆ Encourage health promotion and disease prevention by both physicians and patients to promote healthier lifestyles and disease prevention. ◆ Encourage physicians to practice in accordance with the highest ethical standards to provide voluntary care for persons who are without insurance and who cannot afford health services.

Comments: In late 1991 the AMA's Board of Trustees refined Health Access America. Those refinements are reflected in the above summary.

SPONSOR: American Nurses Association

PLAN: Nursing's Agenda for Health Care Reform, 1991

GOAL: To restructure, reorient and decentralize the health care system to guarantee access to services, contain costs and ensure quality care.

Provision	Description
Coverage	◆ Universal access.
Benefits Package	<ul style="list-style-type: none"> ◆ To be set by the federal government. ◆ To include defined levels of: primary health care services, hospital care, emergency treatment, inpatient and outpatient professional services and home care services; preventive services; prescription drugs, medical supplies and equipment and laboratory and radiology services; mental health services and substance abuse treatment and rehabilitation; hospice care; some long-term care services; and some restorative services. ◆ Some long-term care coverage, but also payment for LTC through privately purchased insurance, new savings and tax incentives and home equity conversion opportunities.
Financing	<ul style="list-style-type: none"> ◆ Offset some of the new costs of the plan by some of the cost-saving initiatives contained in the plan. ◆ Distribute responsibility for financing equitably among individuals, employers and government. ◆ A public plan administered by the states for the poor, high-risk populations and potentially medically indigent. Employers and individuals can also buy into this plan. ◆ Require employers to offer, at a minimum, the nationally standardized package of essential services, or to pay into the public plan for their employees.
Insurance/ Small Business	
Beneficiary Cost Sharing	◆ Deductibles and co-payments for those who can afford them.
Provider Re- imbursement	<ul style="list-style-type: none"> ◆ Fair and consistent payment rates to providers. ◆ No payment to providers at the point of service; no balance billing permitted.
Administrative Costs	
Manpower Development	
Research	◆ Condition the use of advancements in clinical practice and technology on satisfying criteria related to cost efficiency and therapeutic effectiveness.
Quality Assur- ance/Practice Guidelines	◆ Development of multidisciplinary clinical practice guidelines.
Other Major Provisions	◆ Promote the use of managed care and case management.

Comments: This plan represents a coalition effort by more than 50 national nursing organizations. The ANA will be issuing white papers and additional briefing papers to flesh out its plan.

SPONSOR: American Society of Internal Medicine

PLAN: Ending Separate and Unequal Health Care, April 1990

GOAL: Provide health insurance for everyone by requiring employers to provide coverage for employees and by expanding the Medicaid program.

Provision	Description
Coverage	◆ Universal
Benefits Package	◆ Mandate a federally defined set of basic benefits for Medicaid that would include medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care and a limited mental health benefit. ◆ Includes long term care provisions to: (1) encourage the availability of private long term insurance and (2) establish a new Medicare benefit to assist individuals in paying for long term care.
Financing	◆ Require all employers to offer employees a basic package of health insurance benefits. ◆ Convert Medicaid from a welfare program to a source of funding for all individuals, regardless of income, who are unable to obtain employer-based health insurance, and require uniform eligibility standards. ◆ Increase federal government funding for the expanded Medicaid program to reduce the financial burden on the states. ◆ Provide tax incentives for individuals to set aside funds to pay for health expenses in order to supplement financing from employer-based health insurance and public programs ("Health IRAs"). ◆ Place a reasonable tax cap on the amount of health care premiums an employer can deduct as a business expense. Any amount in excess of the cap is taxable income to the employee. ◆ A substantial increase in federal excise taxes in alcohol and tobacco. Increase the surcharges on driving under the influence (DUI) offenses and drug convictions to help states finance access to care. ◆ Redirect budget priorities toward expanding access to care for the poor; <i>e.g.</i> , use savings from the elimination of price supports for tobacco growers as a source of funding. ◆ If additional funding is necessary, consider increases in personal income tax and payroll tax.
Insurance/ Small Business	◆ Provide special assistance to small businesses to make the cost of offering health insurance more affordable. Allow for phase-in; designate regional insurers and establish risk pools by allowing businesses to substitute an "actuarially equivalent" plan for the required standard benefit package; provide a federal subsidy in hardship cases; pre-empt state laws that mandate minimum benefits; and permit full tax deductions for the costs of health insurance premiums. ◆ Reform the market for health insurance. Prohibit experience rating and pre-existing condition exclusions and establish special rules for marketing to small groups.
Beneficiary Cost Sharing	◆ Require some level of patient cost-sharing in all insurance plans. ◆ Support varying co-payments by type of service, with reasonable co-payments on primary care, diagnostic and surgical services, based on the patient's ability to pay. ◆ Require Medicaid recipients with incomes above the poverty level to contribute to the cost of Medicaid coverage, with the contribution and cost-sharing varying on a sliding scale based on income.
Provider Reimbursement	◆ Reform physician payment under the Medicaid program to ensure adequate incentives for physician participation and to introduce proper incentives into the system. ◆ Base Medicaid reimbursement on the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule, provided that the reimbursement under the state program would be no less than would be paid under the Medicare RBRVS fee schedule for a comparable service. ◆ Physicians who adhere to practice guidelines should receive payment for services without excessive demand for documentation and appeals to get claims paid.
Administrative Costs	◆ Eliminate administrative "hassles" that impede access to care.
Manpower Development	

Continued . . .

Research	
Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Place a high priority on studying the outcomes of different medical interventions and developing practice guidelines to modify physician behavior and provide a basis for setting payment criteria. ◆ Continue efforts to analyze the costs and benefits of medical technology. <i>See Provider Reimbursement.</i>
Other Major Provisions	<ul style="list-style-type: none"> ◆ Institute reforms in the medical liability system, such as tort reform and limitations on contingency fees and punitive damages. ◆ Encourage selective contracting for certain high-cost, non-emergency procedures.

Comments: This summary also includes recommendations made in a document issued in September 1990 by ASIM, "Financing and Cost Containment Proposals."

SPONSOR: The Blue Cross and Blue Shield System

PLAN: No Name Given; Presented In Testimony Before the House Ways and Means Committee, October 1991

GOAL: To restructure the health insurance industry, focusing on affordability of health care and laying the foundation for a major effort to increase coverage.

Provision	Description
Coverage	◆ Universal.
Benefits Package	◆ Set benefits package that balances comprehensiveness of coverage with affordability.
Financing	◆ Continue present tax policies that permit employers to deduct the costs of health benefits. ◆ Government subsidies for employees who cannot afford private insurance. ◆ An expanded Medicaid program for those who cannot afford private insurance even with government subsidies.
Insurance/ Small Business	◆ Give the self-employed the same tax credit as that granted to businesses. ◆ Develop subsidies and tax incentives that would encourage small employers to contribute to employee and dependent premiums. ◆ Replace insurers' incentives to avoid serving high-risk groups by incentives to improve the management of the costs of their care. ◆ Support small group market reforms that assure that: (1) states have a range of options to choose from in making private insurance available to small employers; (2) small group coverage is provided at fairly established rates; (3) no small employer is dropped from coverage because of poor claims experience; (4) all carrier requirements are enforced effectively; and (5) lower-cost health insurance products are available. ◆ Portability of insurance, so that pre-existing condition exclusions and waiting periods can be eliminated.
Beneficiary Cost Sharing	
Provider Reimbursement	◆ "Qualified carriers" would negotiate with providers for favorable prices. ◆ Reward "qualified carriers" who have demonstrated their ability to contract for high quality and efficiently provided services through managed care and selective contracting techniques. <i>See Quality Assurance/Practice Guidelines.</i>
Administrative Costs	
Manpower Development	
Research	
Quality Assurance/Practice Guidelines	◆ Focus on outcomes of care rather than the numbers of services provided. ◆ Cover the most appropriate service in the most appropriate setting. ◆ Use "qualified carriers" to manage the cost and quality of care provided and measure the appropriateness through reliance on outcomes measures that evaluate services according to the improvements they make in patients' lives. ◆ Do not cover outmoded and unnecessary services.
Other Major Provisions	◆ Reform of the medical liability system.

