94-185 EPW

CRS Report for Congress

Summary Comparison of Selected Health Care Reform Bills

Health Section
Education and Public Welfare Division

March 2, 1994

Congressional Research Service • The Library of Congress

SUMMARY COMPARISON OF SELECTED HEALTH CARE REFORM BILLS

SUMMARY

A wide range of legislative proposals have been introduced in the 103rd Congress for expanding access to health insurance. This report summarizes, in a comparative format, seven proposals that embody different viewpoints on the issue. Together, they represent a spectrum of approaches, ranging from those that would rely on tax incentives or other assistance for individual insurance purchasers, to mandating employer contributions to health premium costs, to establishing a national health insurance system. The following bills have been included in this side-by-side comparison:

H.R. 3600/S. 1757 (President Clinton's plan) would require all persons to obtain a comprehensive health benefits package from large insurance purchasing cooperatives called health alliances. Health plan premiums would be paid through a combination of employer and individual contributions, supplemented by Federal subsidies for many firms, early retirees, and persons with incomes below certain levels. A national health care budget would be established for expenditures for services covered under the comprehensive package. This budget would limit both initial premiums and the year-to-year rates of increase that could be charged by health plans participating in the alliances. Ultimately premiums could grow no faster than the rate of growth in per capita gross domestic product, unless Congress specifies a different inflation factor.

H.R. 1200/S. 491 (McDermott/Wellstone) would establish a single-payer national health insurance program that would be federally mandated and administered by the States. This program would replace private health insurance and public program coverage. The program would provide coverage of comprehensive health and long-term care benefits. A national board would establish a national health budget which would be distributed among the States, based on the national average per capita cost of covered services, adjusted for differences among the States in costs and the health status of their populations.

H.R. 3080/S.1533 (Michel/Lott) is an incremental proposal that seeks to improve the availability and affordability of insurance. All employers would be required to offer, but not pay for, a basic health benefit plan. The proposal includes regulation of underwriting and rating practices in the small group market and requirements that insurers offer three different health plans and portability of coverage. It also includes measures to encourage development of multiple employer purchasing groups.

H.R. 3222/S.1579 (Cooper/Breaux) also seeks to improve the availability and affordability of insurance but within a managed competition structure. States would establish health plan purchasing cooperatives (HPPCs) that would contract with accountable health plans (AHPs). AHPs would be required to cover a uniform set of benefits and comply with premium rating and underwriting standards. All employers would be required to offer, but not pay for, coverage in an AHP. Small employers with 100 or fewer employees would have to participate in the HPPC; larger employers could offer their own AHP. Health plan expenses would be tax deductible up to the cost of the lowest-cost basic plan in the area. An excise tax would be imposed on employer contributions in excess of this level.

H.R. 3698/S.1743 (Stearns/Nickles) resembles the Heritage Foundation's health reform proposal. All persons would be required to purchase health insurance through a plan meeting Federal standards relating to minimum benefits and rating and underwriting practices, or through a State-established health plan. Current tax exclusions for employer-sponsored health plans would be replaced with refundable tax credits for a portion of the premium cost of qualified health insurance plans and for other medical expenses. Employers currently providing health benefits would be required to convert them into added wages.

H.R. 3704/S.1770 (W.Thomas/Chafee) would require all persons to purchase coverage through a qualified health plan, or face a penalty for noncompliance. All employers would be required to offer their employees enrollment in a qualified health plan, or face a penalty for noncompliance. No employer, however, would be required to make contributions for coverage of an employee. Small employers and individuals could participate voluntarily in State-established purchasing cooperatives or select other qualified plans. All plans would have to offer standard benefits and would be subject to restrictions on rating and underwriting practices. Federal subsidies in the form of vouchers would be phased-in for low-income persons, subject to savings being achieved under the Medicare and Medicaid programs.

H.R. 3918/S. 1807 (Santorum/Gramm) is an incremental proposal that seeks to improve the availability and affordability of insurance. New Federal tax exclusions, deductions, and refundable credits would be made available to individuals for the purchase of health insurance and/or for contributions to medical savings accounts. The proposal would also prohibit certain insurance underwriting practices, and would subsidize premium expenses for certain persons with preexisting conditions. Phase-in of new Federal subsidies would be contingent on the achievement of Federal savings under the Medicare and Medicaid programs.

TABLE OF CONTENTS

I. GENERAL APPROACH 1
II. ADMINISTRATIVE STRUCTURE 5
A. Federal Role 5
B. State Role 6
C. Employer Role 8
D. Employee/Individual Role 9
III. PURCHASING ALLIANCES/COOPERATIVES 11
A. Regional Alliances/Cooperatives 11
B. Treatment of Large Employers 12
IV. FINANCING 14
A. In General 14
B. Employer 15
C. Employee/Individual 16
D. Federal Subsidies 18
E. Limitation on Federal Subsidies 20
F. State Payments 21
G. Federal Revenues, Tax Expenditures, and Savings 22
1. Federal Revenues 22
2. Tax Code Changes: Employers, Employees, and Health Plans 24
3. Federal Program Savings 30
V. BENEFITS 32
VI. BENEFICIARY COST-SHARING 34
VII. PROVIDER PAYMENTS 37
VIII. EXPENDITURE TARGETS AND PREMIUM REGULATION 41
A. Expenditure Targets 41
B. Premium Targets 43
IX. PRIVATE HEALTH INSURANCE REFORM 45
A. General Approaches 45
B. Availability 48
C. Portability 54
D. Rating Restrictions 57
E. Risk Adjustment and Reinsurance 59
F. Other Requirements 61
X. ADMINISTRATIVE SIMPLIFICATION 64
A. Overview 64

B. Unique Identifier Numbers 68
C. Health Security Cards 68
D. Confidentiality of Health Care Information 69
E. State Quill Pen Laws 69
XI. MALPRACTICE 71
A. Tort Reforms 71
B. Alternative Dispute Resolution (ADR) 79
C. Practice Guidelines 74
D. Enterprise Liability 75
XII. ANTI-TRUST 76
XIII. QUALITY 78
XIV. FRAUD 81
XV. MEDICARE 84
A. Medicare and Revised System 84
B. New Medicare Benefits 86
C. Reductions in Medicare Spending 87
XVI. MEDICAID 89
XVII. LONG-TERM CARE 92
A. New Federal Program 92
B. Medicaid and Long-Term Care 93
C. Private Long-Term Care Insurance 94
1. Tax Code Clarifications 94
2. Long-Term Care Insurance Standards 95
D. Other Provisions 96
XVIII. OTHER FEDERAL PROGRAMS 98
A. Military Health Care 98
B. Department of Veterans Affairs 99
C. Federal Employees Health Benefits Program 100
D. Indian Health Service 101
XIX. UNDERSERVED AREAS/POPULATIONS 104
XX. HEALTH PROFESSIONS EDUCATION AND TRAINING 107
A. Graduate Medical Education 107
B. Health Professions Education and Training 110

A number of individuals at CRS contributed to this document. Richard Price served as project manager. Others contributing included Phillip Brogsdale, Waymond Elliott, Melvina Ford, Celinda Franco, Beth Fuchs, Shelley Harlan, Janet Kline, Mark Merlis, Jennifer O'Sullivan, and Mallary Stouffer.

SUMMARY COMPARISON OF SELECTED HEALTH CARE REFORM BILLS

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
I. GENERAL APPROACH All U.S. citizens and legal residents would be required to obtain a comprehensive health benefits package from large insurance purchasing cooperatives called health alliances. Large employers with more than 5,000 employees could establish their own alliances. States could provide the comprehensive benefits through a single-payer system. Only State-certified health plans could provide coverage through the alliances. Health plans would be required to accept every eligible person enrolled by an alliance and could not impose preexisting coverage restrictions. Premiums for these plans would have to be community-rated. Health plan premiums would be paid through a combination of employer and individual	**I. GENERAL APPROACH** All U.S. citizens and legal residents would be entitled to coverage of comprehensive health and long-term care benefits through a federally established national health insurance program administered by the States. This program would replace private health insurance, Medicare, Medicaid, and other Federal health programs. All policies regarding implementation of the program would be established at the Federal level by a Health Security Standards Board. This Board would also establish a national health budget which would be distributed among the States, based on the national average per capita cost of covered services, adjusted for differences among the States in costs and the health	**I. GENERAL APPROACH** All employers (excluding certain new and small employers) would be required to offer employees a group health plan that covers essential and medically necessary medical, surgical, hospital, and preventive services. Employer-offered group plans would be required to limit the use of preexisting condition exclusions and provide portability and renewability protections. No employer, however, would be required to make contributions to the cost of coverage under a plan. Insurers selling insurance to small employers (defined as having 2 to 50 employees) would be required to offer a standard benefits plan, a catastrophic plan, and a medical savings account option (that includes catastrophic coverage and a medical	**I. GENERAL APPROACH** All U.S. citizens and legal residents would be eligible to enroll in accountable health plans (AHPs). AHPs would be required to cover a uniform set of benefits and comply with premium rating standards and limit preexisting condition restrictions. A Health Care Standards Commission (National Health Board under S. 1579) would make recommendations to Congress on a uniform set of benefits, including cost sharing. Small employers (defined as firms having 100 or fewer employees) would be required to enter into agreements with health plan purchasing cooperatives (HPPCs) for offering their employees coverage. Larger employers would have to offer a plan (which could be a "closed" plan available only to that	**I. GENERAL APPROACH** All residents of a State (who are not beneficiaries of other Federal programs) would be required to purchase federally qualified health insurance or be covered under a State program that provides equivalent coverage. Qualified health insurance plans would be required to cover all medically necessary acute medical care; have premiums that varied only on the basis of age, sex, and geography; guarantee coverage to all persons seeking enrollment; and limit preexisting condition exclusions. Current tax exclusions for employer-sponsored health plans would be replaced with refundable tax credits for a portion of the premium cost of qualified health insurance plans and for other medical expenses. At a minimum, tax	**I. GENERAL APPROACH** All U.S. citizens and legal residents would be required to purchase coverage through a qualified health plan. All employers would be required to offer their employees enrollment in a qualified health plan. Small employers with 100 or fewer employees could either join a purchasing group or offer standard or catastrophic benefits through a qualified health plan. Large employers would be required to offer both a standard and catastrophic benefit package, and could form their own purchasing groups, arrange coverage from a qualified plan, or self-insure. No employer would be required to make contributions for coverage of an employee. All qualified plans would have to cover benefits recommended by the	**I. GENERAL APPROACH** Employers would be required to offer employees three options for health insurance and to make equal contributions to the plan selected by the employee, in order for group health plan expenses to be tax deductible. Employers, however, would not be required to make contributions to employees' health insurance coverage. Premiums for a health plan and/or medical savings account contributions would be excluded from taxable income for all persons (including the self employed) not eligible for employer-paid coverage. Refundable tax credits for catastrophic insurance coverage would be available for persons with incomes below 200 percent of the Federal poverty level and not

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
contributions, supplemented by Federal subsidies for many firms, early retirees, and persons with incomes below certain levels. Current Medicare beneficiaries would continue to be covered under the program as they are today, except that the working aged would continue to be covered under their employer-paid plans. Persons enrolled in an alliance managed care plan before becoming Medicare eligible could, on turning 65, choose to remain in the plan and receive benefits through it. States would have the [illegible]tion of integrating p[illegible]pecified [illegible]edicare [illegible] health [illegible]ified	status of their populations. With their allocations, States would make payments to providers according to prospective budgets or fee schedules negotiated between States and providers. States could also make payments to comprehensive health service organizations based on their budgets or on risk-adjusted capitation payments. Services would be financed by a combination of new individual and corporate taxes and premiums, and additional tax code changes.	savings account to pay for unreimbursed medical expenses). Insurers would be required to accept every small employer and every eligible employee of a small employer who applies for coverage under a plan. Insurers would be required to limit premium variations charged to small businesses and also to limit premium increases from 1 year to the next. The bill also facilitates the ability of employers to form groups for the purpose of purchasing health coverage. The deductibility of health insurance premiums would be increased for the self-employed and those not receiving employer-sponsored coverage. Medicare would continue to cover persons as it does today. States would be given the option of allowing Medicaid beneficiaries to enroll in private insurance plans. States	firm's employees) directly, rather than through the HPPC. No employer, however, would be required to make contributions for coverage of an employee in an accountable health plan. Health plan expenses would be tax deductible up to the cost of the lowest-cost basic plan in the area. An excise tax would be imposed on employer contributions in excess of this level. The tax deductibility of health insurance premiums for the self-employed would be increased and individuals who pay any part of an AHP premium would be able to deduct their payments. Federal subsidies would be available for providing premium and copayment assistance to persons with incomes below 200 percent of the State's poverty level; this assistance would replace the acute care	credits would be equal to 25 percent of the premium and unreimbursed medical care expenses for those persons whose expenses amounted to less than 10 percent of their gross incomes. Tax credits would increase as premium and medical care expenses increased as a proportion of a person's income. Medical savings accounts established for the purpose of paying medical expenses would also be eligible for a tax credit. Employers would be required to add the value of the coverage they paid for as of December 1996 to employee wages beginning January 1997. Persons receiving health benefits under Medicare, Medicaid, and other Federal health programs would not be eligible for these tax credits. A new Federal program of grants to the States would assist persons with incomes below 150 percent of the Federal	Benefits Commission. They would be required to limit variations in premiums and would be required to limit preexisting condition exclusions. Health insurance premiums would be deductible for qualified plans up to a capped amount. A tax-favored medical savings account would be available for those individuals electing a catastrophic benefit plan in order to pay cost sharing expenses. Federal subsidies in the form of vouchers would be phased-in for low-income persons, subject to savings being achieved under the Medicare and Medicaid programs. States would have the option of providing coverage to Medicaid beneficiaries through a private purchasing cooperative, a managed care plan, or other alternative. The Secretary of Health and Human Services (HHS) would develop a legislative proposal for	eligible for Medicaid or Medicare. Insurers and employers would generally be prohibited from canceling health insurance plans or denying renewals of coverage. Individuals could purchase new individual policies and groups could move from group to individual plans without being denied coverage because of preexisting conditions or health status. A new Federal program of grants would be available to those States that chose to establish insurance pools for providing premium assistance to persons who have preexisting coverage and who are unable to afford catastrophic insurance coverage. Medicare would continue to cover persons as it does today, or beneficiaries could elect to have Medicare make payments for their enrollment in a

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
noncash Medicaid beneficiaries would enroll in plans through alliances, with most presumably qualifying for Federal subsidies. By January 1, 1998, every eligible person would be insured through the new system or existing Federal programs. A national health care budget would be established by a National Health Board for expenditures for services covered under the comprehensive package. This budget would limit both initial premiums and the year-to-year rates of increase that could be charged by health plans participating in the alliances. Ultimately premiums could grow no faster than per capita gross domestic product (GDP), unless Congress specifies a different inflation factor. New Federal costs would be financed by a tobacco tax, assessment		establishing "health allowance programs" for this purpose could also extend Medicaid coverage to persons with higher incomes and others without insurance coverage. New Federal costs would be financed through Medicare spending reductions, an increase in the regular civil service retirement age, and a requirement that Federal agencies prefund Federal retiree health benefits.	portion of Medicaid. Federal payments to the States for the long-term care component of Medicaid would be phased out. Medicare would continue to cover persons as it does today. New Federal costs would be financed by capping the employer deductibility of health insurance premiums, reducing Medicare spending, and requiring Federal agencies to prefund Federal retiree health benefits.	poverty level to meet the costs of health insurance, acute medical care, and preventive services. Medicare would continue to cover persons as it does today. New Federal costs would be financed through Medicare and Medicaid spending reductions (and, under H.R. 3698, elimination of welfare benefits for most noncitizens).	enrollment of Medicare beneficiaries into qualified health plans. Current Medicare beneficiaries would have the option of obtaining services through their current arrangements or enrolling in qualified health plans with certain maximum Federal payments made toward the premium costs of those plans. If the vouchers for low income persons are fully phased in, all persons would be insured by 2005. New Federal costs would be financed through Medicare and Medicaid spending reductions.	managed care plan or another private insurance plan, including a catastrophic plan with an MSA. Beginning in FY 1995, growth in per capita Federal Medicaid payments to the States for acute and long-term care services would be limited to the percentage change in the medical care component of consumer price index (CPI); States would have to continue to cover all categories of persons eligible for Medicaid in FY 1993. Refundable tax credits, new Federal tax exclusions for health insurance coverage, and premium assistance for persons with preexisting conditions could be delayed, if Medicare and Medicaid expenditure targets were exceeded.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
on corporate alliances, reductions in spending in existing Federal programs, and tax code changes.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
II. ADMINISTRATIVE STRUCTURE **A. Federal Role** The Federal Government would establish standards for the regional and corporate alliances, set alliance-specific budgets, and oversee the system's operation through a newly established National Health Board and existing Federal departments. The Board would issue regulations prescribing requirements for State programs, including the regional alliances, and review and approve State plans. It would interpret and update the comprehensive benefit package and recommend changes to reflect changes in technology and other factors. It would develop and enforce national alliance budgets. It would establish a risk-adjustment system to be used by the alliances to	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** An American Health Security Standards Board would be required to develop policies, procedures, and guidelines related to eligibility, enrollment, benefits, provider participation standards, national and State funding levels, methods for determining payments to providers, the determination of medical necessity and appropriateness with respect to coverage of certain services, assisting States with planning for capital expenditures and service delivery, planning for health professions education funding, allocating funds for the promotion of primary care and assisting the medically underserved, and encouraging States to develop regional planning mechanisms. The Board would also	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** The Secretary of HHS would be required to request the National Association of Insurance Commissioners (NAIC) to develop standards for health insurance plans, and if it fails to do so within the time specified or the Secretary finds them inadequate, the Secretary would be required to specify these standards. If the Secretary finds that a State has not implemented and provided adequate enforcement of the standards, then the Secretary would be required to provide for a mechanism for the implementation and enforcement of the standards. The Secretary would play a similar role in developing models for reinsurance or allocation of risk mechanisms for health	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** A newly established Health Care Standards Commission (National Health Board under S.1579) would be required to make recommendations to Congress for a uniform set of effective benefits, including cost sharing. The Commission would be required to register health plans meeting specified standards as AHPs. It would be required to organize a Benefits, Evaluations, and Data Standards (BEDS) Board that would make recommendations to the Commission about the uniform set of benefits; the standards for information to be provided by health plans; auditing standards to ensure accuracy of this information; and aggregate data on coverage decisions made	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** The Secretary of HHS, in consultation with NAIC, would be required to develop standards for qualified health plans and procedures for certifying that plans meet the standards. The Secretary would be required to review State regulatory programs for enforcing standards and assume responsibility for enforcement in States that fail to assure that plans meet standards. The Secretary would also be required to provide grants to the States to assist persons with incomes below 150 percent of the Federal poverty level to meet the costs of health insurance and health services.	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** A newly established Benefits Commission would be required to make recommendations to Congress on the types of services and items to be covered under a qualified health plan for both standard and catastrophic packages, as well as cost sharing required under both packages. Changes to the package could be recommended to Congress once a year. The Commission could also submit a proposal to Congress concerning changes necessary to achieve savings needed for vouchers for low-income persons. The Secretary of HHS would be required to carry out activities for certifying health plans offered by a multi-State employer. The Secretary would also carry out all activities related to certifying health plans	**II. ADMINISTRATIVE STRUCTURE** **A. Federal Role** The Secretary of HHS would establish and administer a program to provide allotments to States to enable them to operate insurance risk pools to provide health insurance coverage to individuals who have preexisting conditions and who can not afford coverage. The Secretary would be required to promulgate regulations for implementing refundable tax credits for catastrophic coverage for persons not eligible for Medicaid or Medicare and with income below 200 percent of the Federal poverty level.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
adjust premiums to reflect the different mix of high- and low-risk individuals in the plans. It would establish and manage a performance-based system of quality management and improvement. HHS would audit regional alliance performance. The Department of Labor would be responsible for enforcing requirements applicable to employers under regional health alliances and the administration of corporate alliances.	establish a national health security budget which would specify total expenditures available for covered services and how these expenditures would be allocated to the States. The Board would be required to establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. The Board would review and approve State plans for providing health services to its residents. The Board would also provide funds to the Public Health Service for various direct health block grant programs.	insurance plans offered to small employers.	by health plans and recommendations for evaluations of particular technologies. The Commission would be required to organize a Health Plan Standards Board to make recommendations about standards for AHPs. The Commission would be required to establish rules for the risk adjustment of premiums by HPPCs. The Commission would also be required to establish standards for identifying chronically underserved areas which have inadequate access to the uniform set of benefits, insufficient price competition for services, and poor quality of care.		in those States failing to operate approved programs. The Secretary of HHS, in consultation with the Secretary of Labor, would be required to establish standards for large employer plans. The Secretary of HHS would also establish standards for quality assurance programs for health plans.	
B. State Role	**B. State Role**	**B. State Role**	**B. State Role**	**B. State Role**	**B. State Role**	**B. State Role**
States would be required to submit to the National Health	States would be required to submit to the Board a plan for	States would be required to submit a report to the Secretary	States would be required to designate geographic areas where	States would be required to establish regulatory programs to	States would be required to establish geographic areas in	States would have the option of establishing insurance pool programs