Comments: In March 1991 the Blue Cross and Blue Shield Association issued a publication, "Reforming the Small Group Health Insurance Market," an overview of the problems and the solution.

SPONSOR: The Business Roundtable

PLAN: Health Care Policy Principles, May 1991

GOAL: Improvements in the accessibility, cost and quality of health care services.

Provision	Description
Coverage	◆ Universal access to needed health care services.
Benefits Package	◆ No mandated benefits. ◆ Design health benefit plans to reinforce individual accountability for factors under their control that influence health care cost (e.g., relating employee contribution to lifestyle choices).
Financing	◆ Build on the present employment-based system of coverage. ◆ Improve the Medicaid program so that it can cover all of the poor. ◆ More emphasis on the use of managed care for Medicare recipients. ◆ Tax incentives for individuals to encourage them to provide for their own health care needs. ◆ Use managed care principles for publicly financing health care programs.
Insurance/ Small Business	◆ Reform the small group insurance market to achieve greater availability of coverage and stability in pricing. ◆ Establish reinsurance pools for uninsurable individuals and groups.
Beneficiary Cost Sharing	◆ Cost sharing by employees, including deductibles, co-insurance and co-payments.
Provider Re- imbursement	
Administrative Costs	
Manpower Development	
Research	◆ Make support for continued research and development in health care an objective of our health care system.
Quality Assur- ance/Practice Guidelines	◆ Develop clear standards for appropriate care. ◆ Continue to refine and disseminate health care quality indicators to purchasers of health care. ◆ Support efforts to expand and coordinate technology assessment, health care outcomes research and the development of medical practice guidelines.
Other Major Provisions	◆ Reduce the cost of health care services. ◆ Expand managed care through the private market and eliminate barriers to the operation of managed care plans (both state and federal laws). ◆ Restrict tax exempt financing for health care facilities and equipment to needed modernization and conversion of existing services. ◆ Tort reform is needed.

Comments: The principles in the document summarized above are "a working document to guide The Business Roundtable's policy decisions in the legislative process. Changing circumstances may require that specific principles be reconsidered from time to time"

SPONSOR: Catholic Health Association

PLAN: Charting the Future, 1990

GOAL: Global systemic health care reform.

Provision	Description
Coverage	◆ Access to those health care services necessary for the development and maintenance of life is a basic human right.
Benefits Package	◆ The federal government must determine a basic level of health care services sufficiently comprehensive to promote good health, to provide appropriate treatment for persons with disease and disability, and to care for persons who are chronically ill or dying.
Financing	◆ Financing the delivery of basic comprehensive health care services is a societal obligation. The federal government must ensure that a financing mechanism, imposed on individuals, organizations, and governmental units, will be based on an equitable and progressive formula.
Insurance/ Small Business	
Beneficiary Cost Sharing	
Provider Re- imbursement	◆ Adequate, equitable, timely, and predictable payments to health care providers.
Administrative Costs	◆ The structure and regulations for the administration of the health care system must be simple, coherent, responsive, and cost-effective and must be monitored and evaluated on a timely basis.
Manpower Development	◆ The health care system must include provision for support of research, education and training.
Research	<i>See Manpower Development.</i>
Quality Assur- ance/Practice Guidelines	◆ There must be effective measures for ensuring appropriate utilization of services, and promotion of the efficient and cost-effective use of facilities, equipment, and services. ◆ Ensure that processes and standards are established and used for evaluating and improving outcomes and ensuring the appropriateness of health services.
Other Major Provisions	◆ Include incentives to individuals to practice good health. ◆ Protect the right of all parties to the free exercise of their ethical and religious beliefs. ◆ The protection, promotion, maintenance, and enhancement of health is a responsibility shared by individuals and families, private businesses and organizations, voluntary agencies, and government, In addition, government at all levels is primarily responsible for preventing or correcting situations that threaten the health of the population.

Comments: The document on which this summary is based, along with a document entitled "With Justice For All?," are considered to be "foundational documents." A comprehensive health care reform proposal is expected during 1992.

SPONSOR: Senator John Chafee (R-R.I.) and Other Senate Republicans

PLAN: Health Equity and Access Improvement Act of 1991 (S. 1936), November 1991

GOAL: To provide improved access to health care.

Provision	Description
Coverage	◆ BasiCare will be a state plan for people not eligible for other coverage.
Benefits Package	◆ A model plan is to be developed by the National Association of Insurance Commissioners (NAIC). ◆ If NAIC fails to develop a plan, then HHS should develop one that includes: basic hospital, medical and surgical services, including preventive care. ◆ Standards for managed care plans will be developed by a Managed Care Advisory Committee.
Financing	◆ Provide incentives for employers to offer insurance. ◆ Medicaid will remain available. ◆ Replace the current health care Earned Income Tax Credit with a refundable tax credit for low income individuals and families. ◆ A new, annual tax credit for all taxpayers and their dependents applied to the cost of purchasing specified preventive health services, provided those services are not already covered by the taxpayer's insurance (e.g., cancer screening, childhood immunization, well child care).
Insurance/ Small Business	◆ Special tax credit for small employers offering basic health insurance, managed care or dependent coverage, to be phased out over 5 years. ◆ Make small businesses eligible for an additional Managed Care Credit. ◆ Make the deduction for health insurance for the self-employed permanent. ◆ Insurance market reforms for small employers will include providing benefits and coverage consistent with the model health care insurance benefits plan; offering the insurance at the same price as other contracts issued within the same class of business; coverage of all eligible employees, spouses and dependent children; a limitation on pre-existing conditions not to exceed 6 months; renewability; premium increases limited by law.
Beneficiary Cost Sharing	◆ Reasonable cost-sharing on the part of beneficiaries; appropriate co-payments and deductibles.
Provider Reimbursement	
Administrative Costs	
Manpower Development	◆ Provide incentives for practice in a rural area, including special tax credits, special treatment for interest on student loans and excluding from gross income any money repaid on a National Health Service Corps Loan. ◆ A variety of grants to increase health care in medically underserved areas, including the recruitment, training and compensation of clinical and associated administrative personnel.
Research	
Quality Assurance/Practice Guidelines	
Other Major Provisions	◆ Medical liability reform such as: expedited malpractice settlements; alternative dispute resolution procedures; limitation on damages; imposition of the collateral source rule; limitation on attorney's fees; uniform statute of limitations; special rules regarding the alleged malpractice during the delivery of a baby. ◆ Grants to develop and establish a nationwide risk retention group to provide professional liability insurance to migrant and community health centers.

Comments: This is one of the few Republican health care reform plans introduced into Congress. In October, Senator Dave Durenberger (D-Minn.) introduced the American Health Security Act of 1991 (S. 700).

SPONSOR: Committee for National Health Insurance: Health Security Action Council

PLAN: The Health Security Partnership, November 1990

GOAL: A national-state, equity-based, cost-contained, quality-assured, consumer-oriented, universal national health program for the United States.