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
Board a plan that describes the health care system the State would be establishing. States would be required to establish one or more regional alliances responsible for providing coverage to residents in every area of the State. States would certify health plans to participate in alliances, after they had established a process for assessing the quality of health plans, their financial stability, and capacity to deliver the guaranteed benefit package. To the maximum extent practicable, States would have to ensure that all consumers had the opportunity to purchase coverage from a certified health plan at a price equal to or less than the average premium for the alliance. States would be responsible for ensuring plan solvency and operating guarantee funds to protect providers and consumers in the event	their health security programs for providing health services to their residents. One or more neighboring States could submit a regional health security program instead of separate State programs. States would make payments to providers according to prospective budgets or fee schedules negotiated between the States and providers.	of HHS on its plans for implementing and enforcing insurance standards and models for reinsurance. If the Secretary determined that a State has failed to implement standards, then the Secretary would be required to do so.	not-for-profit HPPCs would be established, and, in initial years of operation, the HPPC board members would be appointed by the Governor. States could increase the size threshold for required participation of small firms in HPPCs so long as no more than one-half of all employees in the State purchased coverage through HPPCs. States would be required to establish satisfactory protection of enrollees in AHPs with respect to the potential insolvency of the plan. States could identify chronically underserved areas and develop plans to respond to them.	certify that health plans meet required standards. They would be required to establish programs to provide health insurance coverage for persons who did not voluntarily purchase coverage privately.	which individuals and small employers could form purchasing groups. They would also be required to certify health plans as qualified plans and enforce insurance reform standards; establish procedures for purchasing groups; prepare comparative information concerning qualified plans and purchasing groups; provide for a risk adjustment program for the premiums of qualified plans; establish an arbitration process for the coverage and payment of claims; and specify an annual general enrollment period. States could choose to establish their own health reform systems, provided they were approved by the Secretary of HHS, but waivers for this purpose would not be provided for the establishment of single-payer systems.	to provide premium assistance to an individual who has a preexisting condition and who is otherwise unable to purchase affordable catastrophic insurance coverage. If they established these programs, States would be required to accept bids from private insurance carriers that desire to administer the program and provide catastrophic health insurance plans under the program, or, after determining that no bids were acceptable, would administer the program themselves.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
of plan insolvencies. States could establish a statewide fee schedule for reimbursement of fee-for-service providers. States could elect to establish a single-payer system rather than one based on alliances, or a single-payer system that served a part of the State.						
C. Employer Role All employers would be required to pay a fixed percentage of the weighted average premium (WAP) for each regional alliance on behalf of employees and their dependents (see "Financing" below).	**C. Employer Role** All employers would be required to pay higher payroll taxes and the top corporate tax rate would be increased (see "Financing" below).	**C. Employer Role** All employers (excluding certain new and small employers) would be required to offer employees a group health plan that covers essential and medically necessary services and to provide for payroll deductions of premium costs.	**C. Employer Role** Small employers would be required to enter into agreements with HPPCs for offering coverage to employees, and they would be required to provide for payroll deduction of premium costs. Larger employers would have to offer coverage in a qualifying accountable health plan directly, rather than through the HPPC. The plan could be a "closed" plan, open only to the firm's own employees.	**C. Employer Role** Employers would be required to provide for payroll deduction of health insurance premium costs. They would be required to add the value of the coverage they paid for as of December 1996 to employee wages beginning January 1997.	**C. Employer Role** Small employers could either join a purchasing cooperative in the geographic area in which it does business or offer standard or catastrophic benefits through a qualified health plan. They would be required to collect and send premiums and any operating fees to the cooperative or plan on behalf of employees. Large employers would be required to offer both a standard and catastrophic benefit package, and could form their own purchasing groups, arrange coverage from a	**C. Employer Role** In order for group health plan expenses to be tax deductible, employers would be required to offer employees three options for health insurance coverage and to make equal contributions to the plans selected by employees. These would include the employer's existing health plan; an HMO, preferred provider organization, or managed care plan; or a combination of a catastrophic health plan and a medical savings account. Employees would have an annual opportunity to select among the options. If

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
					qualified plan, or self-insure.	an employee selected an alternative plan, the employer's contribution could be based either on average contributions for employees or actual contributions under the existing plan for the specific employee. Employers would also be required to make advance payments of refundable tax credits for those low income employees eligible to receive such assistance for catastrophic coverage.
D. Employee/Individual Role Each employee would be required to pay the difference between 80 percent of the WAP and the premium for the plan he or she selects. Individuals not fully covered through employment would pay both the required employer and employee shares of their premiums, subject to certain limits for low-income persons.	**D. Employee/Individual Role** Individuals would be required to pay new and/or higher taxes (see "Financing" below).	**D. Employee/Individual Role** No provision.	**D. Employee/Individual Role** No provision.	**D. Employee/Individual Role** All persons would be required to purchase federally qualified health insurance or be covered under a State program that provides equivalent coverage. Federal assistance would be phased-in for helping low income persons to meet the costs of health insurance and medical care.	**D. Employee/Individual Role** All persons would be required to obtain health insurance coverage, or face a penalty for noncompliance. Federal assistance would be phased-in for helping low-income persons to purchase coverage.	**D. Employee/Individual Role** Persons eligible to receive refundable tax credits for catastrophic coverage (those below 200 percent of the Federal poverty level), as well as those with family income exceeding 200 percent of the Federal poverty level, would be barred from participation in federally subsidized pools for persons with preexisting conditions if they had

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						not obtained catastrophic coverage within 1 year of enactment. No Federal, State, or local law could restrict collection of unpaid medical bills for such individuals.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
III. PURCHASING ALLIANCES/ COOPERATIVES	**III. PURCHASING ALLIANCES/ COOPERATIVES**	**III. PURCHASING ALLIANCES/ COOPERATIVES**	**III. PURCHASING ALLIANCES/ COOPERATIVES**	**III. PURCHASING ALLIANCES/ COOPERATIVES**	**III. PURCHASING ALLIANCES/ COOPERATIVES**	**III. PURCHASING ALLIANCES/ COOPERATIVES**
A. Regional Alliances/ Cooperatives	**A. Regional Alliances/ Cooperatives**	**A. Regional Alliances/ Cooperatives**	**A. Regional Alliances/ Cooperatives**	**A. Regional Alliances/ Cooperatives**	**A. Regional Alliances/ Cooperatives**	**A. Regional Alliances/ Cooperatives**
States would be required to establish one or more regional alliances for providing coverage to all residents of the State. The alliance area would have to encompass a large enough population to ensure that the alliance would have sufficient market share to negotiate effectively with health plans. No more than one alliance per area would be allowed. Area boundaries could not be drawn so as to concentrate racial or ethnic minority or socioeconomic groups. Alliances could not divide metropolitan statistical areas (MSAs) or cross State lines. Alliances would contract with certified health plans to provide	No provision.	No provision.	States would be required to designate regional HPPCs that would be required to enter into agreements with each accountable health plan covering the uniform set of benefits. All portions of a MSA would be required to be within the same HPPC and HPPC areas would be required to have at least 250,000 eligible individuals. One or more contiguous States could provide for the establishment of a HPPC area that includes adjoining portions of the States, so long as it did not divide an MSA. HPPCs would be required to offer enrollment in plans to all eligible persons residing in its area. They would be required	No provision.	States would be required to designate health care coverage areas (HCCAs) in which individuals and small employers could form purchasing groups. No MSA could be incorporated into more than one HCCA and the number of individuals residing within a HCCA could not be less than 250,000. Interstate agreements for regions encompassing more than one State could be established, so long they did not divide an MSA. A State could authorize one or more purchasing groups in a geographic area. Purchasing groups would be required to enter into agreements with each qualified plan that desires to be made available through the	The General Accounting Office (GAO) would be required to study the regulatory and legal impediments at the Federal, State, and local levels of government that restrict the ability of small business and other organizations from joining together voluntarily to allow employees or members to pool their health insurance purchases. The GAO would be required to report to Congress with appropriate recommendations within 2 years after enactment.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
coverage to residents of the alliance. An alliance would be required to offer a contract to any certified plan seeking to serve in its area unless the plan's proposed premium exceeded the per capita premium target within the alliance by more than 20 percent. The alliance would also be required to ensure that at least one fee-for-service plan was available among plan offerings, and would establish a fee schedule to pay providers under fee-for-service plans if its State did not have one. Alliances could use financial incentives to encourage plans to move into areas with inadequate services.			to enter into agreements with small employers for enrolling employees in health plans. They would be required to distribute to eligible individuals and employers information, in comparative form, on the prices, health outcomes, and enrollee satisfaction of different plans. They would receive and forward premiums. They would not perform any activity related to payment rates for providers or approval or enforcement of premium rates for plans. HPPCs could use financial incentives to encourage plans to serve persons in underserved areas.		group. They would be required to offer enrollment in qualified plans to all eligible employees of small employers and other eligible persons residing in the area served by the group, and could collect and forward premiums. Purchasing groups would not perform any activity relating to payment rates for providers.	
B. Treatment of Large Employers Employers and rural electric and telephone cooperatives could choose between joining regional alliances or forming corporate	**B. Treatment of Large Employers** No provision.	**B. Treatment of Large Employers** No provision.	**B. Treatment of Large Employers** Large employers would have to arrange for coverage for their workers on their own, rather than through a HPPC.	**B. Treatment of Large Employers** No provision.	**B. Treatment of Large Employers** Large employers with more than 100 employees could form their own purchasing groups for offering health insurance. Large	**B. Treatment of Large Employers** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
alliances if they had more than 5,000 full-time employees or members. Multiemployer plans would have different requirements to become a corporate alliance. Corporate alliances would have to enroll all eligible persons and provide the comprehensive benefit package. They would have to provide premium assistance for workers paid less than $15,000 (see "Financing" below). They could purchase insurance from a State certified health plan or self-insure. In either case, they would have to offer a choice of at least 3 plans, one of which would have to be a fee-for-service plan. Corporate alliances would be assessed a 1 percent payroll tax.					employers would be ineligible to purchase insurance through an individual and small employer purchasing group.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
IV. FINANCING	**IV. FINANCING**	**IV. FINANCING**	**IV. FINANCING**	**IV. FINANCING**	**IV. FINANCING**	**IV. FINANCING**
A. In General	**A. In General**	**A. In General**	**A. In General**	**A. In General**	**A. In General**	**A. In General**
A WAP would be calculated for four family types for each alliance area. Aggregate employer contributions would equal 80 percent of WAP and employee would pay the difference between 80 percent of the WAP and actual premium. Nonworkers would pay the entire premium. Limits would be placed on liability for employers and low-income individuals; these shortfalls would be made up by Federal subsidies. The bill provides for a tobacco tax, assessment on corporate alliances, savings in existing Federal programs, and tax code changes.	An American Health Security Trust Fund would be set up to pay for services. Appropriated to the Trust Fund would be all new taxes (including a new health security premium) and the funds which would otherwise be appropriated for Medicare, Medicaid, Federal Employees Health Benefits Program (FEHBP), and Civilian Health and Medical Program of the United States (CHAMPUS). Medicare trust fund balances would be transferred to the Fund.	Tax incentives would be provided for persons establishing medical savings accounts. The deductibility of health insurance premiums would be increased for the self-employed and those not receiving employer-sponsored coverage. Federal financing for state health allowance programs would be available to the extent that payments did not exceed what would have been made under Medicaid. The bill provides for Medicare savings and an increase in the regular civil service retirement age.	An individual choosing to buy coverage would be liable for the premium and the HPCC overhead amount. Premium and cost sharing assistance would be provided under Federal low income assistance program for persons below 200 percent of the State adjusted poverty level (120 percent of the State-adjusted poverty level for a Medicare-eligible individual). Full payment of premium costs would be provided for very low income (below 100 percent of poverty) if they enroll in low cost plan. Payments for moderately low income would be on a sliding scale. Individuals would be able to deduct their AHP premium payments. Employer deductions are capped at the cost of the lowest-priced AHP. The bill	Current tax exclusions for employer-sponsored health plans would be replaced by individual tax credits. Individuals would be entitled to a tax credit for a portion of the amounts spent on qualified health insurance premiums or out-of pocket medical expenses. Individuals would also be entitled to a tax credit equal to 25 percent of the amount contributed to a medical savings account, up to a maximum contribution. Employers would be required to add the value of the coverage they paid for as of December 1996 to employees wages beginning January 1997. Federal payments would be made under a new Federal grant program to help persons below 150 percent of poverty meet the costs of health insurance coverage, acute care services, and	Low-income individuals (who were not Medicaid eligible) would receive a voucher which would be applied against the cost of the premium for a qualified health plan. The voucher program expansion would be phased-in subject to achievement of savings under Medicare and Medicaid. All purchasers of qualified health plans would receive a deduction up to the applicable dollar premium limit; employer premium payments up to this limit would not count as income to the employee. Contributions to a medical savings account would be fully deductible up to the applicable dollar limit. These accounts could be used to pay for cost-sharing expenses under catastrophic plan or long-term care.	New Federal tax exclusions, deductions, and credits would be made available to individuals for the purchase of health insurance and/or for contributions to medical savings accounts (MSAs) to be used for medical care expenses. In addition, grants would be made available to States to operate subsidized insurance pools for persons unable to obtain coverage because of preexisting conditions. Phase-in of the new subsidies would be contingent on the achievement of Federal savings under Medicaid and Medicare. Nonbinding expenditure targets would be established for each program, based on spending in FY 1994. The Medicaid target would increase by 6.8 percent in FY 1995, 6.9 percent in FY 1996, and 7 percent in FY 1997

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
			provides for savings in Federal programs.	disease prevention services. Priority would be given to persons who are not on Medicaid, eligible for tax credits, and who have unreimbursed medical expenses in excess of 5 percent of adjusted gross income. States could charge a premium for insurance provided under this program. Savings would be provided in Medicare and Medicaid.	Savings would be provided in Medicare and Medicaid.	and later years. Target increases for Medicare would be 9.4 percent for FY 1995, 8.9 percent for FY 1996, 8.5 percent for FY 1997, and 8 percent for FY 1998 and later years. To meet the targets, Federal Medicaid spending would be subject to binding per capita growth limits (see below); limits would not be established for Medicare.
B. Employer The employer would pay a fixed percentage of WAP for the alliance for each class of enrollee, such that aggregate employer payments for the class equal 80 percent of the WAP. Liability would be limited to 7.9 percent of payroll. Liability would be further limited for firms with less than 75 employees and average wages less than $24,000. Employer would make pro rata payments for part-time workers with	**B. Employer** Not applicable.	**B. Employer** Employers would specifically not be required to make any premium payment for their employees.	**B. Employer** None required.	**B. Employer** Employers would be required to add the value of the coverage they paid for as of December 1996 to employees wages beginning January 1997.	**B. Employer** None required.	**B. Employer** Employers would have the option of contributing to employees' health insurance premiums and/or MSAs, but would not be required to do so. An employer that provided health benefits would be required to make an equal contribution to (at the employee's option) its existing health plan; an HMO, preferred provider organization (PPO), or managed care plan; or a combination

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
worker liable for remainder of employer share (subject to limits if nonwage income less than 250 percent of poverty). Corporate alliance employers would pay 80 percent of corporate-specific WAP except that for workers paid less than $15,000, they would pay the greater of 80 percent of WAP or 95 percent of least costly plan. Self-employed would pay 80 percent of WAP up to 7.9 percent of self-employment income with liability limited by a percent of earnings cap for earnings under $24,000.						of a catastrophic health plan and an MSA. Employees would have an annual opportunity to select among the options. If an employee selected an alternative plan, the employer's contribution could be based either on average contributions for employees or actual contributions under the existing plan for the specific employee.
C. Employee/ Individual Employees (and self-employed) would pay the difference between 80 percent of WAP and actual premium. Families with adjusted gross incomes (AGI) less than $40,000 would pay	**C. Employee/ Individual** A health security premium, equal to 7.5 percent of taxes otherwise owed would be applied to individual income taxes.	**C. Employee/ Individual** States could require certain state health allowance program participants to pay all or a portion of the premiums and cost-sharing. Contributions for persons between 100	**C. Employee/ Individual** Individual choosing to buy coverage would be liable for premium and HPCC overhead amount. Premium adjustments would be provided for low income. Very low-income would	**C. Employee/ Individual** All individuals would be required to have minimum private health insurance coverage. States would be required to establish a program to provide coverage at least equal	**C. Employee/ Individual** An individual would be liable for any premium not otherwise paid by employer or through a voucher. As of January 2005, any individual who was not covered under a qualified health	**C. Employee/ Individual** Individuals choosing to obtain coverage would pay their own premiums, potentially with Federal assistance through the tax system (see below) or through a State-operated