Provision	Description
Coverage	◆ Universal eligibility, either through an employer's insurer or through the state.
Benefits Package	<ul style="list-style-type: none"> ◆ Require each state to provide a federally mandated set of benefits including physician, hospital, preventive, mental health, substance abuse, rehabilitative, and long-term care services, and in-hospital drugs. ◆ Allow states to include additional services. ◆ Include preventive services in basic benefits. ◆ Provide eligibility for nursing home care which may be custodial in nature. ◆ Expand the personal care-home care services of those who are impaired in two or more activities of daily living.
Financing	<ul style="list-style-type: none"> ◆ Integrate Medicare and Medicaid into Health Security Partnership (HSP) after several years. ◆ Divide financing equally among the federal government, the states, and private insurance/consumer payments. ◆ Develop biennial national and state budgets. ◆ Allow individual states to develop financing sources. ◆ Control state funds through a single state organization.
Insurance/ Small Business	
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ Limit annual family payments to \$2,500, deductibles to \$200 for individuals and \$500 for families, and 20% for co-payments. ◆ Prohibit payments for those below poverty or for pre- and post-natal care and well-baby care for those below 150% of poverty.
Provider Re- imbursement	<ul style="list-style-type: none"> ◆ Reimburse hospitals on the basis of prospective total budgets, with individual states determining payment schedules. ◆ Reimburse physicians using a relative value schedule, prohibiting balance billing.
Administrative Costs	◆ Simplify administrative procedures.
Manpower Development	◆ Establish a national resources development fund to make grants to states for new and expanded medical services and resources, to develop different ways of delivering care, and to assist in medically underserved areas.
Research	
Quality Assur- ance/Practice Guidelines	◆ Establish a national commission to develop federal standards of care.
Other Major Provisions	

SPONSOR: Alain Enthoven and Richard Kronick

PLAN: A Consumer Choice Health Plan for the 1990s

GOAL: A universal health insurance plan based on managed competition with mixed public and private sponsorship.

Provision	Description
Coverage	◆ Universal.
Benefits Package	◆ Require all plans to include the basic benefits package of HMO Act subject to tighter definitions and restrictions.
Financing	◆ Require employers to provide health care coverage to all full time employees and dependents. ◆ Require employers to pay 80% of average cost of basic coverage for employees and dependents and an additional 8% payroll tax on the first \$22,500 in wages for uncovered employees. ◆ Require self-employed, retirees, and uninsured with sufficient income to pay 8% tax on adjusted gross income up to a set ceiling. ◆ Subsidize premiums of low income persons. ◆ Provide subsidies to everyone not covered through employment or by an existing public program to purchase, either through employers or public sponsors, health care coverage.
Insurance/ Small Business	◆ Partial elimination of the employees tax exclusion of employers health insurance contribution. ◆ Provide assistance to small businesses to reduce the burden of providing coverage.
Beneficiary Cost Sharing	◆ Limit total out of pocket expenditures for deductibles and coinsurance to 100% of the annual premium.
Provider Reimbursement	◆ Develop a performance-based system of pay for physicians.
Administrative Costs	
Manpower Development	
Research	
Quality Assurance/Practice Guidelines	◆ Develop broad-based programs in technology assessment, risk-adjusted monitoring of outcomes, and outcomes management for effective managed competition.
Other Major Provisions	

Comments: Richard Kronick is also credited with helping the National Leadership Coalition for Health Care Reform formulate its plan. Alain Enthoven has been described as "one of the two most important intellectuals in helping shape the ideas expected to guide the Bush health proposals." The Enthoven/Kronick plan appeared in two articles, "A Consumer-Choice Health Plan for the 1990's (First of Two Parts)," *New England Journal of Medicine*, vol. 320, no. 1, pp. 29-37 and "A Consumer-Choice Health Plan for the 1990's (Second of Two Parts)," *New England Journal of Medicine*, vol. 320, no. 2, pp. 94-101.

SPONSOR: The Heritage Foundation

PLAN: A National Health System for America, 1989

GOAL: Access to adequate health services for all Americans.

Provision	Description
Coverage	
Benefits Package	<ul style="list-style-type: none"> ◆ Repeal state-mandated benefits laws. ◆ The federal government should establish basic regulations to ensure that all plans comply with the broad objectives of the national system.
Financing	<ul style="list-style-type: none"> ◆ Federal tax policy should encourage the purchase of common medical services out-of-pocket and insurance coverage for expensive, unpredictable illnesses. ◆ Replace the tax exclusion for employer-provided health insurance with tax deductions and refundable tax credits for individuals' purchases of health insurance or their out-of-pocket expenses. ◆ Provide federal subsidies to low income individuals for whom the cost of purchasing health care is an unreasonable burden. ◆ Require all households to purchase or enroll in a prepaid health plan to cover both common medical services and catastrophic conditions. ◆ Allow individuals to join the health plan of their choice. ◆ Provide each Medicare beneficiary with a voucher to purchase private health insurance, replacing the current Medicare system. ◆ Eliminate the link between eligibility for public assistance and Medicaid coverage. ◆ Government should pay for essential long term care expenses for those elderly who cannot afford to meet the cost or who cannot pay without great hardship. ◆ Encourage the purchase of LTC insurance for those elderly who can afford it.
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Establish insurance risk pools in every state.
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ Abolish Medicare taxes and premiums and readjust coinsurance and deductibles to cover Medicare costs. ◆ Allow individuals to contribute to private health care savings accounts to defray out of pocket health expenses during retirement.
Provider Reimbursement	
Administrative Costs	
Manpower Development	
Research	
Quality Assurance/Practice Guidelines	
Other Major Provisions	

SPONSOR: Health Insurance Association of America

PLAN: Health Care Financing for All Americans, 1990

GOAL: Expanding coverage through the workplace and expanding public coverage for the poor and near poor.

Provision	Description
Coverage	◆ For all workers and for the poor and near poor, regardless of employment status.
Benefits Package	◆ Eliminate state-mandated benefit laws.
Financing	<ul style="list-style-type: none"> ◆ Tax subsidies to low-income individuals and families and a 100 percent tax deduction for the self-employed. ◆ States pay the employees' premium contributions, copays and deductibles for poor employees. ◆ Allow the near-poor to "buy in" to a package of primary and preventive care services only. ◆ Deduct medical expenses from income when determining eligibility for Medicaid. ◆ Expand Medicaid to cover all poor Americans.
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Reform the insurance market for small employers so that they can afford to offer health insurance to their employees. ◆ Small employer market reforms: guaranteed coverage on a continuing basis; no denial of coverage for high-risk employees; guaranteed renewability. ◆ Create high risk pools in each state for medically uninsurable individuals who are not part of an insured employer group. ◆ Provide targeted tax assistance for small employers. ◆ Insurers should encourage their clients to support illness prevention and wellness programs. ◆ Portability of insurance: once a person is covered in the employer market and has satisfied an initial plan's pre-existing conditions, those requirements would not have to be met again when changing jobs or when the employer changes carriers. Limit the variation in rates for groups similar in geography, demographic composition and plan design. Limit annual premium increases.
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ Provide consumers with strong financial incentives to be economical in choosing providers and in utilizing medical services. ◆ Provide financial incentives to encourage employees to choose the most economical plan when employees have a choice of providers or of health plans with different benefits and/or premium levels.
Provider Reimbursement	◆ Give insurers the flexibility to develop and market plans that incorporate innovative arrangements with providers and include appropriate incentives for consumers to choose cost-effective care.
Administrative Costs	◆ The federal government and other payers should work cooperatively to reduce administrative costs related to filing, coding and payment of claims, using the most efficient technologies available.
Manpower Development	<ul style="list-style-type: none"> ◆ Governmental policies that directly or indirectly influence physician supply and distribution should be explicitly formulated to match total supply to need and to improve the geographic and specialty distribution of physicians. ◆ Government policies that directly or indirectly influence the supply and distribution of health facilities and equipment should be explicitly formulated to match total supply to need and to improve distribution.
Research	
Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Coverage and reimbursement for the cost of services that have been demonstrated to be medically necessary, medically effective, and cost-effective. ◆ Federal and state governments should provide health care consumers and policy makers with data and information that will facilitate more appropriate use of the health care system and enhance efforts to improve efficiency and quality of care. ◆ Determine what constitutes cost-effective care. ◆ Establish mechanisms to develop medical practice guidelines and protocols.
Other Major Provisions	<ul style="list-style-type: none"> ◆ Reform of the malpractice system to provide mechanisms and incentives to: minimize the occurrence of malpractice; fairly compensate injured patients; discourage suits that are without merit; improve the efficiency of dispute resolution; and assure that awards are reasonable. ◆ Give the health insurance industry access to health system data and information that is adequate to monitor, analyze, and understand past trends, to anticipate future changes and to shape the direction of health policy.

SPONSOR: Senator Bob Kerrey (D-Neb.)