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
up to income-related cap. (There would be no income related cap for corporate alliance employees.) Employers could pay the individual/family share if they did so for all employees. Nonworkers would pay: (i) 80 percent of WAP (with liability limited for those with nonwage income less than 250 percent of poverty), plus (ii) remainder of actual premium (except that families with AGI less than $40,000 would pay up to income-related cap). Early retirees would pay the difference between 80 percent of WAP and actual premium, except families with AGI less than $40,000 would pay up to income-related cap. Employers with existing commitment to provide retiree benefits would pay the retiree's share (up to 20 percent of WAP).	A monthly $65 long-term care/health care premium would be imposed on all aged; singles with incomes below $8,500 and couples below $10,700 (as adjusted for cost-of-living) would be exempt.	percent and 200 percent of poverty would be based on a sliding scale. Contributions could also be required for those enrolled on an optional basis by the State.	not be liable for any premium if they enrolled in a AHP with a premium at or below the lowest premium established by an open AHP in the area; they would be liable for 10 percent of any excess premium if enrolled in higher cost plans. Moderately low-income premium adjustments would be based on a sliding scale.	to that of a federally-qualified health insurance plan to any resident who refused to voluntarily purchase coverage. States could impose a premium for this coverage on individuals who were not eligible under the new grant program (targeted toward the low income), consistent with the cost of coverage and the individual's ability to pay.	plan or equivalent plan would be required to pay a penalty equal to the average yearly premium of the local area plus 20 percent.	preexisting condition insurance pool. Individuals could also choose to establish MSAs with their own funds and/or employer contributions.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
D. Federal Subsidies Federal subsidies would make up shortfalls due to limits on employer, employee, nonworker, and retiree premium liabilities (as noted above). Federal assistance would be provided for the low-income for required deductible and coinsurance payments in regions where there was no low cost-sharing plan with a premium at or below the WAP. The Federal payment would be made in a lump sum to regional alliances equal to the difference between alliance payments (premiums and administrative costs) and alliance receivables (employer and individual contributions, Federal contributions for any Medicare beneficiaries enrolled in the alliance, and Federal and State payments mandated under Medicaid).	**D. Federal Subsidies** The Trust Fund would pay each State an amount equal to the product of the State capitation amount and the Federal contribution amount with the Federal contribution ranging from 81 percent to 91 percent of the State's weighted average share of the national budget.	**D. Federal Subsidies** Federal matching would be provided for Medicaid expenditures for acute care services under the State Health Allowance programs; no Federal matching would be available for persons with incomes over 200 percent of poverty.	**D. Federal Subsidies** The Federal premium assistance amount for very low income would equal the base Federal premium amount reduced by any employer payment. The base Federal premium amount for an individual residing in a HPPC area would equal the product of the reference premium rate (lowest premium established by an open AHP in the area) and the national subsidy percentage (i.e., total Federal amount available divided by the total amount of assistance that would be provided if full funding were available). Assistance for moderately low income would be based on a sliding scale. Low-income Medicare individuals would be eligible for assistance with Medicare premiums; very low-income Medicare individuals would also	**D. Federal Subsidies** Federal payments would be made under a new Federal grant program to help persons below 150 percent of poverty with the costs of health insurance coverage, acute care services, and disease prevention services. Priority would be given to persons who are not on Medicaid, eligible for tax credits, and who had unreimbursed medical expenses in excess of 5 percent of adjusted gross income.	**D. Federal Subsidies** Low-income individuals (who were not Medicaid eligible) would receive a voucher which would be applied against the cost of the premium for a qualified health plan. Assistance would be phased-in beginning in 1997 for persons below 90 percent of poverty. The poverty percentage would be increased by 20 percentage points each year from 1998 - 2004 and an additional 10 percentage points in 2005 when the full phase-in of 240 percent would be reached. The amount of the voucher for a family below poverty would equal the average cost of the lowest cost half of qualified plans in the area; as the family's income increased, the amount of assistance would be phased-out based on a sliding scale. If Medicare and Medicaid savings occurred more slowly than anticipated (as measured against	**D. Federal Subsidies** Most Federal subsidies would take the form of new tax credits, deductions, or exclusions for health insurance premiums or MSA contributions. (See G.2, below.) In addition to these tax provisions, there would be Federal grants to States that chose to operate preexisting condition insurance pools. (See section IX for a description of these pools.) Federal allotments would be equal to States' expected losses under the pools and would begin in 1996, or later if Medicare and Medicaid expenditure targets were not met.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
Federal payments would be made under Medicaid on behalf of Aid to With Dependent Children/Supplement Security Income (AFDC/SSI) recipients to the alliance based on 95 percent of the current per capita spending amount for AFDC/SSI recipients, updated for inflation. The Federal share would be determined using the current Medicaid formula. Federal Medicaid matching payments would be made for supplemental benefits provided to AFDC/SSI adults. Federal funding would be provided for the new comprehensive program for children.			be eligible for Medicare cost-sharing assistance. Payments would be made for very low income (including Medicare eligible) for the costs of prescription drugs, eyeglasses and hearing aids and other items and services (other than long-term care) determined to have been commonly provided under State Medicaid programs but not included in uniform effective benefits. Low-income cost-sharing assistance would be provided. An adjusted per enrollee amount would be determined based on total amount available, number of enrollees receiving assistance, and premium class of the enrollee. Full cost-sharing coverage would be provided for very low income Medicare enrollees.		specified baseline numbers), the phase-in would be decelerated; if they occurred more rapidly, the phase-in would be accelerated. In the case of a deficit, the Benefits Commission could submit recommendations to Congress for restructuring benefits or other changes.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
E. Limitation on Federal Subsidies Federal assistance (other than mandated Medicare and Medicaid payments) would be limited to an entitlement cap ($10.3 billion in FY 1996, $28.3 billion in FY 1997, $75.6 billion in FY 1998, $78.9 billion in FY 1999 and $81.0 billion in FY 2000 with increases in future years approximately equal to the growth in the GDP. If these funds were insufficient to meet obligations for alliance payments, the Secretary of DHHS would recommend to Congress actions to eliminate the shortfall; Congress would act on recommendations using an up or down vote similar to that used for military base closings.	**E. Limitation on Federal Subsidies** The weighted average Federal contribution percentage for all States could not exceed 86 percent of the national budget.	**E. Limitation on Federal Subsidies** Federal payments (including disproportionate share (DSH) payments) could not exceed what would have been made in the absence of the allowance program.	**E. Limitation on Federal Subsidies** Federal payments in a year (prior to 2000) would be limited to the sum of the amounts that would otherwise have been payable under Medicaid plus additional amounts from bill's other financing provisions; beginning in 2000, the increase in the annual amount would be tied to the increase in the GDP. For each year the available amount would be reduced by amounts spent for long-term care phase-down assistance, Medicare low-income assistance, low-income cost-sharing assistance, supplemental benefits assistance for very low-income, and certain specified grant amounts. If Federal subsidies are reduced, individuals would not have to make up the shortfall.	**E. Limitation on Federal Subsidies** Total Federal payments under the new grant program would be $14.2 billion in FY 1997, $15.8 billion in FY 1998, $17.4 billion in FY 1999, and $20 billion in FY 2000; the amounts would be increased by 7.5 percent per year in subsequent years.	**E. Limitation on Federal Subsidies** The scheduled phase-in of the voucher program would be subject to achievement of Medicare and Medicaid savings (as measured against specified baseline numbers).	**E. Limitation on Federal Subsidies** If Medicare or Medicaid spending exceeded the expenditure target for a year, certain new Federal tax benefits and/or grants scheduled to be effective in the following year would be delayed. Benefits would be postponed, in the following order, until savings from the delay were at least sufficient to equal the Medicare or Medicaid excess: (a) the tax credit for the purchase of catastrophic coverage for individuals and families with income between 100 and 200 percent of poverty; (b) the same tax credit for single persons below 100 percent of poverty; (c) the credit for couples and families below 100 percent of poverty; (d) the exclusion from gross taxable income of expenditures for health insurance and MSA contributions; (e) grants to States for preexisting condition insurance pools. The separate

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						deduction from gross income for the purchase of catastrophic health insurance and MSA contributions would not be contingent on Medicare and Medicaid savings.
F. State Payments States would be required to make maintenance-of-effort payments to the alliance equal to previous costs of furnishing Medicaid benefits in the comprehensive package to nonwelfare beneficiaries (excluding wrap-around benefits for children), updated for inflation. States would be required to pay the alliance on behalf of AFDC/SSI recipients an amount based on 95 percent of the current per capita spending amount for AFDC/SSI recipients, updated for inflation. State share would be determined using the current Medicaid formula.	**F. State Payments** States would be required to fund covered services if costs for them exceeded the Federal payment.	**F. State Payments** States choosing to operate an allowance program would fund allowance expenditures not paid by Federal government or individual contributions.	**F. State Payments** States would gradually assume full responsibility for long-term care.	**F. State Payments** States would make payments not paid by the Federal government under Medicaid or the new grant program. In FY 1997, the State share of expenditures under the new grant program would have to be at least equal to the Medicaid DSH payments made by the State in FY 1996, updated by the same percentage increase as occurred for FY 1996 over FY 1995; in future years the amount would be increased by the CPI.	**F. State Payments** States would be required to continue Medicaid coverage for any category of persons eligible as categorically needy in FY 1994.	**F. State Payments** States would be required to continue Medicaid coverage of classes or categories of individuals eligible during FY 1993. A State that chose to operate a preexisting condition insurance pool would be required to fund the administrative costs of the pool.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
States would pay State share on continued Medicaid for extra benefits for AFDC/SSI adults.						
G. Federal Revenues, Tax Expenditures, and Savings	**G. Federal Revenues, Tax Expenditures, and Savings**	**G. Federal Revenues, Tax Expenditures, and Savings**	**G. Federal Revenues, Tax Expenditures, and Savings**	**G. Federal Revenues, Tax Expenditures, and Savings**	**G. Federal Revenues, Tax Expenditures, and Savings**	**G. Federal Revenues, Tax Expenditures, and Savings**
1. Federal Revenues	**1. Federal Revenues**	**1. Federal Revenues**	**1. Federal Revenues**	**1. Federal Revenues**	**1. Federal Revenues**	**1. Federal Revenues**
The tobacco tax would be increased by $0.75 per pack with similar increases for other tobacco products. Corporate alliances would be assessed a 1 percent payroll tax. For 1998 - 2000, corporations would be assessed approximately 50 percent of their existing retiree health care costs. The Medicare hospital insurance tax would apply to all State and local employees.	A health security premium, equal to 7.5 percent of taxes paid, would be applied to individual income taxes. The employer hospital insurance payroll tax (currently 1.45 percent of wages) would be set at 7.9 percent. (All State and local employees would be covered.) The self-employment tax rate would be set at 8.35 percent of income. Individual tax rates would be increased (from 28 percent to 31 percent and 31 percent to 34 percent) and a new top rate added (35 percent for families with taxable incomes over $200,000). A 10 percent millionaire's surtax tax	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
	would be added. The minimum tax rates would be increased. Additional individual tax changes would include making permanent the overall limitation on itemized deductions and the phaseout of personal exemptions for high income taxpayers; limiting the deduction for moving expenses; eliminating the deduction for club membership fees; making permanent the top estate and gift tax rates; and increasing the amount of social security benefits included in income. The upper limit on the amount of earnings subject to the Medicare payroll tax would be removed. The top corporate rate would be increased to 38 percent. Additional code changes would include increasing recovery period for nonresidential property; increasing taxation of income of controlled foreign					

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
	corporations attributable to imported property; changing rules applying to securities held by securities dealer; repealing deduction for intangible drilling and development costs; repealing percentage depletion for oil and gas wells; repealing application of like-kind exchange rules to real property; and making permanent changes in estimated tax provisions. (Note: Some of these tax provisions were included in OBRA 1993; sponsors have indicated they are exploring replacement financing options.)					
2. Tax Code Changes: Employers, Employees and Health Plans After January 1, 2004, health benefits provided by an employer to an employee would be taxable as income, to the extent the benefits	**2. Tax Code Changes: Employers, Employees and Health Plans** No provision.	**2. Tax Code Changes: Employers, Employees and Health Plans** The tax deduction for health premiums for the self-employed would be gradually increased to 100 percent.	**2. Tax Code Changes: Employers, Employees and Health Plans** A 34 percent excise tax would be imposed on employer contributions exceeding the cost of the lowest priced AHP plan meeting minimum standards. The	**2. Tax Code Changes: Employers, Employees, and Health Plans** Current tax exclusions would be replaced by individual tax credits. (If the amount of credit exceeds tax liability, the difference is payable to the individual.)	**2. Tax Code Changes: Employers, Employees and Health Plans** Tax deductions would be allowed for premium payments for qualified health plans up to the applicable dollar limit (i.e., average cost of lowest priced one-half of	**2. Tax Code Changes: Employers, Employees and Health Plans** Premium payments for a catastrophic health insurance plan would be fully deductible, regardless of whether the taxpayer itemized deductions and without

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
exceeded the standard benefits package. Any health benefit plan provided by an employer through a flexible benefit plan (including a flexible spending arrangement or cafeteria plan) would be counted as taxable income effective January 1, 1997. The health insurance deduction for self-employed would be raised to 100 percent. However, if a self-employed proprietor also paid for coverage of employees, the deduction would be limited to the percentage paid for his/her employees. Premiums for long-term care insurance policies could be deducted as medical expenses to the extent the benefit did not exceed $150 per day (adjusted for inflation after 1996). Preferential tax treatment of post		The tax deduction for those not receiving employer provided health coverage would be increased to 100 percent (even if the individual did not itemize). Individuals would be allowed to deduct the cost of a catastrophic health plan from gross income. Individuals would be allowed to make tax free contributions to medical savings accounts in amounts equal to the lowest deductible under any catastrophic plan providing coverage to a beneficiary of the account. Entitlement to the deduction would be based on coverage under a catastrophic plan and (with limited exceptions) no coverage under a more generous plan. A deduction would not be allowed before 1999 for individuals eligible for employer-sponsored coverage. Payments from the account could only be made for	deductibility of health plan expenses of self-employed would be increased to 100 percent. Individuals could fully deduct their AHP premium payments up to the cost of the lowest priced AHP. H.R. 3222: In addition, commonality of interest or geographic location requirement for tax exempt trust status would be eliminated for large employer groups.	Individuals would be entitled to a tax credit for a portion of the amounts spent on qualified health insurance premiums or out-of pocket medical expenses. The percentage credit would be 25 percent of the total spent below 10 percent of gross income, 50 percent of any amount between 10 percent and 20 percent of gross income, and 75 percent of any additional amount. Individuals would also be entitled to a tax credit equal to 25 percent of the amount contributed to a medical savings account (up to a maximum contribution of $3,000 for an individual, plus $500 for each dependent, indexed in future years). In order to receive the credit, payments from the account could only be made for qualified medical expenses (out-of-pocket expenses and health insurance premiums).	qualified health plans offered in the area). Full deduction would be permitted up to limit for premiums paid by employer, employee (even if employee does not itemize) and self-employed. Employer-paid premiums in excess of this amount would be taxable to employee. The dollar limits would be determined annually by the Secretary. Contributions to an MSA would be fully deductible up to the applicable dollar limit if paid by employee; they would be excludable from income if paid by employer. Cost of catastrophic benefit plan premiums would be subtracted from the applicable dollar limit in making this determination. Payments from the account could only be made for medical care and long-term care not otherwise compensated by insurance or otherwise; payments for health plan coverage are	being subject to the current requirement that medical expenses are deductible only to the extent that they exceed 7.5 percent of gross income. A catastrophic plan is defined as one that covers specified services with a deductible (both individual and family) of at least $3,000; this minimum would be indexed for inflation. A similar deduction would be established for individual and employer contributions to an MSA for a taxpayer who has catastrophic coverage and is under age 65. (Taxpayers over age 65 would be eligible if they chose an MSA/catastrophic coverage option in lieu of Medicare; see Medicare, below.) Annual contributions could not exceed $3,000 or the applicable minimum catastrophic deductible for the year. Distributions from an MSA would be tax-exempt if they were used to pay expenses

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
retirement medical and life insurance reserves and retiree health accounts maintained by pension plans would be eliminated. Preferential tax treatment of certain health care organizations would be eliminated under specified conditions.		medical care, long-term care, and payments for premiums for a catastrophic coverage or long-term care policy or a medicare supplemental policy. Employer contributions to a medical savings account would not be subject to employment taxes. Premiums for long-term care insurance policies could be deducted as medical expenses to the extent the benefit did not exceed $200 per day (adjusted for inflation after 1994) Commonality of interest or geographic location requirement for tax exempt trust status would be eliminated for large employer groups under certain conditions.		Individuals who failed to enroll in insurance plans would be unable to claim the personal exemption on their taxes. Individuals would be able to exclude from gross income amounts withdrawn from individual retirement plans or 401(k) plans for long term care insurance.	excluded except for catastrophic coverage, long-term care coverage, and Medicare supplemental policies and premiums. Employer contributions would be exempt from employment taxes. Premiums for long-term care insurance policies could be deducted as medical expenses to the extent the benefit did not exceed $100 per day (adjusted for inflation after 1995). Commonality of interest or geographic location requirement for tax exempt trust status would be eliminated for large employer groups. Payments under life insurance contracts for terminally ill persons would be treated as death benefits for tax purposes. The definition of deductible medical care would be expanded for tax purposes to include qualified long-term care	counted toward the catastrophic deductible (but not to pay for health insurance). If the MSA balance exceeded the deductible, excess amounts could be used for long-term care services or distributed to the taxpayer (in the latter case, only interest earned on the excess would be taxable). Employer contributions to MSAs would also be exempt from payroll taxes. Both the catastrophic insurance and MSA deductions would be effective in the first taxable year after enactment. (Unlike other tax changes, these would not be contingent on Medicare and Medicaid savings.) Premium payments for a health insurance plan and/or MSA contributions would be excluded from taxable income for all individuals (including the self-employed) not eligible for employer-paid coverage. (This exclusion differs from

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
					services. Payments for qualified long-term care policies would be treated the same as payments for accident or health insurance policies.	the deduction above in that it is available for any kind of health insurance, not just catastrophic, and is available to taxpayers over age 65.) The exclusion for a year could not exceed the national per employee average of employer contributions to health plans in the preceding year. Again, employer contributions to insurance or MSAs would not be subject to payroll taxes. The exclusion would be phased in, with 33 percent of expenses excluded in 1996, rising in steps to 100 percent in 2001. Phase-in could be delayed if Medicare and Medicaid expenditure targets were not met. There would be a refundable tax credit for catastrophic health insurance plan premiums paid by persons not eligible for Medicare or Medicaid. For the purpose of this credit, a catastrophic

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						plan would be one with a deductible equal to the greater of $3,000 or 20 percent of adjusted gross income. The credit would equal 100 percent of premiums for families with income below 100 percent of the Federal poverty level and would phase down to zero for those with incomes at 200 percent of the poverty level. Persons eligible for the credit could receive advance payments from their employers during the year. The credit would be available to couples and families below 100 percent of poverty in 1997 and to single persons below 100 percent of poverty in 1998. For couples and families below 200 percent of poverty, 33 percent of the credit would be available in 1999; the full credit would be available to all persons in 2000. Phase-in could be delayed if Medicare and Medicaid expenditure targets were not met. No Federal, State, or local