PLAN: Health USA Act of 1991 (S. 1446)

GOAL: To provide for an equitable and universal national health care program administered by the States.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Universal for all U.S. citizens, either through a state-operated fee-for-service health plan, or a private health plan.
Benefits Package	<ul style="list-style-type: none"> ◆ Inpatient and outpatient hospital care, including emergency services; physician services and services of other health professionals as authorized under state law; laboratory and diagnostic tests; preventive care services; prescription drugs; mental health and substance abuse services; nursing homes for certain qualified persons; home health services for certain qualified persons. ◆ Allow private health plans to charge for additional benefits, although no federal financing will be available for such benefits.
Financing	<ul style="list-style-type: none"> ◆ Use what is currently spent by the federal government on Medicaid, Medicare and CHAMPUS to fund the program. Additional funding from a payroll tax, and other changes to the tax code. ◆ State funding from what is currently paid for Medicaid and state and local indigent care programs. New funds from state revenues or taxes. ◆ Create a National Health Commission, within the Department of Health and Human Services, to recommend an annual fiscal year budget to Congress based on a national average per capita cost for covered benefits. Pay the states based on the number of state residents, with adjustments for special social, economic, geographic or other conditions that affect the costs of providing the services in the state. ◆ Require each state to establish an annual fiscal year budget.
Insurance/ Small Business	
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ Twenty percent coinsurance for covered services, including a \$5 copayment for the first physician visit for an illness; a \$100 deductible. ◆ Limits on cost-sharing: \$1,000 for an individual; \$1,500 for a family of two; \$2,000 for a family of three or more. ◆ No cost sharing for preventive and hospital services. Protect low-income individuals from financial barriers.
Provider Reimbursement	<ul style="list-style-type: none"> ◆ Fee schedules based on a national relative value scale, expenditure targets, and the direction of certain services to certain types of providers, to be negotiated by state health plans. ◆ All payments to providers must be accepted as payment in full. ◆ Make payments for institutional services, including hospitals and nursing care facilities, directly to each institution by the state program. Base payments on an annual prospective budget negotiated with each institution. ◆ Separate capital spending from patient care spending for hospitals as a way to permit increased cost control and more effective allocation of resources.
Administrative Costs	<ul style="list-style-type: none"> ◆ Institute a uniform billing and payment system for physician services. ◆ Dissemination by state programs of uniform comparative information about plans will reduce plan marketing. Simplify enrollment.
Manpower Development	<ul style="list-style-type: none"> ◆ Encourage states to earmark money for costs associated with research and teaching activities in patient care settings. ◆ National Health Care Commission will consider and make recommendations regarding national and regional needs for health professionals and services with special consideration of rural and other medically underserved areas and populations. This will include the number and specialties of health professionals in such areas and recommendations of economic, educational or other incentives and programs that may be used to attract health professionals to these areas. ◆ The Commission will also encourage the further development of university or state based programs to train health professionals for work in underserved areas.
Research	<i>See Manpower Development.</i>

Continued . . .

Quality Assurance/Practice Guidelines	<ul style="list-style-type: none">◆ Further development of medical effectiveness research and of practice guidelines and treatment protocols.
Other Major Provisions	<ul style="list-style-type: none">◆ State programs would establish criteria for participation by private health plans.◆ National Health Care Commission will work to help the states carry out their programs. It will be advised by a National Advisory Board.◆ States may join with neighboring states to act as a region in the administration of state programs.

SPONSOR: Senate Majority Leader George Mitchell (D-Me.), Senators Edward Kennedy (D-Mass.), Don Riegle (D-Mich.) and Jay Rockefeller (D-W.Va.)
PLAN: HealthAmerica: Affordable Health Care For All Americans (S. 1227), 1991
GOAL: Access to affordable, quality health care for all Americans.

Provision	Description
Coverage	◆ Universal access.
Benefits	◆ A basic benefits package to include coverage of hospital care, physician care, diagnostic tests and limited mental health coverage. Also, key preventive services, including prenatal care, well-baby and child care, pap smears and mammograms. ◆ Provide hospital, physician, prenatal and well-baby, diagnostic tests, and limited mental health benefits to individuals covered by both employer provided and public insurance. Disallow exclusions due to pre-existing conditions.
Financing	◆ Develop a program of financing so that the federal budget deficit is not increased. ◆ Tie premiums to ability to pay. ◆ Require employers to pay 80% of premium costs, employee to pay 20%. Cost of premiums for low-income citizens, whether working or unemployed, subsidized through AmeriCare. ◆ Require all employers to either: (1) provide coverage meeting basic standards to their workers and their families, or (2) contribute a percentage of their payroll to a new public insurance program, AmeriCare. AmeriCare will replace Medicaid and be administered through the states.
Insurance/ Small Business	◆ Provide help to small businesses in meeting coverage requirements, through phase-ins, subsidies, and exemptions if 75% of currently uninsured workers for these business are covered voluntarily.
Beneficiary Cost Sharing	◆ Impose co-payments and deductibles. <i>See Financing.</i>
Provider Re- imbursement	◆ Set up a Federal Health Expenditure Board to establish a process of rate negotiations between purchasers and providers of health care within overall national health expenditure goals. ◆ Use state consortia to control costs at the state level; for example, by negotiating rate and volume levels with providers within the state.
Administrative Costs	◆ Reduce excessive administrative costs. ◆ Require the use of standardized billing forms, require small insurers to work together at the state level for the purpose of paying bills and reform the small business insurance system to cut the overhead costs paid to insurance companies.
Manpower Development	
Research	
Quality Assur- ance/Practice Guidelines	◆ Establish a program of outcomes research to determine which care is necessary or unnecessary. ◆ Develop practice guidelines. ◆ Develop private and public managed care programs to encourage patients to use providers who practice efficient, high quality medicine. ◆ The Federal Health Expenditure Board will gather and publish cost and quality data on providers, so that patients, insurers and others can use the most efficient, high quality providers. ◆ Establish an enhanced program of technology assessment.
Other Major Provisions	

Comments: During December 1991 Senator Mitchell and other Senate Democrats (Sens. Jay Rockefeller, W.Va., Tom Daschle, S.D., Edward Kennedy, Mass., and Harris Wofford, Pa., and host senators Rob Graham, Fla., Wyche Fowler and Sam Nunn, Ga., John Glenn and Howard Metzenbaum, Ohio, Don Riegle and Carl Levin, Mich., and Tim Wirth, Colo.) held a series of five field hearings around the country on health care reform. Several hundred additional "town meetings" were held nationally by Congressional Democrats in January. Also in January an amended version of this bill was approved by the Senate Labor and Human Resources Committee on a 10 to 7 vote along party lines.