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						law could restrict collection of unpaid medical bills for individuals eligible for the credit but not obtaining coverage. Penalty-free withdrawals from qualified retirement plans would be permitted for the purchase of Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. Employer and individual deductions and exclusions for a health insurance plan would be contingent on the plan's compliance with portability and permanence requirements (see section IX). In addition, the individual exclusion and business expense deduction for employer-paid health benefits would be available only if the employer complied with the requirement for equal contributions to alternative plans.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
3. Federal Program Savings Medicare savings would be achieved by reducing payments to hospitals, physicians, skilled nursing facilities, and home health services. The Part B premium (currently equal to 25 percent of program costs) would be increased for individuals with incomes over $90,000 and couples with incomes over $115,000; the increase (equal to an additional 50 percent of program costs) would be phased-in with the full increase applicable to those with incomes $15,000 over the threshold amount ($30,000 for couples). Enforcement of secondary payer program would be expanded. Coinsurance would be imposed for home health and laboratory services. The Secretary would be required to report to Congress by June 30,	**3. Federal Program Savings** Payments would no longer be made under Medicare, Medicaid, FEHBP,and CHAMPUS.	**3. Federal Program Savings** Medicare Part B premiums would be increased for individuals with AGI over $100,000 and couples with incomes over $125,000; the increase is phased in with the full increase (equal to an additional one-third of program costs) applicable to those with incomes $50,000 above the threshold amount. The regular civil service retirement age would be increased to 62. Federal agencies would be required to prefund Federal retiree health benefits.	**3. Federal Program Savings** Medicare payments would be reduced for hospitals, physicians, home health services, skilled nursing facility services, and hospice services. The Part B premium would be increased for individuals with incomes over $75,000 and couples with incomes over $100,000; the full increase (equal to an additional 50 percent of program costs) would be applicable to persons with incomes $75,000 over the threshold amount. Medicaid would be repealed; Federal payments for long-term care services would be phased-out over four years. Federal agencies would be required to prefund Federal retiree health benefits.	**3. Federal Program Savings** H.R. 3698 and S. 1743: Medicare savings would be achieved by reducing payments to hospitals. The growth in Medicaid payments to the States would be capped at 20 percent above the 1993 level in FY 1995. In subsequent years, Federal Medicaid spending for acute care would grow at 2.5 percent above the CPI. Medicaid DSH payments would be eliminated. H.R. 3698: Welfare benefits (other than emergency Medicaid) would be eliminated for noncitizens, except for refugees and permanent resident aliens over age 75 who have been legal residents for 5 years. S. 1743: Copayments would be imposed for lab and home health services, and payments for all Part A services would be reduced.	**3. Federal Program Savings** Medicare changes would make permanent the provision setting the beneficiary Part B premium equal to 25 percent of program costs, reduce payments for outpatient hospital services, eliminate the DSH adjustment, eliminate payments to hospitals for enrollees bad debt, and impose cost-sharing on lab and home health services. The Part B premium would be increased for individuals with incomes over $90,000 and couples over $115,000; the increase would be phased-in with the full increase (equal to an additional 50 percent of program costs) applicable to those with incomes $10,000 above the threshold amount. Medicaid savings would be achieved through a cap on Federal payments for acute care services, increasing State flexibility to	**3. Federal Program Savings** Growth in per capita Federal Medicaid payments to States would be limited to the percentage change in the medical care component of the CPI; limits would apply separately to acute care and long-term care services.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
1999, on whether the projected rate of Medicare growth will exceed the target rate (i.e., annual growth in private premium rate targets, plus one percentage point), and, if so, make recommendations to achieve the target rate. Provision of Medicaid acute care would be transferred to regional alliances and be subject to per capita rate of increase limits. Medicaid disproportionate hospital share payments would be eliminated.					contract for coordinated care services, and phased-in elimination of hospital DSH payments.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
V. BENEFITS	**V. BENEFITS**	**V. BENEFITS**	**V. BENEFITS**	**V. BENEFITS**	**V. BENEFITS**	**V. BENEFITS**
Comprehensive standard package would include hospital services; health professional services; medical and surgical services; some mental illness and substance abuse treatment; family planning services and services for pregnant women; hospice care; home health care or institutional extended care as an alternative to inpatient treatment; ground, air, and water ambulance services; outpatient laboratory, radiology, and diagnostic services; prescription drugs; outpatient rehabilitation services; durable medical equipment and prosthetic and orthotic devices; vision care including eyeglasses and contact lenses for children to age 18; dental care for individuals under 18 and emergency dental services for others; and health education and training classes offered at the discretion of a	Comprehensive services that are "medically necessary and appropriate" for maintenance of health, diagnosis, treatment, or rehabilitation would include hospital care; professional services of practitioners; community-based primary care including care furnished in school-based settings; clinical preventive services according to a periodicity schedule established by the Board; long term care services including nursing facilities, home and community-based care, and hospice care; prescription drugs; preventive and prophylactic dental care for children under 18; mental health services and substance abuse treatment; outpatient physical, occupational and speech therapies; durable medical equipment; home dialysis; emergency	Bill provides for "MedAccess" standard, catastrophic, and Medisave health insurance plans, each of which is to cover only essential and medically necessary service, including medical, surgical, hospital, and preventive services. The NAIC would be requested to establish actuarial equivalence rules and set target actuarial values for standard coverage and catastrophic coverage. The target for standard coverage would be the actuarial value of benefits currently typically offered in the small employer health coverage market. The target for catastrophic coverage would be the estimated actuarial value of a plan with a deductible midway between the minimum and maximum permitted. Health insurance plans would be considered to provide	Annually, a 5-member commission would specify a uniform benefit set for Congressional consideration. The uniform set would include clinical preventive services, and medically appropriate diagnostic services and categories of treatments that all AHPs would be required to cover in the following year. Congress could disapprove and reject the Commission's recommendations by enacting, within 44 days, a joint resolution introduced within 10 days of the date the recommendations were sent by the commission. The Commission could develop guidelines to specify appropriate uses of treatment. An AHP could provide treatments not determined by the Commission to be medically appropriate	Federally qualified health insurance plans would be required to cover all medically necessary acute care including physician services; inpatient, outpatient, and emergency hospital services and alternatives to hospitalization; and prescription drugs. The bills specify that abortion services would not be required. They prohibit insurance plans from excluding coverage for selected illnesses or treatments if consistent with medically accepted practices.	Individuals could elect a standard benefit package or a catastrophic benefit plan established by a commission and approved by Congress. Those electing a catastrophic plan would be able to establish a tax-favored medical saving account that could be used to pay for treatment. A standard benefit package would include medical-surgical services; medical equipment; safe and effective prescriptions and biologicals; preventive services; rehabilitation and home health services; services for substance abuse and severe mental illness; hospice care; and emergency transportation and other transportation for nonelective medically necessary services in frontier and similar areas.	Catastrophic health insurance plans would be required to cover at least the following services: inpatient hospital services (other than in an institution for mental diseases); outpatient hospital services; services of rural health clinics and federally-qualified health centers; laboratory and x-ray services; nursing facility services for persons aged 21 or older; early and periodic screening, diagnostic and treatment services (as defined under Medicaid); physicians' services and medical and surgical services furnished by dentists; and services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
health plan. Clinical preventive services would be available consistent with a periodicity schedule promulgated by the National Health Board. Preventive services would include age-appropriate immunizations and specified screening tests. The Board would interpret and update the benefit package and recommend revisions to the President and the Congress.	ambulance services; and prosthetics. States or employers could provide additional benefits.	standard or catastrophic coverage if benefits were determined to have a value within 5 percentage points of the target actuarial values. A Medisave plan would consist of a catastrophic health plan and a medical savings account.	according to specified criteria.		A benefits commission would clarify covered items and services and submit proposals to Congress to vote up or down. The commission could suggest modifications no more than annually, but could not specify particular procedures or treatments.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
VI. BENEFICIARY COST-SHARING A health plan would offer a either a lower cost-sharing schedule, higher cost-sharing schedule, or combination cost-sharing schedule. All schedules would have out-of-pocket limits of $1,500 for an individual and $3,000 for a family (indexed for inflation). Any plan electing to sell the lower cost-sharing option would also have to offer a point-of-service option to the enrollees. Under lower cost-sharing plan, enrollees would pay the following copayments: $10 for ou atient services, $25 ital emergency utpatient services, ental	**VI. BENEFICIARY COST-SHARING** No deductibles, coinsurance, or copayments would be applicable for covered services. No balance billing would be permitted for covered services.	**VI. BENEFICIARY COST-SHARING** A standard coverage MedAccess plan would have substantial cost sharing; a catastrophic coverage plan would have a deductible at least equal to $1,800 for an individual and $3,600 for a family (up to a maximum of $2,500 for an individual and $5,000 for a family; these amount; a Medisave plan would integrate the catastrophic plan with a medical savings account. States could require certain State health alliance program participants to pay all or a portion of premiums and cost sharing of a group health plan. The amount of the contribution for persons between 100 percent and 200 percent of poverty would be based on a sliding scale. Contributions could also be required for other persons enrolled on an optional basis by the	**VI. BENEFICIARY COST-SHARING** An AHP would be required to provide for uniform cost-sharing and to prohibit balance billing for uniform benefits. An AHP could not offer additional benefits if it had the effect of reducing cost-sharing below the uniform cost-sharing. The uniform cost-sharing (established as part of the uniform benefit package) would: include only those amounts that would constrain consumers from seeking unnecessary care, balance the impact on premiums and utilization of appropriate services, establish an annual limit, and prohibit the imposition of such charges on covered clinical preventive services. The AHP would be required to reduce cost sharing amounts for low income persons eligible	**VI. BENEFICIARY COST-SHARING** Maximum health insurance plan deductibles would be $1,000 per individual and $2,000 per family prior to 1998; future increases would be tied to the CPI. The out-of-pocket limit would be $5,000 for years prior to 1998 with future increases tied to the CPI.	**VI. BENEFICIARY COST-SHARING** The Commission would be required to specify the cost-sharing requirements for the standard package and the catastrophic package. The standard package would include deductibles, copayments, coinsurance and out-of-pocket limits; the catastrophic package would include a general deductible (larger than any under the standard package) and out-of-pocket limit (and could include other deductibles, copayments, and coinsurance specified by the plan). The Commission would establish multiple cost sharing schedules that varied by the type of delivery system used. The Commission would establish a limit on total cost-sharing that could be incurred by a family within a class of family enrollment. The Commission could not set cost-sharing	**VI. BENEFICIARY COST-SHARING** Catastrophic health insurance plans eligible for the new premium tax deduction would have a deductible (both individual and family) of at least $3,000; this amount would be indexed in future years to the CPI for all urban consumers. Catastrophic health insurance plans eligible for the new premium tax credit would have a deductible equal to the greater of 20 percent of adjusted gross income or $3,000 (this figure would not be indexed).

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
other specified services such as hospice and home health care. The Board would determine the amount of coinsurance for out-of-network services; in general, it would be at least 20 percent and the same for all out-of-network services. Under the higher cost sharing plan, individuals would pay a $200 deductible and families $400; a separate $250 deductible would apply to drugs. Enrollees would pay 20 percent coinsurance (50 percent for outpatient psychotherapy and 40 percent for certain dental services); no coinsurance would apply for preventive services, including well-baby and prenatal care. Under the combination cost-sharing plan, enrolles using preferred providers would pay the low cost sharing amounts; those using out-of-network providers		State. Certain current Medicaid beneficiaries would be protected from increased cost-sharing charges.	for cost-sharing assistance to nominal amounts.		requirements for severe mental illness that did not apply to other items and services.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
would pay the higher amounts. Providers would not be permitted to balance bill, i.e., charge or collect from the enrollee a fee in excess of the applicable fee schedule payment amount.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
VII. PROVIDER PAYMENTS Providers would enter into agreements with health plans for the purposes of reimbursement for the provision of all covered services in the comprehensive benefit package. After negotiations with providers the regional alliances would establish a fee schedule to pay providers under the fee-for-service component of any health plan. States could adopt a state-wide fee schedule for fee-for-service plans which would be used by plans within the alliances. Providers would not be allowed to balance bill, that is charge or collect from a patient a fee in excess of the fee schedule adopted by the alliance for services covered under the guaranteed benefit package. An alliance or State could use prospective	**VII. PROVIDER PAYMENTS** Each State would make payments to hospitals and nursing facilities for services under an annual prospective global budget developed through annual negotiations between the State health security program and facilities based on a nationally uniform system of cost accounting established by the Board. Payments for home health services, hospice care, home and community-based long-term care services, and facility-based outpatient services would be based on a global budget, a capitation amount, a fee schedule developed by the State program, or an alternative prospective payment method approved by the State. Independent health care practitioners would be entitled to be paid a fee	**VII. PROVIDER PAYMENTS** No provision.	**VII. PROVIDER PAYMENTS** No provision.	**VII. PROVIDER PAYMENTS** No provision.	**VII. PROVIDER PAYMENTS** No provision, except that direct providers of services would be required to collect and provide all standardized information required by a qualified general access health plan in order to receive payment for services furnished under a benefits package (other than emergency services).	**VII. PROVIDER PAYMENTS** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
budgeting to contain costs under fee-for-service plans. In this instance, the relevant providers would negotiate with the alliance or State to develop a budget for the fee-for-service plans, including spending targets for each sector (physicians, hospitals, home health care, etc.).	for each billable covered service. The Board would develop models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services or for a basic group of services, such as primary care services. Providers would be prohibited from balance billing for benefits provided, and payment received from a State health care security program would constitute payment in full. If a provider knowingly and willfully billed for an item or service or accepted payment in excess of the State program's payment, the Board could impose sanctions for each violation. State programs would be required to establish a prospective payment schedule with fees designed to provide incentives for					

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
	practitioners to choose primary care medicine (including general internal medicine and pediatrics) over medical specialization. Fees would be based on a relative value scale, conversion factors, volume performance standards, adjusted by class of service (mental health, substance abuse treatment, dental, and other services) and geographic area, similar to that established under the Medicare program. Provider payments would not be made under a State health security program for any cost attributable to capital expenditures which had not been approved by the State program. Comprehensive health service organizations would receive payments from the State health security program based on a global budget or a capitated amount for its enrollees.					

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
	An Advisory Committee on Prescription Drugs would be required to make recommendations to the Board to establish classifications of prescription drugs and biologicals necessary for the maintenance or restoration of health, and the Board would be required to determine a maximum product price recognized as the cost of the drug. Independent pharmacies would be paid the drug's cost to the pharmacy (not more than the established price set by the Board) plus a dispensing fee. The Board would also be required to establish a product price list for approved durable medical equipment and therapeutic devices and equipment.					

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
VIII. EXPENDITURE TARGETS: PREMIUM TARGETS	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**	**VIII. EXPENDITURE TARGETS: PREMIUM TARGETS**
A. Expenditure Targets	**A. Expenditure Targets**	**A. Expenditure Targets**	**A. Expenditure Targets**	**A. Expenditure Targets**	**A. Expenditure Targets**	**A. Expenditure Targets**
If the growth in national health care spending was not slowed through price competition in the newly restructured private insurance market and other reforms, a "backstop" budgeting and premium regulation process would be triggered. A national health care budget would be established by the NHB for expenditures for services covered under the comprehensive benefit package. The health budget would be enforced by the NHB. For each year, alliances would submit the final bids and enrollments for each health plan to the NHB. Based on these premiums and enrollments, the NHB would compute the	The Board would be required to establish an annual budget that would not exceed the budget for the preceding year increased by the percentage increase in the GDP. The budget would consist of components for capital expenditures, administrative costs, and operating and other expenditures, and the Board would allocate funds to the State health security budgets established and submitted by the State programs. State budgets would be required to limit administrative expenses to 3 percent of total expenditures. State health programs could provide up to 1 percent of the budget for programs to provide assistance to workers	No provision.	No provision.	No provision.	No provision.	Nonbinding expenditure targets would be established for Medicaid and Medicare, based on spending in FY 1994. The Medicaid target would increase by 6.8 percent in FY 1995, 6.9 percent in FY 1996, and 7 percent in FY 1997 and later years. Target increases for Medicare would be 9.4 percent for FY 1995, 8.9 percent for FY 1996, 8.5 percent for FY 1997, and 8 percent for FY 1998 and later years. To meet the targets, Federal Medicaid spending would be subject to binding per capita growth limits (see below); limits would not be established for Medicare.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
weighted average accepted bid for each alliance. The NHB would then notify each alliance if the WAP exceeded its per capita premium target, and if so, the amount of its reduced WAP. If the alliance's weighted average accepted bid did not exceed its per capita premium target,then it would be in compliance. If it exceeded the target, then plans whose premiums exceeded the target would be required to reduce their premiums. In the first year, those plans whose premiums exceeded the target would be subject to the payment reduction. In subsequent years, the reduction would be applied to those plans whose dollar increase exceeded the allowed dollar increase for the alliance (i.e., the CPI plus percentage allowances in early years). Any health plan would be able to voluntarily reduce its bid to come into	involved in the administration of health insurance system who might experience economic dislocation as a result of implementation of this health program. State health programs would be required to establish a process for approving capital expenditures. If State spending exceeded its annual budget, the State would be required to continue to fund covered health services from its own revenues; if a State provided all covered services for less than the amount budgeted for a year, the State would be allowed to retain its full Federal payment for the year.					

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
compliance with the targets.						
B. Premium Targets	**B. Premium Targets**	**B. Premium Targets**	**B. Premium Targets**	**B. Premium Targets**	**B. Premium Targets**	**B. Premium Targets**
The NHB would establish a national baseline per capita premium "target" using current per capita health expenditures for the comprehensive benefit package, trended forward to 1996, reflecting projected increases in private health care spending (including up to 15 percent in administrative costs). With this national per capita baseline target as a reference point, the NHB would then calculate for each alliance a per capita premium target, adjusted to reflect existing regional variations in spending, rates of uninsurance and underinsurance, and other specified factors. The weighted average of all the alliance targets would have to equal the	No provision.	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
national per capita baseline target. The per capita premium targets for each alliance would be updated by the CPI to reflect inflation. An additional allowance of 1.5 percentage points would be provided in 1996, dropping to 1.0 in 1997, 0.5 in 1998, and no allowance in 1999. In 1998, the NHB would recommend to Congress an inflation adjustment factor for the years beginning with 2000. Corporate alliances would also be subject to similar budget constraints. In addition to reducing alliance payments to health plans exceeding the target, the plan premium reductions resulting from this enforcement process would affect the premiums paid by employers and consumers to the alliance and the payments made by the plans to providers.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
IX. PRIVATE HEALTH INSURANCE REFORM	**IX. PRIVATE HEALTH INSURANCE REFORM**	**IX. PRIVATE HEALTH INSURANCE REFORM**	**IX. PRIVATE HEALTH INSURANCE REFORM**	**IX. PRIVATE HEALTH INSURANCE REFORM**	**IX. PRIVATE HEALTH INSURANCE REFORM**	**IX. PRIVATE HEALTH INSURANCE REFORM**
A. General Approach	**A. General Approach**	**A. General Approach**	**A. General Approach**	**A. General Approach**	**A. General Approach**	**A. General Approach**
To sell health insurance through a regional or corporate alliance, an insurer (health plan) would have to be certified by the State as being in compliance with Federal standards. All insurance covering the comprehensive benefits package would be regulated in this manner. (Other than insurance sold to large employers (generally over 5,000 employees) through a corporate alliance), certified plans would be sold through regional alliances to individuals, not employers. All plans would have to meet minimum conditions of participation established by the NHB, including standards for financial solvency, marketing, consumer protection, confidentiality, complaints review,	No provision, except that each State health security program would be required to prohibit the sale of health insurance in the State if payment under the insurance would duplicate payment for any items or services for which payment would be made under the State program.	The bill would limit the use of preexisting condition clauses and require continuity and renewability of coverage for all group health plans, including multiemployer plans (Taft-Hartleys), and multiple employer arrangements. In general, States would be responsible for regulating the group insurance market unless the Secretary of HHS determined that such regulation was not adequate. In that case, the Federal Government would enforce the market rules. Additional requirements would be applied to insurers selling to small employers (2 to 50 employees). All such insurers would have to sell standardized policies called MedAccess plans.	The bill would apply Federal insurance regulation to health plans sold to individuals and employers as well to health plans sponsored by employers. All plans seeking qualification as AHPs (and thus qualification for favorable tax treatment) would have to register with the NHB. The NHB would be responsible for specifying and enforcing the Federal insurance requirements and for collecting and distributing certain AHP information. States would be responsible for regulating the solvency of insured plans; the NHB would do so for plans that are not insured. AHPs sold to employers with fewer than 100 employees and to	To become a qualified health insurance plan (and thus eligible for the favorable tax treatment described above), a health plan would have to meet specific Federal standards. These standards would be developed by the NAIC, or in the event of its failure to do so, by the Secretary of HHS, and would in general apply to individual and employer-sponsored policies. (By 1997, insured employer-sponsored plans would have to comply with the bill's requirements to become qualified health insurance plans. Sponsors of self-insured plans would come under the bill's requirements upon enactment. Note that starting in 1997, employers would no longer be making direct premium payments to	The bill provides for standards for qualified health plans, i.e., those plans under which all persons must be covered once mandated individual coverage became effective. Small employers (fewer than 101 employees) and insurers selling to persons not connected to an employer or other group would have to offer coverage under a *qualified general access plan*, which would have to meet specific rating, underwriting and other rules and offer the standardized benefit package (see "Benefits"). Large employers would have to offer coverage under a *qualified health plan*. The Secretary of HHS would be required to request that the NAIC develop specific	The bill generally prohibits insurers and employers from canceling health insurance plans or denying renewals of coverage. It would enable individuals to buy new individual policies and groups to move from group to individual plans without being denied coverage because of preexisting conditions or health status. It would also change existing health insurance continuation coverage requirements under Consolidated Omnibus Budget Reconciliation Act (COBRA, P.L. 99-272) to enable eligible persons to buy COBRA policies with high deductibles. In addition, the bill would prohibit insurance plans effective after the date of enactment from

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
verification of provider credentials, data management and reporting, utilization management, and disenrollment for cause. Insurers selling policies to supplement the comprehensive benefit package or cover its cost-sharing requirements would have to comply with Federal and State requirements. Corporate alliances would be overseen by the Federal Government (through the Department of Labor) and would have to comply with new Federal standards and the Employee Retirement Income Security Act (ERISA), as modified by this bill. In the years prior to full implementation of the alliance system, the insurance market would be regulated by the States (or in the absence of effective State regulation, the Secretary of HHS)		The bill does not regulate the nongroup (individual) market. The NAIC would develop the rules for regulating the market; if it failed to develop adequate rules and standards, the Secretary of HHS would do so. The States would be required to implement and enforce the standards. A State could implement more stringent standards but it could not implement standards preventing the offering by an insurer of at least one MedAccess standard, catastrophic, and medisave plan. The Secretary would establish an Office of Private Health Care Coverage within HHS to report annually to Congress on the implementation and enforcement of the MedAccess standards, and evaluate the impact of the reforms on the availability of affordable health coverage for small employers that	individuals not obtaining insurance through employers could only be sold through HPPCs. All AHPs would have to: provide for the uniform set of effective benefits (specified by the NHB); adjust the cost sharing for low-income individuals; meet quality standards specified by the NHB; not discriminate in enrollment or provision of benefits; establish standard premiums for the uniform set of effective benefits; meet certain financing solvency requirements; and meet additional requirements. Open AHPs (those whose enrollment is not limited to a particular group of individuals such as the plan of a large employer) would have to meet additional requirements as described below. Employers could provide and insurers could sell insurance supplementing the uniform effective benefit	insurers for employees' insurance. See "Financing," above.) The standards for federally qualified health plans would be implemented and enforced by the States. If a State failed to establish regulations or if the State's regulatory program was decertified by the Secretary of HHS, the standards would be enforced by the Secretary.	standards to implement the standards for qualified general access plans. If within a specified deadline, the NAIC failed to develop such standards (in the form of a model act and model regulations) or the Secretary found that such standards were inadequate, the Secretary would be required to develop them. States would be required to establish a program to certify qualified general access plans. If the State failed to do so, its responsibilities would be assumed by the Secretary. In the period prior to State action, an insurer could only offer an insured health plan that met specific Federal standards related to guaranteed eligibility, availability, and renewability; nondiscrimination; financial solvency; rating limits; and mediation procedures.	increasing their premiums based on the preexisting condition or health status of the insureds. The bill would preempt State and local laws restricting the formation of small employer purchasing groups as well as State and local laws mandating benefits or restricting managed care and utilization laws. Conditional upon funds being available from savings in the Medicare and Medicaid programs, the bill provides for Federal allotments to States that establish insurance pools for individuals who would otherwise be unable to purchase high deductible insurance policies as a result of their preexisting conditions. The allotments would assist the States in providing premium subsidies for pool coverage for eligible individuals.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
under Federal transitional rules relating to underwriting, rating, and portability. To ensure the availability of insurance during this transition period, the Secretary could organize a national risk pool financed through enrollee premiums and assessments on insurers and self-funded plans.		purchase group health coverage for employees.	package. Such coverage could not duplicate the uniform benefit package or reduce the required cost-sharing.		In general, many of the same standards applicable to qualified general access plans (e.g., guaranteed eligibility for coverage; nondiscrimination based on health status; benefits; enrollment; information; and quality assurance) would apply to qualified large employer plans but only to the employees of the large employer. These and standards specifically applicable to large employer plans, i.e., financial solvency, payment of premiums, mediation procedures, and offering of different benefit packages, would be specified by the Secretary of HHS in consultation with the Secretary of Labor, and where appropriate, taking into consideration those standards established by the NAIC. Health plans offered under the FEHBP would have to comply with the standards for large employer plans.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
B. Availability A certified plan would have to accept every eligible person enrolled by an alliance and could not terminate or limit coverage for the comprehensive benefit package. No plan could engage in any practice that had the effect of attracting or limiting enrollees on the basis of personal characteristics, anticipated need for health care, age, occupation, or affiliation with any person or entity. Also, a plan could not discriminate or engage in any activity, including the selection of service area, that had the effect of discriminating against an individual for these and other specified reasons. Further, a plan could not discriminate on such bases in the selection of providers for its network. With State approval, a plan could limit enrollment on the basis of its capacity and/or financial	**B. Availability** No provision.	**B. Availability** States could ensure availability of insurance to small employers through guaranteed issue (must accept all eligible applicants) or guaranteed availability (must ensure that there is a source of insurance for those eligible and wanting to buy). Under a guaranteed issue approach, all insurers selling in the small group market would have to offer health insurance coverage to each small employer in a State through a MedAccess standard, catastrophic, and medisave plans. Insurers offering MedAccess plans to small employers would be required to accept every small employer who applied for coverage and every eligible individual who applied for enrollment during open enrollment periods or within 30 days of losing previous employer coverage. (Federally qualified and certain	**B. Availability** Open AHPs would have to have an agreement with each HPPC for each HPPC area in which they are offered. In general, an open AHP would have to accept all eligible individuals who applied for coverage (i.e., eligible employees of small employers and eligible individuals not obtaining insurance through an employer) during an open enrollment period. Coverage could not be refused or terminated except for cause (e.g., nonpayment of premiums, fraud or misrepresentation; or plan termination). Network AHPs could deny coverage for an eligible individual if the person lived outside the network area, or if the plan had reached capacity, but only if such denials were applied uniformly, without regard to or insurability.	**B. Availability** On or after January 1, 1998, all qualified health plans would have to sell insurance to all applicants at standard rates (see "Rating" below) and could not cancel or refuse to renew coverage except for cases of nonpayment of premiums, or fraud or misrepresentation on the part of the policy holder.	**B. Availability** Qualified general access plans. Once market reforms were enforced by the States, an insurer could not exclude from coverage any eligible employee or eligible individual applying for coverage. It could not deny, limit, or condition coverage under (or the benefits of) the plan based on the health status, claims experience, receipt of medical care, execution of an advanced directive, medical history or lack of insurability, of an individual. An insurer would have to offer qualified general access plans throughout an entire HCCA area. (The insurer could deny coverage under the plan to eligible persons who reside outside the HCCA in which such plan was offered but only if such denial was applied uniformly, without regard to insurability. In addition, an insurer	**B. Availability** An insurer could not cancel an individual or group health insurance plan or deny renewal of coverage under such a plan other than for cause (i.e., nonpayment of premiums; fraud or other misrepresentation, and noncompliance with plan provisions), or because the insurer was ceasing to provide any health insurance plan in a State, or in the case of an HMO, in a geographic area. An insurer who terminated the offering of health insurance plans in an area could not offer such a plan in the area for 5 years. Employers could not cancel a self-insured group health plan or deny renewal of coverage other than for cause or because the plan was ceasing to provide coverage in a geographic area. Insurers with individual policies in effect on the