SPONSOR: National Association of Children's Hospitals and Related Institutions

PLAN: Principles of Universal Health Care Financial Access, February 1990

GOAL: A package of basic health care services for every American with a guarantee of payment by either public or private sources.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Universal financial access to health care through privately or publicly financed insurance or direct financial assistance to pay for necessary and appropriate health care services. ◆ Do not deny access to basic health care services because of inability to pay, current or pre-existing health conditions, or because of loss or changes in employment, or changes in marital status. ◆ Any individual's participation in a system of guaranteed financial access to health care should be independent of eligibility for income assistance programs. Do not link access to health care to welfare assistance.
Benefits Package	<ul style="list-style-type: none"> ◆ Every American should have financial access to health care services that fulfill defined, minimum national standards, regardless of whether an individual's financial access is publicly or privately financed. Optional coverage of additional benefits should not be precluded. ◆ Include in a minimally acceptable benefits package: inpatient and outpatient hospital, physician and physician-extender, and diagnostic services; prenatal, well baby and well child care; emergency, rehabilitative, mental health, and dental services; and care management.
Financing	<ul style="list-style-type: none"> ◆ Risk pools, publicly or privately funded reinsurance, and other mechanisms.
Insurance/ Small Business	
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ All persons should have a choice of providers and be responsible for sharing costs in order to encourage cost-conscious use of benefits. Offer plans allowing free choice of provider as well as managed care alternatives. ◆ Public financial assistance for cost-sharing by low income families should be available in the form of tax credits, vouchers, and other mechanisms. ◆ Eliminate deductibles and co-payments for prenatal, well baby and well child care, and for poor pregnant women and children. ◆ Limit co-insurance on all other services to 20%; deductibles not to exceed \$250 per year per individual or \$500 per family; and annual out of pocket expenses limited to \$1,000 per child and \$2,000 per family.
Provider Reimbursement	<ul style="list-style-type: none"> ◆ Reimbursement to reflect: (1) the complexity, time and effort of both institutional and practitioner services; (2) the uniqueness and total program of health care institutions, including medical education, community service and research; and (3) the resource needs of pediatric health care. ◆ Reimbursement to be adequate to meet the costs of effective and efficient delivery of health care and to ensure provider participation. ◆ Develop reimbursement rates.
Administrative Costs	
Manpower Development	<ul style="list-style-type: none"> ◆ National health policy built upon the current commitment of both public and private resources to pay for health care, with all payers meeting the costs of persons for whom they are responsible. Ensure that future resources are adequate to meet the direct service costs of providing care as well as the indirect costs of maintaining and improving the health care system, such as medical education, research, and capital development.
Research	<i>See Manpower Development.</i>
Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ A policy for universal financial access should include quality of care and provide measures to encourage cost-conscious behaviors on the part of consumers, providers, and third-party payers.
Other Major Provisions	<ul style="list-style-type: none"> ◆ Encourage and provide consumer education to increase awareness and understanding of available health care benefits, preventive and palliative, and their appropriate use.

Comments: These principles are intended as criteria for evaluating reform plans proposed by others.

SPONSOR: The National Leadership Coalition for Health Care Reform

PLAN: Excellent Health Care for All Americans At A Reasonable Cost

GOAL: Bringing higher quality health care to all Americans at a much lower cost.

Provision	Description
Coverage	◆ Universal coverage.
Benefits Package	◆ Inpatient hospital services, surgical services, qualified provider services, X-rays and laboratory services, prescription drugs, essential emergency services, mental health care and substance abuse with a lifetime maximum, routine physicals/tests, well baby/child care with vision, dental and hearing.
Financing	◆ Require employers to offer at least the standard benefits package or enrollment in Pro-Health, a public program, to both full-time and part-time employees. ◆ Require employers offering Pro-Health to pay a payroll tax of 7 percent, matched by an employee contribution of 1.75 percent. ◆ Require all firms to pay .5 percent of payroll for each employee, up to a maximum, toward the cost of Pro-Health; employees to pay .5 percent of payroll up to the Medicare cap.
Insurance/ Small Business	◆ Phase in provisions regarding employers for small businesses.
Beneficiary Cost Sharing	◆ Employees above poverty pay either 20 percent of the premium if insurance is offered, or 1.75 percent of their salary if Pro-Health is offered. ◆ A deductible of \$200 per person, \$400 per family. ◆ A limit of annual out-of-pocket expenses of \$1,500 per person, \$3,000 per family. ◆ A 20 percent co-payment on all services, except well-baby/child care up to age 18.
Provider Reimbursement	◆ An annual target for health care expenditures in both the public and private sectors to be set by a National Health Review Board, subject to Congressional approval. ◆ Establish payment rates for health care services. All payers would be bound by the rates. The rates would be payment in full. ◆ Allow states to apply for authority to use alternative payment methods, as long as the overall payment level is within the state's allocated share of the national expenditure target. <i>See Practice Guidelines.</i>
Administrative Costs	◆ Universal coverage and uniformity of rates lend themselves to the use of uniform claims forms and electronic billing.
Manpower Development	
Research	◆ The National Board on Health Care Quality to spearhead research efforts to determine what procedures are most effective in what circumstances, and to develop practice guidelines that reflect the findings of that research.
Quality Assurance/Practice Guidelines	◆ Use the practice guidelines developed by the National Board on Health Care Quality in decisions regarding payments to health care professionals, as standards in malpractice cases, and to help health care professionals decide how best to help their patients. <i>See Research.</i>
Other Major Provisions	◆ Use organized delivery systems (ODSs) to manage care, including inpatient, outpatient and long term care. ◆ An independent National Health Review Board to oversee and evaluate the ongoing restructuring of the health care system. It would develop each year's spending plan, update the payment rates, establish and maintain a national data bank on the operations of the health care system and recommend modifications in the standard benefits package.

Comments: Among the prominent citizens leading the Coalition are The Honorable Paul G. Rogers, The Honorable Robert D. Ray and Henry E. Simmons, M.D. Former presidents Jimmy Carter and Gerald Ford are the honorary co-chairs. According to the authors of the plan, it is "intended to be a living document; we fully expect that as we engage in a dialogue with other groups, citizens, and political leaders interested in health care reform, the plan will be refined and elements of it more fully developed and strengthened as appropriate." When the plan was made public shortly after Harris Wofford won a U.S. Senate seat in Pennsylvania on a platform that emphasized the need for health care reform, it was made the headline story by *The Washington Post*.

SPONSOR: National Governors' Association

PLAN: (No name given), August 1991

GOAL: A system that makes health care affordable and available for all Americans. Achieve a national consensus by developing comprehensive, statewide health care reforms.

Provision	Description
Coverage	◆ Eligibility for all Americans.
Benefits Package	
Financing	◆ Use existing Medicaid resources to fund a new public program to provide health care for individuals with incomes below a certain level of poverty and/or individuals who do not receive health insurance through their employment. ◆ Permit states flexibility in administering Medicare, Medicaid, grant programs and other health funds.
Insurance/ Small Business	◆ Find an approach to help small businesses provide insurance for their employees. ◆ Establish national uniform minimum standards for state health insurance reform. ◆ Provide waivers to override ERISA pre-emptions.
Beneficiary Cost Sharing	
Provider Reimbursement	
Administrative Costs	◆ Institute uniform electronic billing systems to reduce administrative overhead. ◆ Reduce cumbersome federal requirements that increase administrative costs.
Manpower Development	◆ Provide incentives for students and mid-career health professionals to serve in primary care professions, particularly in rural and underserved areas. ◆ Greatly expand the National Health Service Corps. ◆ Give priority to graduate medical education in family practice by reorienting existing subsidies through the Public Health Service Act and the Social Security Act. ◆ Expand Public Health Service Act support for graduate training of mid-level health professionals. ◆ Continue to aggressively pursue physician payment reforms that encourage entry into primary care related fields.
Research	◆ The federal government should augment current federal efforts to organize and support biomedical, psychosocial and developmental research, technology assessment, the effectiveness of alternative medical strategies and the relationship between medical procedures and health outcomes.
Quality Assurance/Practice Guidelines	◆ Develop benefit guidelines, based on the results of effectiveness and outcomes research and state experience. <i>See Research.</i>
Other Major Provisions	◆ Reform the medical tort system. ◆ Invest significant funds in statewide reform efforts. ◆ An enhanced federal effort to develop and disseminate health care information. ◆ Develop a long term care program.

Comments: This summary represents an agreement achieved at the 1991 meeting of the National Governor's Association. Because of partisan politics, it was not possible for the NGA to adopt a comprehensive plan; instead, it supported a state-based approach to reform that contains many options but few specifics.

SPONSOR: The Pepper Commission (The U.S. Bipartisan Commission on Comprehensive Health Care)

PLAN: A Call for Action

GOAL: Assure health coverage for all Americans through a job-based public system.