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
stability, but only if enrollment was limited uniformly, without regard to insurability. During the period of transitional reforms, an insurer could not cancel a policy that was enforce on the date of enactment of an individual or group. The Secretary would be authorized to organize a national risk pool to ensure that health insurance was available during the transition period for individuals who lose coverage or who are unable to obtain coverage because of health status. Pools would be financed through enrollee premiums and assessments on insurers and self-funded plans. States with existing pools could continue their operation to enroll those currently insured through the pools into the new Federal pool, maintaining the same level of State financial contributions.		other HMOs would be exempt from this requirement under specific conditions.) Under a qualified availability approach, a State could set up a mechanism under which insurers participating in the small group market would have to participate in an assigned risk pool among some or all insurers (see "Reinsurance" below) and ensure that through this pool, small employers have access to a MedAccess standard, catastrophic, and medisave plans.			could apply to the certifying authority (State or Secretary) to limit enrollment in a plan under specific conditions such as limited capacity.) Qualified access plans would have to be renewed at the employer or enrollee's option unless the plan was terminated for cause (nonpayment of premiums; fraud or misrepresentation; or change in residence to a HCCA not served under the plan). An insurer could terminate a qualified general access plan made available through a specific type of delivery system (such as an HMO) if it does so uniformly across the HCCA and provides adequate notice. In this event, it could not market such a policy in the State for five years. During the transition period, an insurer could deny enrollment to those who fail to apply for coverage on a timely	date of enactment would have to offer persons insured under those policies the option to purchase new policies. Premiums for such new policies could not be increased based on the health of the insured. Payments by enrollees for individual policies failing to comply with these requirements would not be deductible as an individual medical expense. A State could establish a risk pool program for persons with preexisting conditions who would otherwise be unable to obtain catastrophic insurance policies at premiums less than 150 percent of the area average for their age and gender, and who met other criteria. A catastrophic plan is defined by the bill as a plan covering medical services having at least a $3,000 deductible, indexed for inflation. States fulfilling requirements specified below could receive

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
					basis, generally meant to be during an annual initial enrollment period lasting at least 30 days or immediately after losing coverage from another source, such as employment.	Federal allotments to cover costs in excess of amounts collected from enrollee premiums. The bill authorizes such sums as may be necessary to fund the State allotments which would be available beginning in 1996. However, Federal allotments would be available only if the requisite Medicare and Medicaid savings were achieved. (See "Financing" above.) To be eligible to receive a Federal allotment, a State would have to apply to the Secretary at such time, in such manner, and containing such information, as the Secretary may by rule require. The application would have to include an assurance by the State that all administrative costs of the insurance pool program would be borne by the State from resources other than the Federal allotment.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						The State's pool program would provide premium assistance to eligible individuals to obtain catastrophic insurance from the pool. The State would be required to accept bids from private insurance carriers that desire to administer the pool and provide catastrophic health insurance plans to individuals with preexisting conditions. The State could accept such a bid, or, after determining that no such bids were acceptable, could administer the program itself. In considering bids, the State (in consultation with private carriers) would be required to compile a profile of individuals with preexisting conditions, including information on: (1) the number of such persons eligible for premium assistance; (2) the estimated cost of providing medical services to eligible persons; (3) the estimated amount of

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						premiums to be paid by eligible individuals; (4) the estimated amount by which the cost of the medical services would exceed received premiums; (5) the estimated amount of Federal assistance needed to cover the excess costs; and (6) other information determined appropriate by the State. Eligibility for premium assistance would be determined by the pool administrator. To be eligible, a person would have to have a preexisting condition, have been charged more than 150 percent of the average premium (for the person's area, age, and gender) for a catastrophic health insurance plan, and not have any avoidable health conditions (including medical conditions relating to smoking, alcohol abuse, and other activities harmful to health) which are the sole reason for having been

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						charged a premium in excess of 150 percent of the average. A preexisting condition is a condition having been diagnosed or treated during the 6-month period prior to the start of coverage. Anyone with income above 200 percent of poverty, or who was eligible for a partial or full tax credit to purchase catastrophic insurance (see "Financing" above), but who failed to purchase a catastrophic policy within 1 year after enactment, also would not be eligible for premium assistance under this pool program. The amount of premium assistance available to an eligible individual would equal the amount by which the premium paid by the individual for the catastrophic plan exceeded the greater of 150 percent of the average premium paid for catastrophic insurance plans by persons of the same

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						area, age, and gender or 7.5 percent of the individual or family adjusted gross income. Premium assistance would not cover charges attributable to any avoidable health conditions, including medical conditions related to smoking, alcohol abuse, drug abuse, and other activities harmful to health.
C. Portability	**C. Portability**	**C. Portability**	**C. Portability**	**C. Portability**	**C. Portability**	**C. Portability**
On full implementation prohibits imposition of pre-existing condition exclusions. During the transition, permits use of an exclusion only by an[illegible] insured or self-[illegible] only if the plan [illegible]n exclusion [illegible]	No provision.	Provides that a preexisting condition exclusion under any group health plan could apply only to a condition diagnosed or treated within 3 months before the first day of coverage (without regard to any general waiting period for new employees) and could last no more than 6 months; no exclusion could be imposed on newborns or for services related to pregnancy. Requires that the exclusion be waived for a condition if the enrollee was previously	Provides that a preexisting condition exclusion under any AHP could apply only to a condition diagnosed or treated within 3 months before the first day of coverage (without regard to any general waiting period for new employees) and could last no more than 6 months; no exclusion could be imposed on newborns or for services related to pregnancy. Provides that, if a new enrollee is in a period of continuous coverage for a service, the exclusion	Provides that no preexisting condition exclusion could be imposed by a federally qualified plan after January 1, 1998, on an individual who was continuously insured under any private plan or specified federally-funded public plan for 1 year prior to the date of application for the plan. Requires State regulatory systems to provide for a "passback" for such persons, under which the new plan would pay the previous plan a portion of	Provides that a preexisting condition exclusion under any qualified plan (including general access and large employer plans) could apply only to a condition diagnosed or treated within 3 months before the first day of coverage (without regard to any general waiting period for new employees) and could last no more than 6 months; no exclusion could be imposed on newborns or for services related to pregnancy. Provides that, if a new enrollee is in a period of	The COBRA continuation of coverage requirements under the Internal Revenue Code would be amended to require that the coverage provided to persons qualified for COBRA be identical to the coverage provided similarly situated active employees except that such COBRA coverage also be offered with an annual $1,000 deductible and a $3,000 deductible. The bill would also provide for termination of COBRA coverage once a person

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
6 months; no exclusion could be imposed on newborns. Provides that, if a new enrollee is in a period of continuous coverage for a service, the exclusion period for the service is to be reduced by 1 month for each month in the period of continuous coverage. Defines a continuous coverage period as beginning on the date the individual was enrolled in any public or private plan covering the service and ends when the individual has not been so enrolled for more than 3 months. Permits an employer or self-insured plan to impose a uniform waiting period for coverage of new employees, provided there is no discrimination against employees or dependents on the basis of health status.		covered for the condition under any other health plan within 60 days before enrollment, or within 6 months in the case of an enrollee losing coverage because of termination of employment. Permits an employer to impose a 60 day waiting period for coverage of new employees. An insurer could not require an employer to impose a waiting period.	period for the service is to be reduced by 1 month for each month in the period of continuous coverage. Defines a continuous coverage period as beginning on the date the individual was enrolled in any AHP covering the service and ends when the individual has not been so enrolled for more than 3 months. Provides that persons enrolling in an AHP before July 1, 1995, shall be deemed to have been in a period of continuous coverage during the 6 months ending January 1, 1995. Requires immediate offering of AHP enrollment to new employees.	premiums received, and the previous plan would be responsible for claims relating to a preexisting condition for the lesser of 2 years or the period of treatment or spell of illness for the condition. For persons not continuously covered, permits an exclusion for no longer than the lesser of 1 year or the number of months before application during which the individual was not insured and the condition had been diagnosed. Prohibits imposition of an exclusion for persons applying for coverage during 1997.	continuous coverage for a service, the exclusion period for the service is to be reduced by 1 month for each month in the period of continuous coverage. Defines a continuous coverage period as beginning on the date the individual was enrolled in any qualified plan or equivalent health care program covering the service and ends when the individual has not been so enrolled for more than 3 months. Provides that coverage must be offered during the month following the month a new employee is hired. An insurer could not require an employer to impose a waiting period.	became eligible for employer based coverage for more than 90 days. Individuals would be permitted to make penalty-free withdrawals from their qualified retirement plans to pay the premiums for COBRA coverage. *Conversion Rights.* Persons under a group health plan in *effect on the date of enactment* would have to be offered by the plan's insurer (or, in the case of a self-insured plan, the plan's sponsor) the option to purchase an individual policy upon leaving the group. The premium for this plan could be based on actuarial data and on the preexisting condition and health status of the insured. The insurer would also have to offer the employer or group sponsor the option to purchase a *new* group plan, the premium for which could not be increased based on the health of the group's insured. In addition,

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						the insurer would have to offer an individual leaving a *new* group plan the option of converting to an individual policy, the premium for which could not be based on any preexisting condition or increased due to the health status of the insured. A self-insured plan *in effect on the date of enactment* would have to offer its enrollees the option to enroll in an individual health plan and contract with one or more insurers to provide such individual policies to those electing them. Premiums for such individual policies could be based on the insured's preexisting conditions or health status. For self-insured plans *in effect after the date of enactment*, the premiums for persons converting to individual policies would be rated on actuarial data but could not be based on any preexisting condition or health of

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						the insured and could not be increased based on the health of the insured. Payments made by employers on behalf of employees to group health plans failing to meet these provisions would not be deductible for the employer and would be included as taxable income to employees. (Such tax penalties would not apply to the COBRA provision. Employers failing to comply with the COBRA provision would be subject to an excise tax.)
D. Rating Restrictions On full implementation, requires health plans to community rate; that is, rates for the comprehensive benefits could not vary except by family type within an alliance area (or, for a corporate alliance, within a designated premium area based on labor market or health	**D. Rating Restrictions** No provision.	**D. Rating Restrictions** Limits variation in premium rates charged by an insurer to small groups. Insurers could divide their small group business into classes, based on marketing method, acquisition of groups from another insurer, participation of a group in an association, use of	**D. Rating Restrictions** Requires all AHPs to establish standard rates for the uniform set of benefits. Rates could vary only by HPPC area, family type, and age, and could not be changed during a calendar year. The Commission would establish standard rate factors to reflect family	**D. Rating Restrictions** Premium rates charged by a federally qualified health insurance plan could vary only by age, sex, and geography; rates would have to be the same for new applicants and existing policyholders with similar demographic characteristics. A plan could offer discounts to	**D. Rating Restrictions** Limits variation in premium rates charged by an insurer to individuals and groups under a qualified general access plan (but not under a large employer plan). For enrollees under age 65, rates could vary only by age, family type, benefit plan (standard versus	**D. Rating Restrictions** See above discussion of health plan conversion rules under "portability." For existing insurance contracts, there is no limitation on rating. For newly issued individual and group contracts, rating must be done on an actuarial basis but cannot be

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
care delivery areas). Rate factors for family types would be established by the Board. During the transition, restricts changes in premiums for health insurance plans in effect as of the date of enactment. Premiums could be modified for changes in age, gender, family composition, or geographic distribution of enrollees or for changes in plan benefits or terms, but not for changes in health status of specific enrollees or employer groups. Premium increases related to health costs or utilization would have to apply equally to all purchasers, except that separate increases would be permitted for individuals and for groups under 100; variation in premium increases based on claims experience would be permitted for groups of more than 100. Overall premium increases in excess of a percentage specified by		managed care in the plan, or other factors approved by the State. The index rate for a class of business (the average of the lowest and highest rates established for the class) could not be more than 20 percent higher than the index rate for any other class. This limit would not apply to a class if (a) the class is one for which the insurer has never rejected eligible small employers or individuals; (b) groups are not involuntarily transferred into or out of the class; and (c) the class is currently available for purchase. An insurer could transfer any employer from one class to another involuntarily, or offer a voluntary unless a similar offer was made to other employers in the class. Within a class, rates could vary by demographic characteristics, including age, gender,	type and age; the highest age factor could be no more than twice the lowest age factor.	enrollees participating in health promotion, prevention, or screening programs.	catastrophic), and HCCA. (Coverage areas would be established by States and could not split an MSA or contain fewer than 250,000 people.) The insurance reform standards would specify permissible rating factors for family type and age groups; the highest age factor could be no more than twice the lowest age factor. In addition, the difference in rates from one age group to the next (within the under 65 population) could not exceed 20 percent in the first year a State's certification program was operating, phasing down to 10 percent in the sixth and later years. The insurance reform standards could allow premium variations based on differences in marketing and administrative costs, but rates could not vary for this reason within a particular purchasing group.	based on any preexisting condition or health status of the insured. The bill would preempt State and local laws restricting health plans from reducing premiums or allowing incentives for individuals to pursue healthy lifestyles.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
the Secretary would be subject to prior approval.		geographic area, family composition and group size. For groups with comparable demographic characteristics, rates could vary by health status or other factors, but the highest rate could not exceed the lowest by more than 50 percent in the first 3 years after the State has established its standards, or more than 35 percent in later years. The annual premium increase for any employer within a class of business could not exceed the increase in premiums charged to newly covered employers in the same class by more than 15 percent.				
E. Risk Adjustment and Reinsurance On full implementation, requires regional alliances to use risk adjustment and reinsurance methodologies established by the Board. Under risk	**E. Risk Adjustment and Reinsurance** No provision.	**E. Risk Adjustment and Reinsurance** States would be required to establish one or more reinsurance or allocation of risk systems for insurers in the small group market, in accordance with models developed by the	**E. Risk Adjustment and Reinsurance** HPPCs would be required to risk-adjust premiums paid to open AHPs, using factors established by the Commission. Factors would reflect relative risk for consumption of	**E. Risk Adjustment and Reinsurance** Federally qualified health insurance plans would be required to participate in a State-administered reinsurance or risk adjustment system designed to compensate	**E. Risk Adjustment and Reinsurance** Each qualified general access plan would be required to participate in a State-established risk adjustment program, using adjustment factors established as part of	**E. Risk Adjustment and Reinsurance** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
adjustment, a plan would be paid more or less than its quoted premium rate depending on the actuarial risk presented by the persons enrolled in the plan as compared to all enrollees in the alliance. The Board would develop factors for use in the adjustment, including demographic characteristics, health status, geography (within an alliance area), socioeconomic status, and any other factors determined by the Board to be material. (Receipt of AFDC or SSI would be included unless the Board determined that other factors accounted for differences in utilization by welfare recipients. States would have the option of making further adjustments to promote enrollment of members of disadvantaged groups. Under the reinsurance system, health plans would make payments to a State-established pool that would		NAIC or the Secretary. (Under reinsurance, an insurer would designate certain individuals or groups as "uninsurable" and these individuals would be covered through a central pool; under risk allocation "uninsurable" applicants would be assigned equitably among small group insurers.) The Secretary could establish a system in a State that failed to do so; the allocation of risk approach would be used in such a State only if the Secretary determined that reinsurance was inappropriate. If the Secretary established a reinsurance system, costs of such a system would be financed through a tax on employer group premiums of all health insurers in the State (including large group insurers but not self-insured plans).	services, as well as differences in utilization resulting from higher proportions of enrollees eligible for low-income cost-sharing assistance. HPPCs would also have the option of using special risk-adjustment factors for AHPs serving individuals in designated urban or rural underserved areas. In addition, there would be a system for equitably distributing among open and closed AHPs, and across HPPC areas, any required reductions in plan revenues for persons eligible for low-income premium assistance.	for disproportionate distributions of risks among plans.	the insurance reform standards. Factors would reflect relative risk for consumption of covered health services and would, to the extent possible, be determined without regard to the delivery system used in the provision of services.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
compensate plans for part of the cost of treating specified classes of high-cost enrollees and specified high-cost treatments or diagnoses.						
F. Other Requirements Health plans selling through the regional alliances would be prohibited from distributing marketing materials making false or materially misleading information and would have to get prior approval of all marketing materials from the alliance. Plans could not selectively market and could not condition the sale of the comprehensive benefit package upon the purchase of another policy. Plans would be required to provide information on costs, provider qualifications, utilization control and quality assurances procedures, and the rights and	**F. Other Requirements** No provision.	**F. Other Requirements** The bill contains no specific prohibitions on marketing. The following State laws would be preempted: (1) mandated benefit laws (including laws requiring a type of benefit, coverage, or provider); (2) anti-group laws which restrict the ability of 2 or more employers from obtaining coverage through an insured multiple employer group; (3) specific restrictive laws on managed care plans; and (4) laws regulating MEWAs that provide health benefits and meet certain Federal standards. To be exempt from State laws, MEWAs that	**F. Other Requirements** An AHP could pay a commission or other remuneration to an agent or broker for marketing the plan to individuals or groups but could not vary such remuneration based, directly or indirectly, on the anticipated or actual claims experience associated with the group or individuals to which the plan was sold. Open AHPs would be required to enter into risk-sharing agreements under Medicare (if eligible), and to enter into an agreement with the Office of Personnel Management to offer a health plan under the Federal Employees Health Benefit Program.	**F. Other Requirements** Insurers would be allowed to select agents to market their plans and to determine the amount and form of compensation of those agents except that the insurer could not terminate or refuse to renew the agent's contract for any reason related to the age, sex, health status, and other characteristics used to determine the insurance risk of an applicant placed by the agent with the plan, and the insurer could not directly or indirectly enter into an agreement or arrangement with an agent that provides for, or results in, any consideration provided to such agent for the issuance or renewal of a policy to vary on	**F. Other Requirements** The bill would prohibit marketing or other practices by an insurer selling to small employers or individuals that is intended to discourage or limit the issuance of a qualified general access plan to an eligible employee or eligible individual on the basis of health status or other risk factors. An insurer could not vary commissions or other remuneration to an agent or broker on the basis of the claims experience or health status of individuals enrolled. Insurers selling qualified general access plans would have to meet financial solvency requirements.	**F. Other Requirements** The bill does not include provisions regulating the marketing of insurance policies or requiring insurers or other entities to provide plan information to consumers. The bill would override State laws that prohibit two or more employers or groups from obtaining coverage under a multiple employer health plan. It would also preempt States and localities from requiring the coverage of specific benefits, services, or categories of health care or services of any type of employer under any group health plan (and not just those marketed by purchasing groups). Additionally, it would

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
responsibilities of consumers and patients. A plan would also have to establish a benefit claims dispute procedure, which would provide consumers with the right to appeal to the alliance ombudsman or pursue other legal remedies. The proposal would modify ERISA's preemption of State regulation of employer benefit plans so that States would only be preempted from regulating employers and health benefit plans in corporate alliances. The proposal would further amend ERISA to establish certain requirements for employers and others sponsoring health benefit plans in corporate alliances. These would include such requirements as: ensuring that all enrollees would be provided with at least the guaranteed benefit package; complying with		are not fully insured would have to be granted an exemption by the Federal Government conditioned upon paying a filing fee, providing specific information, demonstrating adequate reserves, and solvency. The bill specifies additional requirements for MEWAs seeking an exemption from State regulation and provides for changes in ERISA and the Internal Revenue Code to encourage the establishment of MEWAs.	The following State laws would be preempted: (1) mandated benefit laws (including laws requiring types of benefits, coverage, or providers); (2) specific restrictive laws on managed care plans ("network" plans); and (3) laws restricting utilization review programs. In general, MEWAs could not have a role in marketing policies to small employers with benefits duplicating the uniform set of effective benefits.	account such risk factors. The Secretary, in consultation with the NAIC, is required to develop nonbinding standards for premium rating practices and guaranteed renewability of coverage which, if the insurer so elects, is more generous (additional benefits or lower cost sharing) than the requirements specified in the bill for federally qualified health insurance plans. The insurer or new sponsor of an employer-sponsored health plan (be it an employer, union, purchasing cooperative or other entity) would have to notify all of the primary insured beneficiaries of the plan of their right to convert to a federally qualified health insurance plan offered by the insurer with benefits identical to, or actuarially equivalent, to those the of the employer-sponsored plan	Insurers selling qualified health plans (not just qualified general access plans) would have to provide information designed to enable consumer comparison of plan performance, use uniform claims forms (see "Administrative Simplification"), maintain a quality assurance program that complies with the bill's standards (see "Quality"), and establish a mediation procedures program (see "Malpractice"). The bill provides for large employer plan termination procedures to ensure timely payment of all benefits for which the plan is obligated and for regulations to be established to provide for temporary coverage of affected persons. The bill would amend ERISA to extend its various enforcement, reporting, and disclosure provisions to large employer health plans in	preempt for 5 years after enactment State laws imposing certain restrictions on the use of managed care and utilization review by group health plans. The bill would require the GAO to study the regulatory and legal impediments at the Federal, State, and local levels of government that restrict the ability of small business and other organizations from joining together voluntarily to allow employees or members to pool their health insurance purchases. The GAO would be required to report to Congress with appropriate recommendations within 2 years after enactment. (See III.A above.)

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
information and notification provisions; ensuring compliance standards with respect to uniform claims; complying with grievance and benefit dispute procedures; and complying with financial reporting standards. A State electing the State-wide single payer option could require all employers, including large, self-funded employers to participate in the single-payer system. The bill would also preempt specific State anti-managed care laws, and certain State corporate practices acts relating to the corporate practice of medicine and to provider ownership of health plans or other providers. Multiple employer welfare arrangements (MEWAs) could not market health insurance duplicating the comprehensive benefit package.				and the rates of that coverage. Beneficiaries would have 60 additional days to decline or accept the new coverage. Beginning in 1997, the employer sponsored plan could only offer such coverage at rates which vary only be age, sex, and geography except that the combined total of the new rates could not exceed the total group rate paid by employers and employees or both under the employer-sponsored plan on the last day it is or was in force. The bill includes no specific language amending the laws governing MEWAs.	which the employer contributes. It also would change ERISA to eliminate State regulation of multiple employer welfare arrangements providing health benefits that are certified by the Secretary of Labor. Such certification would be conditioned upon satisfying specific requirements (e.g., the MEWA meets the standards for qualified large employer plans, is administratively feasible, and protects the rights of covered persons). The following State laws would be preempted: (1) mandated benefit laws (including laws requiring types of benefits, coverage, or providers); and (2) specific restrictive laws on managed care plans ("network" plans).	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
X. ADMINISTRATIVE SIMPLIFICATION	**X. ADMINISTRATIVE SIMPLIFICATION**	**X. ADMINISTRATIVE SIMPLIFICATION**	**X. ADMINISTRATIVE SIMPLIFICATION**	**X. ADMINISTRATIVE SIMPLIFICATION**	**X. ADMINISTRATIVE SIMPLIFICATION**	**X. ADMINISTRATIVE SIMPLIFICATION**
A. Overview	**A. Overview**	**A. Overview**	**A. Overview**	**A. Overview**	**A. Overview**	**A. Overview**
Within two years of enactment, the Board would be required to develop and implement a health information system to collect, report, and regulate the collection and dissemination of health care information, including data on enrollment in health plans; clinical encounters and services provided; administrative and financial transactions and activities of the alliances; and other insurance functions. The health information system would be developed and implemented in a manner consistent with the privacy and security standards established by the Board (described below) and the objectives of reducing administrative costs, specifying the uses and	The American Health Security Standards Board would be required to establish policies, procedures, guidelines, and requirements related to eligibility, enrollment, benefits, providers participation standards, the determination of medical necessity and appropriateness, quality assurance, and other administrative duties. The Board would establish uniform reporting requirements and standards to ensure an adequate national data base regarding health practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and providers, including health outcome measures.	The Secretary would be required to adopt standards relating to data elements for use in paper and electronic claims processing under health benefit plans, utilization review and management of care; uniform claim forms, including uniform procedure and billing codes for use with such forms; and uniform electronic transmission of data elements. Standards for electronic transmission of data elements would supersede standards adopted for the submission of paper claims. The Secretary would be required to promulgate standards relating to claims processing data and uniform paper claims within 12 months of enactment; within 24 months of enactment promulgate standards	The Board would be required to promulgate, and could periodically modify, requirements to facilitate and ensure the uniform treatment of individually identifiable health care information in electronic environments. The Board would be required to establish goals and timeframes for the progress to be made by the health care industry in eliminating unnecessary paperwork, and achieving standardization in electronic receipt and transmission of health care claims, health plan information, and eligibility verification. The Board would also require the industry to achieve uniformity in the format and content of basic claim forms under health plans and in the use of common identification numbers	Similar to H.R. 3080/S. 1533, except no provision for grants to demonstrate and conduct research on the application of comprehensive information systems for continuously monitoring patient care and improving patient care, establishing the efficacy of communication links between information systems between health plans and health care providers, or developing regional or community-based clinical information systems.	The Health Care Data Panel would be required to develop regulations for the implementation and ongoing operation of an integrated electronic health care data interchange system. The panel would be responsible for adopting standards for the electronic reporting and exchange of health care information, establishing business practices for the operation of a nationally-linked health care information database system, and developing appropriate civil and criminal penalties for noncompliance.	The Secretary of HHS would be required to adopt standards to reduce the administrative and paperwork burdens of all Federal health care programs by 50 percent within 2 years of enactment, and by an additional 50 percent of the remaining balance over a subsequent 3-year period, for a total reduction of 75 percent over the 5-year period following enactment. The Secretary would be required to adopt standards relating to: 1) data elements for use in paper and electronic claims processing, utilization review, and management of care under health insurance plans; 2) uniform claims forms; and 3) uniform electronic transmission of data elements for purposes of billing and utilization review.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
types of health care data that would be collected and reported. As part of the health information system, the Board would oversee the establishment of an electronic data network consisting of regional centers that would collect, compile, and transmit information. In the interim, the Board would also be required to develop, promulgate, standards, within one year of enactment, to streamline paper health care data transactions. The standards health care benefit forms would include enrollment and disenrollment forms, clinical encounter records, and claim forms for submission of claims for benefits or payment under a health plan. Providers and health benefit plans would be required to use the forms promulgated by the Board on or after 270 days after the publication of the standard forms.		for the uniform electronic transmission of information concerning hospital and physician services; and by a later date determined to be feasible for the uniform electronic transmission of information for other services. If the Secretary determined 2 years after promulgating the standards that a significant number of claims for benefits for services are not being submitted in accordance with these standards, the Secretary could require, after at least 6 months notice, that all health care providers must submit claims to plans in accordance with the standards. The Secretary would make such a determination if it was found that the requirement would result in significant, measurable additional gains in efficiencies for the administration of the health care system. The Secretary could	for beneficiaries and providers of items or services under health plans. Similarly, the Board would be required to establish national goals and time frameworks for the industry in achieving uniformity in the rules for determining the liability of insurers when benefits are payable under two or more health plans.			In order to be eligible for any Federal funds in connection with any State-administered health care program, States would be required to standardize the processing of paper and electronic claims to reduce the administrative and paperwork burdens of such programs by 75 percent during the 5-year period following enactment. At the end of the 4-year period after enactment, if the Secretary determined that a State had not achieved substantial progress toward the required reductions, the Secretary would notify the State regarding the reduction necessary to achieve compliance. If at the end of the 5-year period the State had not achieved the required reductions, the Secretary would reduce Federal payments for health care programs administered by the State by 10 percent. For each subsequent year that the State

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
		impose a civil money penalty on any provider that knowingly and repeatedly submitted claims in violation of such standards. The Secretary would be required to promulgate standards for hospitals concerning electronic medical data. The data standards would include standards for electronic patient care data and protections against its unauthorized use, standards concerning the transmission of electronic medical data, and standards relating to confidentiality of patient-specific information. Data standards would be optional for other providers, but similar to those required for hospitals. The Secretary would be required to provide grants to qualified entities to demonstrate and conduct research on the application of comprehensive information systems for				failed to comply with these requirements, Federal payments for such health care programs would be further reduced by an additional 10 percent. States subject to Federal payment reductions could appeal to the Secretary for a 1-year waiver of such reductions. To achieve further paperwork reduction during the subsequent 3-year period following enactment, the Secretary would be required to modify by regulation the initial standards adopted based on recommendations reported by the Standardized Form Commission. Established within 12 months of enactment, the Commission, composed of 12-20 representatives of private health care providers and insurers, would be required to make recommendations regarding the further standardization of paper

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
		continuously monitoring patient care and improving patient care; would be allowed to provide between 2 and 5 grants to community organizations or coalitions of providers, plans, and purchasers to establish and document the efficacy of communication links between information systems between health plans and health care providers; and would be allowed to provide between 2 and 5 grants to public or private nonprofit entities to develop regional or community-based clinical information systems.				and electronic claims processing to reduce paperwork burdens and enhance the efficiency and productivity of claims processing. The Commission would be required to report findings and recommendations to the Secretary by not later than 24 months after enactment. The Secretary would then be required to take the Commissions recommendations and submit them to Congress for consideration in the form of an implementing bill by not later than 3 months after the Commission had submitted its report. Health care providers or insurers failing to comply with any recommendations of the Commission that are enacted and applicable would be ineligible for payments of claims submitted under any provision of the Social Security Act or the

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						Public Health Service Act.
B. Unique Identifier Numbers	**B. Unique Identifier Numbers**	**B. Unique Identifier Numbers**	**B. Unique Identifier Numbers**	**B. Unique Identifier Numbers**	**B. Unique Identifier Numbers**	**B. Unique Identifier Numbers**
The Board would be required to establish a system to provide for a unique identifier number for each eligible individual, employer, health plan, and health care provider.	State health security programs would be required to assign unique patient and provider identifier numbers to be used in the processing of claims and for other purposes.	Health plans would be required to use standard identification numbers for beneficiaries and providers by January 1, 1995.	No provision.	No provision.	The panel would be required to develop unique identifiers for individual participants, health plans, and providers not later than 9 months after enactment.	No provision.
C. Health Security Cards	**C. Health Security Cards**	**C. Health Security Cards**	**C. Health Security Cards**	**C. Health Security Cards**	**C. Health Security Cards**	**C. Health Security Cards**
The Board would be required to promulgate regulations for the permissible uses of health security cards, the form of the card and information to be encoded in electronic form on the card.	No provision.	The Secretary would be required to adopt standards related to use of a magnetized identification card for Medicare beneficiaries that would help providers determine eligibility and help them bill the Medicare program. The Secretary would also be required to encourage States to design and use Medicaid identification cards for beneficiaries.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
D. Confidentiality of Health Care Information The Board would be required to promulgate standards to safeguard the privacy of individually identifiable health information by no later than 2 years after enactment. The Board would also be required to develop a detailed proposal for legislation to provide a comprehensive scheme of Federal privacy protection for individually identifiable health information three years after enactment. A National Privacy and Health Data Advisory Council would be established to advise the Board on its duties related to health information systems and administrative simplification.	**D. Confidentiality of Health Care Information** The Board would be required to establish standards designed to protect the privacy of identifiable patient data included in the uniform electronic data base.	**D. Confidentiality of Health Care Information** The Secretary would be required to establish standards for confidentiality of health care information, including standards to protect against the unauthorized use and disclosure of information.	**D. Confidentiality of Health Care Information** The Board would be required to promulgate, and could modify, requirements to facilitate and ensure the confidential treatment of individually identifiable health care information in electronic environments. Such requirements would not be applied to States that already had laws in effect providing for the protection of confidentiality and privacy rights, including enforcement provisions of these laws, consistent with the Board's requirements.	**D. Confidentiality of Health Care Information** The Secretary would be required to adopt standards for protecting and assuring the confidentiality of patient information, including standards to protect against the unauthorized use and disclosure of information.	**D. Confidentiality of Health Care Information** The panel would be responsible for adopting standards that include strict measures ensuring the confidentiality of electronically-transmitted patient data.	**D. Confidentiality of Health Care Information** Standards established for uniform electronic transmission of data elements (for billing and utilization review) would include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.
E. State Quill Pen Laws State quill pen laws would be preempted by standards established by	**E. State Quill Pen Laws** No provision.	**E. State Quill Pen Laws** State quill pen laws would be preempted	**E. State Quill Pen Laws** After 1994, State quill pen laws would be preempted.	**E. State Quill Pen Laws** State quill pen laws would be preempted as of January 1, 1996.	**E. State Quill Pen Laws** No provision.	**E. State Quill Pen Laws** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
the Board for the maintenance of medical or health plan records, except in specified circumstances.		beginning January 1, 1994.				

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XI. MALPRACTICE	**XI. MALPRACTICE**	**XI. MALPRACTICE**	**XI. MALPRACTICE**	**XI. MALPRACTICE**	**XI. MALPRACTICE**	**XI. MALPRACTICE**
A. Tort Reforms	**A. Tort Reforms**	**A. Tort Reforms**	**A. Tort Reforms**	**A. Tort Reforms**	**A. Tort Reforms**	**A. Tort Reforms**
The bill would limit attorneys contingency fees (33 1/3 percent of total recovered), reduce awards for payments from collateral sources, and permit periodic payments of damages. A medical malpractice liability action could not be brought without a certificate of merit (i.e., an affidavit signed by a specialist that there is reasonable and meritorious cause for the filing of the action). Individuals seeking to enroll in health plans could obtain information reported to the national malpractice data bank on practitioners for whom reports were made on a repeated basis.	No provision.	The bill would limit noneconomic damages to $250,000; bar punitive damages except in extreme cases and require payment of such damages to State for quality assurance activities; provide for periodic payments of future losses in excess of $100,000; limit attorneys' fees (25 percent of first $150,000 recovered and 10 percent of any excess); eliminate joint liability; specify a 7-year statute of limitations; specify a uniform standard for determining negligence; and provide that a higher standard of proof required for obstetric claims where physician delivering baby did not provide prenatal care. Any party contesting alternative dispute resolution (ADR) ruling would be required to pay opposing parties legal fees unless the amount of damages	H.R. 3222: The bill would limit noneconomic damages to $250,000 and bar punitive damages for manufacturers of medical products. The Health Care Standards Commission would develop and recommend to the Congress alternative limits for payments for noneconomic damages by class of injury. Attorneys' fees would be limited (25 percent of first $150,000 recovered, 10 percent of any excess). Party contesting ADR ruling would be required to pay opposing parties legal fees unless the amount of damages awarded changed in favor of contestant. Individual filing a malpractice action would be required to submit a certificate of merit or post a surety bond with the court.	H.R. 3698 and S. 1743: The bill would permit periodic payments where future losses exceeded $100,000; offset for payments from collateral sources; specify a uniform statute of limitations (2-year from time injury should have been discovered, 4 years from event, whichever is later); limit noneconomic damages to $250,000 (except where court finds that a reduction of a jury award to this level would be unjust); eliminate joint liability for noneconomic damages; and limit awards of punitive damages to extreme cases. H.R. 3698: Attorneys' fees would be limited to 40 percent of the first $50,000 recovered, 33 1/3 percent of the next $50,000, 25 percent of	The bill would limit attorneys' fees to 25 percent of recoveries, cap noneconomic damages at $250,000, reduce awards for payments from collateral sources, permit periodic payments for future losses exceeding $100,000, require 75 percent of punitive damages to be paid to the State health care education and disciplinary program, limit statute of limitations to 2 years (longer for minors), and eliminate joint liability. Attorneys hired to represent a party to a suit would be required to disclose the estimated probability of success, hours required, and attorney fees; at the close of action, a full disclosure of work and hours spent would be required. If court or adjudicating body determined that the	The bill would limit noneconomic damages to $250,000 and would prohibit the award of noneconomic damages for medical product liability claims if the drug or device was approved by the Food and Drug Administration (FDA) or generally recognized as safe and effective pursuant to conditions established by the FDA (except in cases of withheld information, misrepresentation, or illegal payment). It would specify a uniform statute of limitations (2 years from time injury should have been discovered, 4 years from event, whichever is later, with a longer time for minors); eliminate joint liability for economic and noneconomic damages; permit periodic payments where future economic losses exceeded $100,000; and reduce

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
		awarded changes by more than 10 percent in favor of the contestant.	S. 1579: A U.S. Commission on Malpractice Awards would be established to promulgate limits on noneconomic and punitive damages; awards would be limited to amounts set. H.R. 3222 and S. 1579: Both bills would eliminate joint liability for noneconomic damages; allocate punitive awards to State provider licensing and disciplinary activities; permit periodic payments where future losses exceeded $100,000; set a 2-year statute of limitations (longer for minors); set a higher standard of proof where physician delivering baby did not deliver prenatal care; and establish a uniform standard for determining liability.	the next $500,000, and 15 percent of any excess. S. 1743: Attorneys' fees would be limited to 25 percent of first $150,000 recovered, 15 percent of any excess.	claim was frivolous, it would impose a sanction against the attorney or claimant, as appropriate.	awards for payments from collateral sources. Requests for discovery would be specific; the court would award prevailing party reasonable fees and expenses in connection with discovery motion (unless court found that position of unsuccessful party was substantially justified). The court would require the party against whom a judgment was rendered to pay the prevailing party's costs and fees, including attorneys' fees, unless losing party could show that the claim was substantially justified. The bill would limit attorneys' fees (25 percent of first $150,000 recovered, and 15 percent of any excess); require maintenance of records by attorney of record; and specify that the court would determine reasonable expenses and attorneys fees which could not exceed a reasonable amount (based on