Provision	Description
Coverage	◆ A universal job-based/public system of health care coverage
Benefits Package	◆ Require all plans to provide hospital, surgical services, physician, diagnostic tests, limited mental health services, and some preventive services. ◆ Benefits package to include mandatory preventive services.
Financing	◆ Establish a public plan replacing Medicaid for employees who contribute and nonworking individuals who buy in. ◆ Require employers with more than 100 employees to provide private health insurance to employees and non-working dependents or to contribute to the public plan on their behalf. ◆ Require employers who provide private insurance to pay 80% of premiums for full-time employees and dependents and reduced amounts for part-time employees. Employers who contribute to the public plan pay a percentage of the payroll. ◆ Require individuals who receive private insurance to pay 20% of the premium and those who participate in the public plan to pay a percentage of wages as their share. Individuals below poverty pay nothing, those between 100%-200% pay premiums of up to 3% of income. ◆ Use federal revenues and state contributions equal to Medicaid expenditures to complete financing of the public program.
Insurance/ Small Business	◆ Provide assistance to small businesses to stimulate voluntary coverage. ◆ Tax credits for employers with fewer than 25 workers and average payroll below \$18,000; special provisions for businesses of ten employees or less that are at extreme financial risk. ◆ Employers with 100 or fewer workers not required to purchase coverage or contribute to the cost of coverage if coverage targets are met voluntarily. ◆ For all insurers: elimination of pre-existing conditions; no denial of insurance coverage for any individual in the group. ◆ For those selling insurance to the small group market: guaranteed acceptance of all groups; rates set on the same terms to all groups in specified areas; rates may not be increased selectively for any group enrolled in a plan; enrollment for a specified minimum period; at least one basic benefit package must be offered by each insurer in the small group market; if managed care plans are available to large employers in the area, they must also be offered to small groups; establishment of a self-financed voluntary reinsurance mechanism through which insurers could reinsure high-risk individuals or groups.
Beneficiary Cost Sharing	◆ Eliminate all cost sharing for those under 100% of poverty and institute sliding scale cost sharing for those up to 200% of poverty. Subsidize premiums and cost sharing for low income individuals. ◆ Limit deductibles to \$250 per individual and \$500 per family, and coinsurance to 20% for most services, with maximum annual out of pocket expenses limited to \$3,000 per person or family.
Provider Reimbursement	◆ Set reimbursement for the public plan according to rules of the Medicare program.
Administrative Costs	◆ Federal government to administer the public plan, but allow each state to administer the public plan at its option and according to federal rules.
Manpower Development	
Research	

Continued . . .

Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Develop national practice guidelines and standards of care. ◆ Develop a uniform data system covering all health care encounters to provide information on quality assessment and effectiveness. ◆ Develop local review organizations.
Other Major Provisions	<ul style="list-style-type: none"> ◆ Study and conduct demonstration projects related to medical malpractice reform. ◆ Increase federal support for programs in health promotion and disease prevention. ◆ Propose a separate program for long term care.

Comments: Following the death of Congressman Claude Pepper, Senator Jay Rockefeller took over as the chairman of the Commission. Once its report was issued, the Pepper Commission ceased to exist, although many of the ideas it spawned have been advocated elsewhere. It should be noted that Congressman Henry Waxman (D-Calif.) introduced the Pepper Commission Health Care Access and Reform Act of 1991 (H.R. 2535).

SPONSOR: Representative Daniel Rostenkowski (D-Ill.)

PLAN: Health Insurance Reform and Cost Control Act of 1991 (H.R. 3626), November 1991

GOALS: To provide for improvements in health insurance coverage through employer health insurance reform, for health care cost containment, and for improvements in Medicare prevention benefits.

Provision	Description
Coverage	
Benefits Package	<ul style="list-style-type: none"> ◆ For small employers (2 to 50 employees), benefits to include those offered under Parts A and B of Medicare, unlimited inpatient hospital services for children and pregnancy related services. ◆ In addition to what is now covered by Medicare, benefits to include colorectal screening, certain immunizations, well-child services for children under 19, annual mammography screening for women over 64.
Financing	
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Prohibit small employers from self-insuring for health benefits. ◆ Increase the deduction for health insurance for self-employed individuals until it reaches 100 percent in 1995 and thereafter. ◆ Requirements for health insurance plans issued to small employers: guaranteed eligibility for all eligible employees, spouses and dependent children; the plan must be the same as is offered to any other small employer located in the same geographic area; a health maintenance organization may only deny enrollment to employees of small employers if the denial is applied uniformly without regard to health status or insurability; guaranteed renewability; there will be no discrimination based on health status for certain services; limitations on variation in the index rate for any "block of business" (i.e., all of the small employers with a health insurance plan issued by the insurer). ◆ Impose tax penalties on any insurers not meeting the provisions of the Act. ◆ Group health plans may not deny, limit or condition coverage with respect to standard health services on health status, claims experience, receipt of health care, medical history or lack of evidence of insurability. ◆ Exclusions for pre-existing conditions may not exceed 6 months.
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ For employees of small employers: the deductible will be \$250 for an individual and \$500 for a family per year; the deductible does not apply to preventive services; no coinsurance for preventive services or for inpatient hospital services for children; out-of-pocket expenses limited to \$2,500 for an individual or \$3,000 for a family per year.
Provider Reimbursement	<ul style="list-style-type: none"> ◆ HHS shall establish optional payment rates for hospital, physician and other health items and services that will be based on Medicare payment rates. If purchasers make payment on the basis of these rates and make payment on a timely basis, the payment will be considered payment in full.
Administrative Costs	<ul style="list-style-type: none"> ◆ HHS will develop uniform claims forms for use by beneficiaries and providers submitting claims under group health plan, Medicare and Medicaid.
Manpower Development	
Research	
Quality Assurance/Practice Guidelines	
Other Major Provisions	<ul style="list-style-type: none"> ◆ Establish a National Health Care Cost Commission to report to Congress on increases in health care spending and to review payment. ◆ Establish demonstration projects to determine the feasibility and desirability of covering other screening tests.

Comments: A companion bill (S. 1872) was introduced into the Senate by Senator Lloyd Bentsen (D-Tex.). H.R. 3626 can be characterized as an incremental reform bill. Congressman Rostenkowski has also introduced the Health Insurance Coverage and Cost Containment Act of 1991 (H.R. 3205), which is comprehensive reform legislation that has as its goal providing for health insurance coverage for workers and the public in a manner that contains health care costs. As reported in BNA's *Medicare Report* (vol. 2, no. 13, p. 572, Nov. 1, 1991): "While major reform is further off, Bentsen and Rostenkowski said they believe smaller steps can be taken to improve health care access, and small business is a good place to start. 'We know that most of the uninsured are members of the middle class,' Rostenkowski said. 'They're members of working families. Their employer is usually a small business.'"

SPONSOR: Representative Marty Russo (D-Ill.)

PLAN: The Universal Health Care Act of 1991 (H.R. 1300)

GOAL: Health insurance benefits for every citizen, national, or resident alien of the United States.

Provision	Description
Coverage	◆ For every resident who is a citizen or national of the United states or a lawful resident alien. Benefits may be extended to aliens admitted to the U.S. as nonimmigrants.
Benefits Package	◆ Inpatient hospital services; nursing facility services; home health services; hospice care; medical and other health services; prescription drugs and biologicals; preventive health services, including prenatal and postnatal care and preventive care for children; limited inpatient and outpatient mental health services; home and community-based services for those over 18 years who are unable to perform at least 2 activities of daily living; some benefits provided for those under 19 who meet a standard of disability for children.
Financing	◆ Each year there will be a national health budget, and for each state a state health budget. The national health budget will be limited to the amount spent for covered benefits in 1992, increased by a specified factor. This system will replace Medicare, Medicaid, the Federal Employees Health Benefits Program, CHAMPUS, and Veteran's Benefits. ◆ Create a National Health Trust Fund. It will include money collected from specified taxes on wages and on self-employment income. ◆ Increase individual income taxes, the employer hospital insurance tax, and the income tax paid on social security benefits. Repeal the dollar limitation on wages subject to employee and employer hospital insurance taxes. ◆ Except for the low-income elderly, any individual 65 years or older will pay a long-term care/health premium of \$55 per month. This money will be deposited into the National Health Trust Fund.
Insurance/ Small Business	
Beneficiary Cost Sharing	◆ No coinsurance, deductible or copayments for covered benefits. <i>See Financing.</i>
Provider Reimbursement	◆ Payment made only to providers of services which have entered into a participation agreement and meet specified conditions. ◆ Payment for hospital and nursing facility services based on an annual budget for operating expenses for the institution. The budget will be reviewed by a State advisory board. Separate budgets will be prepared for capital expenses and direct medical education. ◆ Payments for home health, hospice care, home and community-based services and facility-based outpatient services based on either a budget or a fee schedule, at the selection of each facility. ◆ A Long-Term Care Payment Review Commission will advise the Secretary of Health and Human concerning payment amounts. ◆ Payments for physicians' and other professional services based on a fee schedule. ◆ Payments for any other items and services on the basis of a fee schedule.
Administrative Costs	◆ A mechanism for enrollment of individuals and issuance of a national health insurance card which may be used for identification and processing of claims for benefits. Automatic enrollment from the time of birth or immigration to the U.S., or at the time an individual attains lawful resident status. ◆ Fiscal agents will contract with HHS to process claims. Only one contract per state.
Manpower Development	◆ The national health budget shall include an amount for total expenditures for direct medical education expenses. The budget shall be based on a national plan for training of medical personnel developed by the Secretary of Health and Human Services and shall provide for state budgets for direct medical education expenses.
Research	
Quality Assurance/Practice Guidelines	
Other Major Provisions	◆ HHS shall have an office in each state to administer this program, or a state may request to administer the provisions itself.