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
						specified criteria). Each nonsettling party could recover contribution and indemnification from any other nonsettling party who, if joined in the original suit would have been liable for damages. Any party who executed a release, dismissal or settlement agreement would be discharged from all claims from nonsettling or other settling parties. In a class action suit, the share of damages awarded to a representative claimant would be calculated in the same manner as for all other claimants; an attorney could not represent the class if the attorney paid or was obligated to pay a fee to a third party to assist the attorney in obtaining representation of any party to the action.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
B. Alternative Dispute Resolution (ADR) No medical malpractice liability action could be brought until the final resolution of the claim under ADR. Each regional alliance and corporate alliance plan would be required to: (i) adopt at least one ADR method developed by the National Health Board (such as arbitration, mediation, or early offers of settlement) for resolution of claims, and (ii) disclose procedures for grievances to enrollees.	**B. Alternative Dispute Resolution (ADR)** No provision.	**B. Alternative Dispute Resolution (ADR)** No medical malpractice liability action could be brought until after initial resolution of the claim under ADR meeting specified standards. Uncontested decision would have the same legal effect as court action.	**B. Alternative Dispute Resolution (ADR)** H.R. 3222: No medical malpractice liability action could be brought until after initial resolution of the claim under ADR meeting specified standards. Uncontested decision would have the same legal effect as court action. S. 1579: The Secretary would make 2-year grants to at least 10 model States for implementation and evaluation of ADR systems.	**B. Alternative Dispute Resolution (ADR)** No provision.	**B. Alternative Dispute Resolution (ADR)** Qualified health plans would be required to provide effective mediation procedures for hearing and resolution of claims. If mediation failed, the parties would participate in ADR. No medical malpractice liability action could be brought until the final resolution of the claim under ADR mechanism established by the State. A party challenging an ADR decision would be required to pay all legal fees if the court decision was less favorable for them.	**B. Alternative Dispute Resolution (ADR)** No provision.
C. Practice Guidelines The Secretary, within 1 year of determining appropriate guidelines were available, would be required to establish a pilot program to determine the effect of applying practice	**C. Practice Guidelines** The Council would develop practice guidelines; however there is no linkage between the guidelines and medical liability claims.	**C. Practice Guidelines** No provision.	**C. Practice Guidelines** The Secretary would make grants to at least 10 States for development of practice guidelines that could be used to resolve liability claims.	**C. Practice Guidelines** No provision.	**C. Practice Guidelines** Providers following guidelines approved by Agency for Health Policy and Research would have a presumptive defense against claims.	**C. Practice Guidelines** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
guidelines in the resolution of malpractice liability actions.						
D. Enterprise Liability	**D. Enterprise Liability**	**D. Enterprise Liability**	**D. Enterprise Liability**	**D. Enterprise Liability**	**D. Enterprise Liability**	**D. Enterprise Liability**
The Secretary would establish a demonstration project by January 1, 1996, in one or more States to test the concept of enterprise liability under which the health plan rather than the individual physician assumed liability.	No provision.	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XII. ANTI-TRUST	**XII. ANTI-TRUST**	**XII. ANTI-TRUST**	**XII. ANTI-TRUST**	**XII. ANTI-TRUST**	**XII. ANTI-TRUST**	**XII. ANTI-TRUST**
The establishment of a fee schedule by a regional alliance would be considered to be pursuant to a clearly articulated and affirmatively expressed State policy to displace competition and to be actively supervised by the State. The bill amends the McCarran-Ferguson Act to repeal the current exemption for health insurers.	No provision.	The Attorney General would establish guidelines under which a limited exemption from antitrust laws would be provided for entities entering joint ventures; liability for these entities would be limited to actual damages. The Attorney General would issue a certificate of public advantage (providing exemption from antitrust laws) to entities entering joint ventures that meet specified criteria; criteria to be met include demonstration of greater efficiencies, expanded access, reduced costs, and elimination of excess capacity. An anti-trust exemption would be provided for medical self-regulatory entities. An Interagency Advisory Committee on Competition, Anti-Trust Policy, and Health Care would be established.	H.R. 3222 and S. 1579: The President would be required to provide for the development and publication of explicit guidelines on the application of Federal anti-trust laws to AHPs. The Attorney General would establish a review process under which an AHP (or organization proposing to establish an AHP) could obtain a prompt opinion from the department of Justice on the plan's conformity with Federal anti-trust law. H.R. 3222: The requirement for issuance of certificates of public advantage same as H.R. 3080.	An exemption from antitrust laws would be established for the following safe harbors (meeting certain requirements): (1) combinations of providers if the number does not exceed 20 percent of the provider type or specialty in the area; (2) activities of medical self-regulatory agencies; (3) participation in surveys; (4) joint ventures for high technology and costly equipment and services; (5) mergers of 2 hospitals if one below 150 beds and 50 percent occupancy; (6) joint purchasing arrangements; and (7) negotiations. The Attorney General could designate additional safe harbors for activities designed to increase access or enhance quality or efficiencies. Further, the Attorney General would issue certificates of review under an expedited waiver process. Under	Same as H.R. 3698/S. 1743. In addition, an Office of Health Care Competition Policy would be established in HHS.	Same as H.R. 3080/S. 1533.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
				certain conditions, joint ventures providing notifications of activities to the Attorney General would be subject to reduced penalties under anti-trust laws.		

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XIII. QUALITY	**XIII. QUALITY**	**XIII. QUALITY**	**XIII. QUALITY**	**XIII. QUALITY**	**XIII. QUALITY**	**XIII. QUALITY**
The Board would establish and oversee the National Quality Management Program administered by the National Quality Management Council. The Council would develop a set of national measures of quality performance to assess the provision of and access to health care services. National measures would be selected to provide information on access, appropriateness, outcomes, health promotion, prevention, and consumer satisfaction. The Council would recommend (in areas where it determined that sufficient information and consensus existed) that the Board establish goals for performance by health plans and providers on a subset of national measures of quality performance. The Council would also evaluate the impact of	H.R. 1200 and S. 491: The Council would collect data from outcomes research and, on the basis of this and clinical knowledge, develop practice guidelines which could vary by area. The Council would develop methodologies for profiling practice patterns and identifying outliers. States would be required to establish one or more entities to conduct quality reviews in accordance with established Federal standards. A State could use alternate standards if it could show they were as efficacious in promoting and achieving quality of care. States would be required to use a uniform electronic data base (using uniform software developed by the Board) for all patient records for systematic quality review and outcomes	Within 6 years of enactment, the State comparative value information programs would be required to include information on quality and outcomes data. The Secretary would be required to provide for the collection and analysis of data on cost, quality, and outcomes. The Secretary would provide up to $10 million a year for demonstrations and research on monitoring and improving patient care. Within 3 years of enactment, the Secretary would report to Congress recommendations regarding restructuring the Medicare peer review quality assurance program given the availability of hospital data in electronic form.	The Commission (Board under S.1579) would be required to establish minimum quality standards that AHPs would be required to meet. HPPCs would be required to conduct enrollee satisfaction surveys and monitor enrollee disenrollment with AHPs. The Commission (Board under S. 1579) would provide for submission of information by a specialized center of care (which is organized for the provision of specific services) on the quality of care provided, including outcomes and risk factors. The information would be analyzed and compared with that of other specialized centers and other providers. A new Agency for Clinical Evaluations would support research on medical effectiveness, conduct effectiveness trials, maintain a	Provision relating to State comparative value information systems, same as H.R. 3080/S. 1533.	Each health plan would be required to have a quality assurance program meeting standards established by the Secretary; plans would be required to provide quality data, including information on outcomes and effectiveness. Federal research on effectiveness and outcomes would be expanded. The Secretary would provide for submission of information by a specialized center of care (which is organized for the provision of specific services) on the quality of care provided, including outcomes and risk factors. The information would be analyzed and compared with that of other specialized centers and other providers. A clearinghouse and other registries on clinical trials research would be developed. A	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
the Act on quality and access. Alliances would be required to publish annual reports outlining the performance of each health plan on the set of national measures of quality performance. They would also publish the results of consumer surveys. The Council would direct the Administrator for Health Care Policy and Research to develop and review clinically relevant practice guidelines. The Council would also direct the Administrator to support research directly related to the identified performance measures. The Board would establish a National Quality Consortium which would establish continuing education programs, advise the Board, the Council and the Administrator, and oversee the development of regional professional foundations.	analysis. Patient confidentiality would be protected. H.R. 1200: Existing Federal requirements for utilization review would be replaced by January 1, 1998. S. 491: State programs could require, as a condition of payment, certifications for services comparable to those required for Medicare. A State could establish a utilization review program and deny payment to the extent services failed to meet coverage standards; routine utilization review for all cases would not be permitted.		clearinghouse on clinical trials and research data, and assure systematic evaluation of existing as well as new treatments and diagnostic technologies.		National Medical Research Trust Fund would be established with funding from voluntary transfers from tax overpayments and from specified health-related civil penalties.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
The Medicare peer review program would be repealed.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XIV. FRAUD	**XIV. FRAUD**	**XIV. FRAUD**	**XIV. FRAUD**	**XIV. FRAUD**	**XIV. FRAUD**	**XIV. FRAUD**
The Secretary and the Attorney General would establish a program: to coordinate the functions of the Attorney General, the Secretary, and other organizations with respect to prevention, detection, and control of health care fraud and abuse; to conduct investigations, audits, and similar activities relating to the delivery of and payment for health services; and to facilitate enforcement of statutes applicable to health care fraud and abuse. The Secretary and Attorney General would coordinate with all applicable law enforcement agencies and with health alliances and health plans. An all-payer health care fraud and abuse account would be established in the Treasury with funds from fines and civil penalties placed in the account; account would be used for covering	Current Federal sanctions would apply to State health security programs in the same manner as they now apply to Medicaid. A national health care fraud data base would be established by the Board; reporting and disclosure requirements would be coordinated with those for the malpractice data base. Each State would be required to establish a State health care fraud and abuse control unit meeting specified requirements. Current limitations on physician self-referrals expanded to additional payers. (Provision drafted before enactment of P.L. 103-66.)	An all-payer anti-fraud and abuse program would be established in the Inspector General's Office: to coordinate Federal, State and local law enforcement programs relating to health care; to conduct investigations, audits, evaluations, and inspections relating to delivery of and payment for care; and to facilitate enforcement of relevant statutes. Authorizes $100 million in FY 1995 and such funds as are necessary in future years. An anti-fraud and abuse trust fund would be established with Federal anti-fraud and abuse penalties deposited to the Fund. Federal health anti-fraud and abuse sanctions would be applied to all fraud and abuse against any health benefit plan.	No provision.	Federal health anti-fraud and abuse sanctions would be applied to all fraud and abuse against any health insurance plan. Federal criminal penalties would be established for attempts to defraud by a health care provider. Rewards would be authorized for information leading to prosecution and conviction.	All payer fraud and abuse control program similar to H.R. 3080; such funds as necessary would be authorized. Establishment of anti-fraud and abuse trust fund provision similar to H.R. 3080. Provision applying Federal anti-fraud and abuse sanctions to any health benefit plan similar to H.R. 3080. At the same time, existing fraud and abuse sanctions would be revised and strengthened. The Secretary would establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements where no finding of liability was made) against providers, suppliers, or practitioners. The information in the	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
costs of prosecuting health care matters and conducting investigations, audits, inspections, and evaluations. An HHS Office of Inspector General Asset Forfeiture Proceeds Fund would be established with funds used for investigations. The fraud and abuse control sanctions under the Social Security Act would apply to all payers. (At the same time, a number of clarifying and strengthening changes would be made in the existing provisions.) The current Medicare and Medicaid limitations on physician self-referrals would apply with respect to health plans. (Changes and clarifications would also be made in these provisions.) Federal criminal penalties would be established for certain fraudulent acts including attempts to defraud an alliance or		Federal criminal penalties would be established for attempts to defraud by a health care provider. Appropriations would be authorized for at least 225 Federal Bureau of Investigation (FBI) agents and support staff, at least 50 U.S. attorneys and support staff, and at least 25 staff in the Inspector General's office to work on health care fraud cases. Rewards would be authorized for information leading to prosecution and conviction.			database would be available to the public, Federal and State agencies, and health plans. The Secretary would publish a listing of adverse actions on a quarterly basis. Federal criminal penalties would be established for attempts to defraud a health care plan.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
plan, false statements, bribery or graft, theft or embezzlement of alliance or plan funds, or misuse of health security card.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XV. MEDICARE	**XV. MEDICARE**	**XV. MEDICARE**	**XV. MEDICARE**	**XV. MEDICARE**	**XV. MEDICARE**	**XV. MEDICARE**
A. Medicare and Revised System	**A. Medicare and Revised System**	**A. Medicare and Revised System**	**A. Medicare and Revised System**	**A. Medicare and Revised System**	**A. Medicare and Revised System**	**A. Medicare and Revised System**
Current Medicare beneficiaries would continue to be covered under the existing Medicare program as they are today, except that the working aged would continue to be covered under their employer-paid plans and could not enroll in Medicare until they ceased working. Persons enrolled in an alliance managed care plan before becoming Medicare eligible could, on turning 65, choose to remain in the plan and continue to receive comprehensive benefits through the plan. Medicare would pay the plan 95 percent of what it would have spent for a comparable individual choosing regular Medicare coverage. States with regional alliance systems could apply to the Secretary to include all (or a	Medicare would be eliminated and current beneficiaries would become entitled to the same comprehensive benefits as all other persons.	Medicare HMO law would be amended to permit Medicare-only HMOs. All Medicare enrollees would be permitted to enroll in plans that provide benefits through provider networks and with lower cost-sharing.	No provision.	The Secretary of HHS would conduct a study on the feasibility of permitting future Medicare beneficiaries, once they turned 65, to retain private insurance coverage and receive, in lieu of Medicare benefits, certificates for purchasing private insurance.	The Secretary of HHS would develop a legislative proposal for enrollment of Medicare beneficiaries in qualified health plans. Current Medicare beneficiaries would have the option of obtaining services through their current arrangements, or enrolling in qualified health plans with payments not to exceed the lesser of the actual premium or 100 percent of the per capita payments made to HMOs or other risk-based plans. Medicare HMO law would be amended to encourage greater enrollment in HMOs and other managed care arrangements. All Medicare enrollees would be permitted to enroll in plans ("Medicare select") that provide benefits through provider networks with lower cost-sharing.	Current Medicare beneficiaries (i.e., those eligible on or before September 30, 1994) could continue to be covered under the existing Medicare program as they are today, or could elect to have Medicare make payments for their enrollment in a managed care plan or another private insurance plan, including a catastrophic plan with a medical savings account. For those electing (by March 31, 1995) to be covered under a private plan, Medicare would make a payment to the plan equal to the lesser of the plan's annual premium or the per capita amount that the Secretary of HHS estimates Medicare would make for groups of beneficiaries (based on residence, age, and gender) still enrolled in