SPONSOR: Representative Fortney (Pete) Stark (D-Calif.)

PLAN: Mediplan Health Care Act of 1991 (H.R. 650), January 1991

GOAL: To assure the provision of health insurance coverage to all residents.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Universal, except for residents of any state if that state does not make its monthly payment into the Mediplan Trust Fund. Automatic enrollment at the time of birth.
Benefits Package	<ul style="list-style-type: none"> ◆ The same benefits as under Parts A and B of Medicare, and additional benefits. ◆ For children (those less than 23 years old): newborn and well-baby care, well-child care, including routine office visits, immunizations, laboratory tests and dental care, unlimited inpatient hospital services, outpatient prescription drugs and biologicals and eyeglasses and hearing aids and associated exams. ◆ For individuals whose modified gross income is less than 100 percent of the poverty level: unlimited inpatient hospital services, outpatient prescription drugs and biologicals, eyeglasses and hearing aids and associated examinations. ◆ For pregnant women: prenatal care, inpatient labor and delivery services, postnatal care, and postnatal family planning services.
Financing	<ul style="list-style-type: none"> ◆ Creation of a Mediplan Trust Fund to replace the current Medicare Trust Funds and to be funded through taxes. ◆ For individuals: payment of a basic and supplemental tax, or equivalent Mediplan health care premium. ◆ Exemption from the basic tax for Medicare beneficiaries. ◆ Payment of a tax by all corporations, including those exempt from taxes under section 501(a), of 2 percent of their modified gross incomes. Imposition of an additional tax on wages paid by employers, not to exceed \$800 per individual annually. ◆ Payment by states of an amount equal to that paid Medicaid in 1991. ◆ Prohibit Medicaid, CHAMPUS and the Federal Employees Health Benefits Plans from paying for services covered by Mediplan.
Insurance/ Small Business	
Beneficiary Cost Sharing	<ul style="list-style-type: none"> ◆ \$500 deductible per individual 23 years and older. No deductible or cost sharing for children, pregnant women, or low-income individuals for the Mediplan benefits. ◆ Limitation on out-of-pocket expenses of \$2,500 per year per individual. A lower limit for individuals whose modified gross income exceeds the poverty level, but is less than twice the poverty level.
Provider Reimbursement	<ul style="list-style-type: none"> ◆ The same payment rates as under Medicare. ◆ For inpatient hospital services: establish new DRGS and weights to reflect the types of discharges occurring under Mediplan. ◆ Prohibition on balance billing. ◆ For obstetrical services: Establish a global fee for obstetrical services; a 5 percent increase in the fee schedule amount for obstetrical services furnished to women who have received prenatal care during the first trimester; payment of 95 percent of the fee schedule amount if a woman receives a cesarean section. ◆ Establish a prospective payment methodology for outpatient prescription drugs and biologicals.
Administrative Costs	<ul style="list-style-type: none"> ◆ Use of a Mediplan card for purposes of identification and claims processing. ◆ Use of fiscal intermediaries and carriers to administer Mediplan. ◆ Require electronic submission of bills.
Manpower Development	
Research	
Quality Assur- ance/Practice Guidelines	
Other Major Provisions	

Comments: Representative Stark has also introduced the Mediplan Long-Term Care Act of 1991 (H.R. 651) and Insurance Reform Act of 1991 (H.R. 2121).

SPONSOR: The Steelman Commission (1991 Advisory Council on Social Security)

PLAN: Commitment to Change: Foundations for Reform, December 1991

GOAL: Improved access to health care, a significant reduction in the rate of growth of health care costs and an increase the rate of growth in the general economy, fundamental reform of many of the basic institutions involved in the delivery and financing of health care, and full involvement of the American people in the commitment to change.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Improved access for children and other underserved populations through school based clinics, the expansion of the Community and Migrant Health Center Program and health insurance reforms.
Benefits Package	
Financing	
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Assist states in offering school based major medical insurance. ◆ Health insurance reforms: improved portability of private insurance and federal legislation to establish new rules for insurance sold to small employers. ◆ Disallowance of state mandated benefits for small employer core benefit plans. ◆ Make the tax treatment of health insurance for the self employed equivalent to that of employees. ◆ Pre-emption of state laws limiting the use of managed care.
Beneficiary Cost Sharing	
Provider Reimbursement	<ul style="list-style-type: none"> ◆ Medicare selective contracting for cost efficient providers of specific high cost procedures. Reimbursement only to certified providers. ◆ Establish Medicare centers of excellence for major surgical procedures. Reimbursement only to designated facilities.
Administrative Costs	<ul style="list-style-type: none"> ◆ Establish an Advisory Council on Health Claim Standardization to develop a uniform claim.
Manpower Development	<ul style="list-style-type: none"> ◆ See <i>Quality Assurance/Practice Guidelines</i>.
Research	
Quality Assurance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Require information on medical treatment outcomes on local and regional health care markets to make assessments easier and correct weaknesses in manpower and facility resource allocation, use trends and financing allocations. ◆ Give effectiveness research and medical practice guidelines broader exposure through development of a medical school curriculum and programs to better inform physicians in their personal practice. ◆ Include basic research to improve health outcomes while reducing costs on the research agenda of the Institute of Medicine. ◆ Establish an Advisory Group on Technology Assessment Data to make technology assessment and data pooling easier.
Other Major Provisions	<ul style="list-style-type: none"> ◆ A commitment to reduce infant mortality. ◆ A reduction in the federal deficit to improve the productive capacity of the economy. ◆ Actions to accelerate the promotion of healthy lifestyles. ◆ Research to foster independent living for impaired persons. ◆ Disease prevention efforts. ◆ Establish an alternative procedure to adjudicate malpractice claims. ◆ Revise rules limiting hospital mergers and joint ventures if increased efficiencies would result. ◆ To assist individuals facing terminal illnesses, establish a registry containing individuals' instructions regarding specified life-prolonging procedures. ◆ Designate a Federal Oversight Commission to identify and support appropriate comprehensive community or state initiatives which would serve as precursors to systemic reform at the national level.

Continued . . .

Comments: The 1991 Advisory Council on Social Security is popularly known as the Steelman Commission because it was headed by Deborah Steelman, George Bush's health policy advisor during his 1988 presidential campaign. Commission members were appointed by HHS Secretary Louis W. Sullivan in 1989 and originally were expected to produce recommendations within a year. The final report was not issued until the end of 1991. Some expect that the majority report will become the blueprint for a series of incremental health care reform proposals expected to be introduced by President Bush. As reported by *The Washington Post*, four members of the 13-member commission--Robert Ball, former Social Security Commissioner, John Dunlop, former Secretary of Labor, Karen Ignani, AFL-CIO health policy director and John Sweeney, president of the Service Employees International Union--issued a minority report that sharply criticized the majority report as "useful only as a shopping list" of "new furniture for a house that is on the verge of collapse."

SPONSOR: U.S. Chamber of Commerce

PLAN: Finding the Best Prescription for the Nation's Health Care Woes, June 1989

GOAL: Immediate action to lessen the number of uninsured, and, ultimately, a system of public and private insurance that would assure universal financial access to appropriate health care.

Provision	Description
Coverage	<ul style="list-style-type: none"> ◆ Expand Medicaid to address the needs of the poor and near-poor. Assure basic Medicaid coverage to all Americans with incomes below the federal poverty level.
Benefits Package	<ul style="list-style-type: none"> ◆ Pre-empt state-level benefit mandates and repeal or simplify federal benefit mandates.
Financing	<ul style="list-style-type: none"> ◆ Allow persons with incomes between 100 and 150 percent of the federal poverty level to purchase, for a sliding-scale premium, primary care coverage through Medicaid. Permit persons with incomes above the poverty level with large medical expenses to "spend down" and become eligible to receive Medicaid coverage once income is reduced to federal poverty level. ◆ Provide access to state pools for high risk individuals. ◆ Promote expanded voluntary coverage through the workplace. ◆ Encourage multiple employer trusts to help small firms obtain health care coverage on a more cost-effective basis. ◆ Provide states the option of paying Medicaid-eligible employees' share of premium and other costs where private employer-based coverage is available.
Insurance/ Small Business	<ul style="list-style-type: none"> ◆ Allow a 100 percent deduction of health benefits costs for self-employed persons and unincorporated firms. ◆ Change insurance underwriting practices to: accept all employees when providing group coverage to a company, guarantee renewal at pooled rates once the group is accepted, impose no new pre-existing condition limitations on an individual who has been continuously insured when that person changes employment or coverage, provide a reinsurance pooling mechanism to spread risks among participating insurers and HMOs.
Beneficiary Cost Sharing	
Provider Re- imbursement	<i>See Quality Assurance/Practice Guidelines.</i>
Administrative Costs	<ul style="list-style-type: none"> ◆ Explore how new information technologies can be used to reduce paperwork and regulatory costs.
Manpower Development	
Research	
Quality Assur- ance/Practice Guidelines	<ul style="list-style-type: none"> ◆ Promote the development of national medical practice standards to assure appropriate and effective care. ◆ Establish computerized medical records systems to monitor and improve the quality, appropriateness and efficiency of medical care. ◆ Produce a mechanism for authorizing reimbursement for new medical technology.
Other Major Provisions	<ul style="list-style-type: none"> ◆ Relate the use of practice standards by physicians to protection from malpractice claims. ◆ Use of managed care technology in Medicare and Medicaid.

Remarks by Richard Darman, Director, Office of Management and Budget (before the House Committee for Ways and Means), October 1991. *Comprehensive Health Reform: Observations About the Problem and Alternative Approaches to the Solution.*

Comments: The Bush administration has yet to propose a comprehensive reform plan. Yet some of the administration's thoughts on the subject can be gleaned from testimony given this past October by Richard Darman, Director, Office of Management and Budget, before the House Committee on Ways and Means. Mr. Darman's reflections are important because he can be expected to play a major role in crafting any health care reform proposal put forward by the administration. In his testimony Mr. Darman made what he termed "eighteen simple observations -- half about the problem, half about solutions." While each observation was accompanied by supporting data or additional explanation, only the observations are reported here, as follows:

About the problem:

1. The growth of federal expenditures for health is part -- an increasingly important part -- of a more general budgetary problem: the explosion of "mandatory" programs.
2. Health expenditures are rising at a rate that is not only high, but also unsustainable.
3. Although real per capita health expenditures have been rising dramatically, there are reasons to be disturbed about both the adequacy and the distribution of the return on this increasing investment.
4. The problem of "the uninsured" is not quite as simple -- in either its incidence or its effect -- as some may naturally think.

5. Although one might think that the massive federal expenditures for health should go substantially to the poor, in fact they go overwhelmingly to the non-poor.
6. Reducing public subsidies for the non-poor can help free limited public funds for other purposes (including expanded health benefits for the poor or the uninsured near-poor) -- but this is a matter of public budgeting and equity, not system-wide cost control.
7. The causes of the health cost explosion are multiple -- and not easy to disentangle in a way that points reliably to a stable solution.
8. Strategies to continue to improve life expectancy are desirable -- but they do not necessarily reduce (and may substantially increase) system-wide costs.
9. If not only average life expectancy, but also maximum life span are likely to increase, costs will increase still more -- and budgetary considerations will become an important additional justification for raising the retirement age and providing satisfactory work opportunities for healthy older Americans.

About the solution:

10. The Administration has advanced publicly a set of responsible initiatives, in which there is reason to have confidence -- but these have not been viewed as "comprehensive"; and many, though worthy, have not been enacted.

11. There are several pending proposals for small group market reforms, which could address a significant portion of the "access" problem -- but these too are not deemed "comprehensive."
12. To meet the political system's current definition of "comprehensive," a plan seems to have to: (a) provide access to affordable health insurance coverage for all (or almost all) Americans; and (b) control the growth of health costs -- but the political system seems to be enforcing a political bargain upon itself: trading cost control for access and vice-versa.
13. In thinking about "comprehensive reform," there are literally thousands of complex technical issues -- but larger than these are two rather basically philosophical issues that should be directly addressed, yet typically are not:
 - In financing increased "access," who should bear the burden of financial responsibility?
 - In seeking to control costs, on what cost-control approach does one wish to rely?
14. Addressing the "access" problem inescapably means shifting tens of billions of dollars (per year) of health care financing.
15. Because many financing options are unappealing, some people seem attracted to supposedly "painless" options such as "administrative" savings -- but upon careful examination, proposals to finance universal access via savings in "administrative costs" generally come up way short.
16. There is an abundance of comprehensive reform plans -- but most current plans have serious problems even without taking basic ideological issues into account.
17. The problems with comprehensive reform proposals can seem so large, upon serious examination, that they become an argument for proceeding incrementally -- but this, too, is problematic.
18. If the risks of incrementalism are deemed unacceptable at this stage, it is necessary to settle upon one of the three basic conceptual alternatives for comprehensive reform: "Canadian-style" vs. "play-or-pay" vs. "pro-competitive."

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PART II



SELECTED BIBLIOGRAPHY

About Part II . . .

This bibliography contains recent articles and documents on topics related to health care reform. It is meant to provide a starting point for anyone interested in further reading and research. Therefore, the journals selected are well-known and readily available. To give readers an understanding of the broad range of issues which drive the health care reform debate, the references are organized by subject matter. Since many publications touch on more than one topic covered in the bibliography, cross-referenced citations are provided.

The articles chosen were published in 1990 or 1991 in twelve leading medical and health policy journals: *Academic Medicine (Acad Med)*, *Annals of Internal Medicine (Ann Intern Med)*, *Health Affairs (Health Aff)*, *Health Care Financing Review (Health Care Financ Rev)*, *Health Services Research (Health Serv Res)*, *Inquiry*, *Journal of the American Medical Association (JAMA)*, *Journal of Health Politics, Policy and Law (J Health Polit Policy Law)*, *Journal of the National Medical Association (J Natl Med Assoc)*, *The Lancet*, *The Milbank Quarterly (Milbank Q)*, and *The New England Journal of Medicine (New Engl J Med)*. In addition, to emphasize the breadth of public interest in this area, three lead magazine articles are included from *Business Week*, *Time* and *U.S. News and World Report*.

Also contained in the bibliography are a number of documents recently published by major government and non-government entities, including publications by the Association of American Medical Colleges, the Group Health Association of America, the Institute of Medicine, the National Academy for State Health Policy, the National Governors' Association, the National Health Policy Forum and the Intergovernmental Health Policy Project, as well as the Congressional Budget Office, the General Accounting Office, the Prospective Payment Assessment Commission, and the U.S. House of Representatives Subcommittee on Health of the Committee on Ways and Means. Some of these organizations and examples of their publications are listed under Additional Sources of Helpful Information.

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