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
portion of) Medicare beneficiaries in the alliances where they would choose among participating health plans. States would have to ensure that a fee-for-service plan was available that provided the equivalent of Medicare benefits at no greater cost to beneficiaries than under the regular Medicare program. States choosing to establish a single-payer system could also include Medicare beneficiaries in their system. Medicare HMO law would be amended to encourage greater enrollment in HMOs and other managed care arrangements. Medicare could also enter into contracts with point-of-service networks, under which enrollees choosing to use networks would pay lower cost-sharing.						Medicare in the coming calendar year. The Secretary would be required to pay persons enrolled in private plans one-half of the amount by which per capita expenditures exceed the plan's premium; the Secretary would be required to pay the full amount of the difference to persons who have private long-term care insurance. Persons becoming eligible for Medicare after September 30, 1994, would have 1 year to elect to enroll in a private plan.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
B. New Medicare Benefits Medicare would be amended to expand coverage of services provided by advance practice nurses in certain settings. Medicare Part B benefits would be expanded to cover outpatient prescription drugs beginning in 1996. The benefit would be subject to a $250 deductible and 20 percent coinsurance, up to an out-of-pocket limit of $1,000 per year; low-income beneficiaries would receive assistance with cost-sharing. The deductible and out-of-pocket limit would be indexed to ensure that the same proportion of beneficiaries received the benefit each year. Medicare would receive rebates from manufacturers (except for generic drugs) equal to the greater of (a) the difference between average retail and wholesale prices or (b)	**B. New Medicare Benefits** Medicare would be eliminated and beneficiaries would become entitled to the comprehensive benefits specified above.	**B. New Medicare Benefits** No provision.	**B. New Medicare Benefits** Medicare Part B benefits would be expanded to cover colorectal screening, tetanus-diphtheria immunizations, well-child care services for eligible persons under 7, and annual screening mammography. Medicare's Part B premium would be increased by $1.40 to finance these new benefits.	**B. New Medicare Benefits** No provision.	**B. New Medicare Benefits** No provision.	**B. New Medicare Benefits** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
17 percent of average retail prices. The Secretary could negotiate rebates for new drugs considered to be overpriced, or could exclude them from coverage. The new prescription drug benefit would be financed by an increase in the Part B premium to cover 25 percent of its costs, with the remainder financed by general revenues.						
C. Reductions in Medicare Spending	**C. Reductions in Medicare Spending**	**C. Reductions in Medicare Spending**	**C. Reductions in Medicare Spending**	**C. Reductions in Medicare Spending**	**C. Reductions in Medicare Spending**	**C. Reductions in Medicare Spending**
The bill would reduce Medicare payments to providers; establish new coinsurance requirements for home health and laboratory services; increase Part B premiums for individuals with incomes greater than $90,000 and couples with incomes greater than $115,000; continue the policy of requiring Medicare to be secondary payer to private health insurance; and require	Medicare would be eliminated.	The Medicare Part B premium would be increased for individuals with incomes greater than $100,000 and couples with incomes greater than $125,000.	The bill includes specific proposals to reduce Medicare payments to providers and to increase Part B premiums for individuals with incomes greater than $75,000 and couples with incomes greater than $100,000.	The bill would reduce Medicare payments to providers and would establish new coinsurance requirements for home health, skilled nursing facility, and laboratory services.	The bill includes specific proposals to reduce Medicare payments to providers; to establish new coinsurance requirements for home health and laboratory services; to increase Part B premiums for individuals with incomes greater than $90,000 and couples with incomes greater than $115,000; and to continue the policy of requiring Medicare to be secondary payer to	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
all State and local employees (some of whom are now exempt) to pay the Medicare hospital insurance payroll tax.					private health insurance.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XVI. MEDICAID	**XVI. MEDICAID**	**XVI. MEDICAID**	**XVI. MEDICAID**	**XVI. MEDICAID**	**XVI. MEDICAID**	**XVI. MEDICAID**
Medicaid would continue for persons over 65 and persons receiving cash benefits under either AFDC or SSI program. On behalf of AFDC and nonelderly SSI beneficiaries, Medicaid payments would be made to regional alliances by the Federal and State governments. These payments would be set at 95 percent of the State's previous per capita spending for providing the comprehensive benefits to AFDC and SSI beneficiaries, updated for inflation. AFDC and SSI beneficiaries would remain Medicaid-eligible for items and services not covered under the comprehensive benefit package. Beneficiaries could choose any plan whose premium was at or below the weighted average premium (WAP). For those in low cost-sharing plans,	Current Medicaid beneficiaries would be integrated into the single-payer plan effective January 1, 1995.	Under an optional State Health Allowance Program (HAP), State payments for premiums to group health plans could be included under Medicaid if at least 1 plan was paid on a capitation basis. Federal payment would be restricted to payment for acute care services. A State opting to establish a program would have to cover all individuals with household incomes up to 100 percent of the Federal Poverty Level (FPL) or a lower percentage if necessary to ensure that total expenditures did not exceed what would have been spent without the expansion. States would be permitted to subsidize group health plan premiums for individuals with household incomes up to 200 percent FPL, requiring the individuals to contribute on a sliding scale basis.	Medicaid would be repealed effective January 1, 1995. Under a new Federal program, premiums for acute health care would be paid for individuals in households with incomes up to 100 percent of the poverty level and sliding scale subsidies would help individuals with incomes up to 200 percent of poverty. Cost sharing for low-income individuals would be nominal. States would gradually assume responsibility for Medicaid long-term care services, redirecting current Medicaid acute care spending to nursing facility services, intermediate care facility services for the mentally retarded, home health care services, and home and community-based services. Between 1995 and 1998, Federal assistance would be available to States that meet the bill's	Federal per capita Medicaid payments for acute care would be capped in FY 1995 at 20 percent above Federal FY 1993 payments for similar services. Actual Federal payments to a State would be the lesser of adjusted per capita amounts spent for adults and children updated in future years by CPI plus 1 percent, or adjusted total Federal payments updated by CPI plus 2.5 percent. States would be required to maintain their Medicaid per capita spending for acute care, updated for inflation. States could apply for 5-year renewable waivers of any Medicaid requirements in order to establish innovative and cost effective programs for acute care services.	States would have the option of providing coverage to Medicaid beneficiaries through qualified health plans instead of through the State's Medicaid program. For a Medicaid-eligible individual enrolled in a qualified health plan, the State would pay the premium and cost-sharing charges, subject to the premium limit for nonmedicaid premium subsidies. Of a State's estimated Medicaid population receiving benefits under AFDC or SSI, 15 percent could enroll in health plans in each of the first 3 years, and 10 percent more in each succeeding year. Enrollment limits could be waived by the Secretary. Federal per capita payments for acute care Medicaid services would be subject to a cap based on FY 1994 Medicaid expenditures excluding DSH payments for the	Growth in per capita Federal Medicaid payments to the States for acute and long-term care services would be limited to the percentage change in the medical care component of CPI. Beginning in FY 1995, Federal Medicaid payments to the States would be equal to per capita amounts spent for acute and long-term care services in FY 1993, updated for medical care inflation, multiplied by the total number of eligible persons receiving services. States would have to continue to extend eligibility to all categories of persons eligible for Medicaid in FY 1993. States could apply for 5-year renewable waivers of any Medicaid requirements in order to establish innovative and cost-effective programs for providing services.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
copayments would be reduced to 10 percent of amounts otherwise applicable. Other current Medicaid beneficiaries would enroll in health alliances, either through employers or as individuals, and would be eligible for income-based premium subsidies, but not for cost-sharing reductions. Each State would make payments to the alliances equal to the State's previous costs for furnishing benefits to nonwelfare Medicaid beneficiaries, updated for inflation. Medicaid coverage for beneficiaries over age 65 would not be modified; Medicaid would continue to serve as a supplement to Medicare for low-income seniors. (See XVII for long-term care.) The bill would establish a new State-administered federally funded program under		States would have more flexibility to enroll Medicaid beneficiaries into managed care arrangements.	maintenance of effort requirements.		services. The cap would be increased annually by 6 percent for each of fiscal years 1997-2000 and by 5 percent for FY 2001 and thereafter. The Medicaid requirement for payment adjustments to disproportionate share (DSH) hospitals would be repealed as would that portion of the so-called Boren amendment that pertains to hospital payments. The option of making DSH payments would be phased out over fiscal years 1996-2000. States would be given more flexibility to contract for coordinated care services under Medicaid.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
which low-income children could receive benefits comparable to those currently available under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment program. Income eligibility standards would be those currently used under Medicaid for non-AFDC children. Funding would be subject to limits based on past spending for the covered services. The bill would establish a Medicaid Commission, with State and Federal representation, which would report within one year after enactment on options for converting remaining Federal Medicaid funding into a block grant, integrating long-term care services with the acute care furnished by health plans, or consolidating the institutional and home-based components of long-term care.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XVII. LONG-TERM CARE	**XVII. LONG-TERM CARE**	**XVII. LONG-TERM CARE**	**XVII. LONG-TERM CARE**	**XVII. LONG-TERM CARE**	**XVII. LONG-TERM CARE**	**XVII. LONG-TERM CARE**
A. New Federal Program	**A. New Federal Program**	**A. New Federal Program**	**A. New Federal Program**	**A. New Federal Program**	**A. New Federal Program**	**A. New Federal Program**
The bill would establish a new capped grant program to the States to cover home and community-based care for severely disabled persons of all ages and income levels. Four categories of disabled persons would be eligible for services, provided they require assistance for at least 100 days: individuals requiring help with three or more activities of daily living (ADLs), individuals with severe cognitive or mental impairment, individuals with severe or profound mental retardation, and severely disabled children under the age of 6. Federal grants to the States would be based on the State's share of disabled persons, its low-income population, wage levels, and required State matching rates. State	Long-term and chronic care services, including nursing facility, home health, and home and community-based care would be included among the comprehensive benefits covered by the national program. Persons with two or more ADLs would be eligible for home and community-based care; children under 18 would also be eligible according to an alternative standard of disability developed by the Board. Payments for home and community-based care for an eligible individual could not exceed 65 percent of the average cost of nursing home care. Persons 65 years of age and older would be required to pay a monthly long-term/health care premium of $65, if their incomes exceeded	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
matching rates would range from 5 to 22 percent of total spending under the program, with higher shares paid by States with above-average income. Persons would be required to pay coinsurance on an income-based sliding scale. Federal funding would be phased in over a 7-year period, beginning with $4.5 billion in FY 1996 and reaching $38.3 billion in FY 2003.	certain levels. H.R. 1200: Long-term care services could be subject to cost sharing.					
B. Medicaid and Long-Term Care All States would be required to allow nursing home residents to qualify for Medicaid through a spend-down program. States would be given the option of allowing single individuals in nursing homes to retain up to $12,000 in assets when applying for Medicaid coverage of their care. The minimum personal needs allowance for persons in nursing	**B. Medicaid and Long-Term Care** No provision (Medicaid would be repealed).	**B. Medicaid and Long-Term Care** State Medicaid plans would be required to allow persons purchasing qualified long-term care insurance policies to disregard, for purposes of Medicaid eligibility, a certain amount of assets that can be attributed to private long-term care insurance benefits.	**B. Medicaid and Long-Term Care** Federal payments to the States for Medicaid covered long-term care services would be phased out over a 4-year period.	**B. Medicaid and Long-Term Care** No provision.	**B. Medicaid and Long-Term Care** No provision.	**B. Medicaid and Long-Term Care** Beginning in FY 1995, growth in per capita Federal payments to the States for long-term care services would be limited to the percentage change in the medical care component of CPI.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
homes would be increased from $30 to $50 per month.						
C. Private Long-Term Care Insurance	**C. Private Long-Term Care Insurance**	**C. Private Long-Term Care Insurance**	**C. Private Long-Term Care Insurance**	**C. Private Long-Term Care Insurance**	**C. Private Long-Term Care Insurance**	**C. Private Long-Term Care Insurance**
1. Tax Code Clarifications	**1. Tax Code Clarifications**	**1. Tax Code Clarifications**	**1. Tax Code Clarifications**	**1. Tax Code Clarifications**	**1. Tax Code Clarifications**	**1. Tax Code Clarifications**
The tax code would be amended to make the costs of qualified long-term care services deductible to the same extent that medical care expenses are currently deductible; these costs would be deductible for persons with two or more ADLs or severe cognitive impairment. Qualified long-term care insurance premiums and benefit payments under these policies would be eligible for the same tax preferences as health insurance and health insurance benefits. Qualified policies would have to meet a number of requirements, including having benefits of not more than $150 per day (adjusted for inflation in future years). Policies	No provision.	The tax code would be amended to make the costs of qualified long-term care services deductible to the same extent that medical care expenses are currently deductible; these costs would also be deductible for expenses incurred for dependent parents and grandparents. Long-term care insurance premiums (up to certain amounts for specified age groups) and benefit payments under these policies would be eligible for the same tax preferences as health insurance and health insurance benefits. Policies would have to meet a number of requirements, including covering persons having two or more ADLs or cognitive	No provision.	The bill would allow accelerated death benefits received under a life insurance contract to be excluded from taxable income for those persons who are terminally ill or who are chronically ill and confined to certain facilities. Withdrawals from individual retirement plans and 401(k) plans would be excluded from income if used for long-term care insurance premiums, and exchanges of life insurance contracts for long-term care insurance contracts would not be taxable.	The tax code would be amended to make the costs of qualified long-term care services deductible to the same extent that medical care expenses are currently deductible; these costs would be deductible for persons living in nursing homes having three or more ADLs or living at home and having two or more ADLs. Qualified long-term care insurance premiums and benefit payments under these policies would be eligible for the same tax preferences as health insurance and health insurance benefits. Qualified policies would have to meet a number of requirements, including having benefits of not more than $100 per day	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
would have to meet certain consumer protection standards in order to be eligible for tax preferences. The bill would allow accelerated death benefits received under a life insurance contract to be excluded from taxable income for those persons who are terminally ill.		impairment for at least 90 days and having benefits of not more than $200 per day (adjusted for inflation in future years). The bill would allow accelerated death benefits received under a life insurance contract to be excluded from taxable income for those persons who are terminally ill or who are chronically ill and confined to certain facilities. Withdrawals from individual retirement plans and 401(k) plans would be excluded from income if used for long-term care insurance premiums, and exchanges of life insurance contracts for long-term care insurance contracts would not be taxable.			(adjusted for inflation in future years). Policies would also have to meet certain consumer protection standards. The bill would allow accelerated death benefits received under a life insurance contract to be excluded from taxable income for those persons who are terminally ill.	
2. Long-Term Care Insurance Standards The Secretary of HHS would be required to promulgate regulations that establish Federal consumer protection standards for long-term care insurance policies.	**2. Long-Term Care Insurance Standards** No provision.	**2. Long-Term Care Insurance Standards** No provision.	**2. Long-Term Care Insurance Standards** No provision.	**2. Long-Term Care Insurance Standards** No provision.	**2. Long-Term Care Insurance Standards** In order to be eligible for tax preferences, long-term care policies would have to meet certain standards specified in the National Association of Insurance	**2. Long-Term Care Insurance Standards** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
The bill specifies certain minimum standards that the regulations would be required to address. Grants would be available to States for operating programs to monitor compliance of insurers with these standards. In order to be eligible for grants, States would have to review and certify all policies sold in the State, establish procedures for reporting and collecting data, and prohibit the sale of any policy that fails to comply with standards.					Commissioners'(NAIC) Model Act and Regulations as well as other requirements. In addition, insurers would face tax penalties if policies did not meet certain other NAIC standards and requirements.	
D. Other Provisions	**D. Other Provisions**	**D. Other Provisions**	**D. Other Provisions**	**D. Other Provisions**	**D. Other Provisions**	**D. Other Provisions**
Tax credits for the working disabled would be established to pay 50 percent of personal care expenses paid or incurred, up to a maximum of $15,000. The maximum annual tax credit would be the lesser of 50 percent of the maximum allowed expenses ($7,500) or of the taxpayer's earned income.	No provision.	No provision.	No provision.	No provision.	No provision.	For Medicare beneficiaries electing to be covered under a private insurance or managed care plan instead of Medicare, the Secretary would be required to pay the full amount of the difference (if any) between their plan's premium and per capita Medicare expenditures, if these persons also had private long-term care

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
The Secretary would be required to conduct a demonstration to test the effectiveness of various approaches to financing and providing integrated acute and long-term care services.						insurance (see "Medicare" above). In addition, balances in a medical savings account in excess of the deductible under a catastrophic health insurance plan could be spent for long-term care, and such expenses would not be included in gross income of the individual for tax purposes.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XVIII. OTHER FEDERAL PROGRAMS	**XVIII. OTHER FEDERAL PROGRAMS**	**XVIII. OTHER FEDERAL PROGRAMS**	**XVIII. OTHER FEDERAL PROGRAMS**	**XVIII. OTHER FEDERAL PROGRAMS**	**XVIII. OTHER FEDERAL PROGRAMS**	**XVIII. OTHER FEDERAL PROGRAMS**
A. Military Health Care	**A. Military Health Care**	**A. Military Health Care**	**A. Military Health Care**	**A. Military Health Care**	**A. Military Health Care**	**A. Military Health Care**
In addition to existing health care services provided by the military, the Secretary of Defense would be allowed to establish one or more Uniformed Services Health Plans to provide health care services to active duty members of the uniformed services. Plans would be required to offer at least the items and services in the comprehensive benefit package and other health care services that the person would be entitled to in the absence of the Health Security Act, and conform, to the extent practicable, with the requirements for other health plans.	Civilian Health and Medical Program of the United States (CHAMPUS) would be eliminated after December 31, 1994.	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
B. Department of Veterans Affairs In addition to the existing health care services provided by the Veterans Affairs (VA), the Secretary of VA would be required to organize health plans and operate VA facilities as or within health plans under the Health Security Act. The VA health plans would be required, to the maximum extent possible, to conform to the requirements for other health plans under the Act, and would be required to provide the items and services in the comprehensive benefit package. In addition, the Secretary would be required to provide veterans with any additional care and services they are eligible to receive under the VA Medical System that were not included in the comprehensive benefit package.	**B. Department of Veterans Affairs** Veterans would continue to be eligible to receive medical benefits and services provided by Veterans Affairs.	**B. Department of Veterans Affairs** No provision.	**B. Department of Veterans Affairs** No provision.	**B. Department of Veterans Affairs** No provision.	**B. Department of Veterans Affairs** No provision.	**B. Department of Veterans Affairs** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
Veterans with service-connected disabilities, low-income veterans, and other special categories of veterans who are enrolled in a VA plan would not be required to pay any kind of cost-share charge (premium, copayment, deductible, coinsurance charge, or other charge).						
C. Federal Employees Health Benefits Program The Federal Employees Health Benefits Program (FEHBP) would be repealed as of December 31, 1997. FEHBP enrollees, active employees and annuitants, would be required to enroll in a health plan offered by the regional alliance in the area where they reside. The Federal Government would be required to offer Federal employees and future annuitants eligibility to enroll in one or more	**C. Federal Employees Health Benefits Program** FEHBP would be eliminated after December 31, 1994.	**C. Federal Employees Health Benefits Program** No provision.	**C. Federal Employees Health Benefits Program** Open AHPs would be required to enter into an agreement with OPM to offer a health plan to Federal employees and annuitants, and family members under FEHBP, under the same terms and conditions (other than amounts of premiums) offered by the AHP to eligible individuals through HPPCs. Beginning on January 1, 1995, enrollment in a FEHBP plan would not be permitted unless the plan was an AHP, and	**C. Federal Employees Health Benefits Program** Each health plan offered under FEHBP would be required to meet the standards applicable to large employer plans, in the same manner and as of the same date that such standards first apply to large employer plans.	**C. Federal Employees Health Benefits Program** FEHBP plans would be required to meet the standards applicable to large employer plans, in the same manner and as of the same date as such standards applied to large employer plans.	**C. Federal Employees Health Benefits Program** No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
FEHBP supplemental plans developed by the Office of Personnel Management (OPM). Current annuitants would be eligible to enroll in a FEHBP supplemental plan and would be eligible for the Government contribution amount toward the premium for such a plan. These supplemental plans would reflect any additional benefits last generally afforded under FEHBP that were not part of the comprehensive benefit package.			the amount of the Federal Government contribution under FEHBP were: 1) for any premium class, the same for all AHPs in a HPPC area; 2) for any individual in a premium class, did not exceed the base individual premium (defined by the bill); and, 3) in the aggregate for any fiscal year, total Government contributions under FEHBP equaled the aggregate amount that would have been made if this provision were not in effect.			
D. Indian Health Service	**D. Indian Health Service**	**D. Indian Health Service**	**D. Indian Health Service**	**D. Indian Health Service**	**D. Indian Health Service**	**D. Indian Health Service**
In addition to existing health care services provided by the Indian Health Service (IHS), Indians, or a descendent of a member of an Indian tribe, an urban Indian, or an other categories of Indians would be eligible to enroll in a health plan offered by the IHS. IHS enrollees would not be	Indians would continue to be eligible to receive medical benefits and services provided by or through the IHS.	No provision.	No provision.	No provision.	No provision.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
subject to any charge for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services provided by the IHS program. An IHS health program could also open enrollment to family members of eligible Indian enrollees. Family members who enrolled in an IHS program would be subject to all charges for health care services. All Indians would remain eligible for any additional benefits provided by the IHS that were not included in the comprehensive benefit package. The IHS would not make payments for premiums charged for enrollment in an applicable health plan or any other cost of health services for eligible Indians who do not enroll in an IHS program, but instead enroll in an applicable health plan.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
The Secretary would be required to ensure that the comprehensive benefit package would be provided by all IHS health programs by January 1, 1999. All IHS health programs would have to meet those Federal certification requirements for health plans determined by the Secretary to apply. IHS health services would be integrated with the alliance system to serve eligible populations.						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS	XIX. UNDERSERVED AREAS/ POPULATIONS
Additional appropriations of $100 million per year would be authorized for community and migrant health centers for each of the fiscal years 1995 through 2000. During the same 5-year period, $2.7 billion would be authorized to be appropriated for the development of community health plans and networks that provide services in health professional shortage areas or to members of medically underserved populations. Grantees would be required to eliminate nonfinancial barriers to service and provide "enabling services" such as transportation, outreach, and patient education. Additional funds would be authorized for the provision of enabling services by public and	Payment methodologies established by the Board would include incentives to promote the provision of services in medically underserved rural and inner-city areas. The basic capitation payment made to comprehensive health service organizations could be adjusted to account for a disproportionate number of medically underserved individuals served by the organization. A State health security program could set additional payments for community-based primary care facilities to cover the costs of serving persons who are not covered under the plan, but whose health care is essential to community health and control of communicable disease. Also, additional	Health centers (community or migrant health centers, or health centers for the homeless) that are receiving grants under the Public Health Service (PHS) Act would be authorized to receive additional grants to (1) promote the provision of off-site services; (2) improve birth outcomes; (3) establish new primary care clinics; and (4) recruit and train providers and cover the costs for unreimbursed services. Appropriations authorized for these grants would be $100 million in FY 1994 increased by $100 million per year to $500 million in FY 1998. Each fiscal year, 10 percent of appropriated amounts would have to be used for off-site services and 10 percent to improve birth outcomes. Up to 50 percent of the	Subject to approval of the Commission (or Board under S. 1579), Governors would be able to designate rural and urban areas of their States as underserved areas. A HPPC could require an AHP to include an underserved area in its service area and apply risk-adjustment factors to increase compensation to the AHP for serving the area's residents. The HPPC would increase payment to such AHPs by the amount of subsidy made available by the State. For each of fiscal years 1995-1999, $5 million would be authorized to award grants to support the development of networks in underserved urban and rural areas. For the development of AHPs in rural areas, $75 million would be authorized to	No provision.	The bills would add 2 new sections to the PHS Act. New section 330A would provide for allotments to States for grants to community-based primary health care entities that serve low-income or medically underserved persons. Funds would be allotted to States according to a statutory formula and based on a State's needy population and Federal funds to the State's health centers receiving grants under section 329, 330, or 340 (community or migrant health centers, or health centers for the homeless) of the PHS Act. New section 330B would provide funds for expanding federally qualified health centers and similar entities to serve more medically underserved.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
nonprofit entities: $200 million for FY 1996, $300 million for each of fiscal years 1997-1999, and $100 million for FY 2000. Loans and loan guarantees for capital costs would be authorized for the development of qualified community health groups--health plans or practice networks that are consortia of public or private providers. The bill would establish an entitlement under which $800 million per year would be paid to hospitals serving vulnerable populations (similar to DSH hospitals under existing Medicare and Medicaid law). An eligible hospital would be identified by the State and have a low-income utilization rate of at least 25 percent. Of the total payable in a year, 75 percent would have to be allocated to hospitals for low-income assistance, and 25 percent for assistance in furnishing inpatient	payments could be made to cover costs for case management, transportation, and translation services.	appropriated amounts could be used for new grants to health centers under the PHS Act. A new project under the PHS Act would provide 50 percent matching grants to increase access to primary health care. The grants would be available to for planning or coordinating service delivery in areas with up to 500,000 people, a significant number of whom are low-income or have no insurance. No construction, renovation, or direct services could be provided under this project.	be appropriated in each of fiscal years 1995-1999. For each of fiscal years 1995-1999, $100 million would be authorized to assist community health centers and migrant health centers in integrating with AHPs and providing the uniform set of benefits. For each of fiscal years 1995-1999 $50 million would be authorized for HHS payments to hospitals serving vulnerable populations. A hospital that applied for and accepted assistance would have to agree to serve all residents of the hospital's area and provide a significant volume to services to people unable to pay. According to standards developed by the Commission (or Board in 1579), 3 years after enactment, a State could identify an area as chronically underserved. In cooperation with each		Authorization for the 2 new sections would be $400 million for FY 1995, increasing by $400 million per year to $1.6 billion for fiscal years 1998 and 1999. The Secretary of HHS would be authorized to conduct demonstration projects under which any Medicare and Medicaid provisions could be waived for the operation of rural health networks that would service Medicare and Medicaid beneficiaries. Public and private entities that received waivers would be eligible to receive planning, development, and operations grants for the networks.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
services not covered under the bill. A clinic, hospital, or health professional that is federally funded, located in a health professional shortage area, or providing services to a medically underserved population, could be certified by the Secretary of Health and Human Services as an *essential community provider*. For 5 years from the time any health plan is offered by a regional alliance, each health plan in the area would be required to enter into provider participation agreements with essential providers in the plan's area or pay for services furnished by such providers at minimum specified rates.			HPPC serving any portion of the area, the State could submit a plan for addressing the problems. Such plan could limit the area HPPCs to a single AHP contract awarded on a competitive basis.			

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
XX. HEALTH PROFESSIONS EDUCATION AND TRAINING	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**	**XX. HEALTH PROFESSIONS EDUCATION AND TRAINING**
A. Graduate Medical Education	**A. Graduate Medical Education**	**A. Graduate Medical Education**	**A. Graduate Medical Education**	**A. Graduate Medical Education**	**A. Graduate Medical Education**	**A. Graduate Medical Education**
Current financing of graduate medical education (GME) would be replaced with a national fund established through assessments on alliances and Medicare. The National Council on Graduate Medical Education would be established to authorize the number of residency positions in primary care and other medical subspecialties, with the goal of reaching 55 percent of residencies in primary care specialties by the academic year 1998-1999. Each year, the Council would be required to make allocations among eligible residency training programs of the annual number of specialty positions designated for the year.	State health security plans would be required to establish an account for funding health professional education in accordance with guidelines established by the Board. The Board would be responsible for coordinating health professional education policies and goals, in consultation with the Secretary, to achieve the national goal of 50 percent of medical residents in residency education programs in primary care by not later than 5 years after enactment. The Board would be required to develop a formula for reducing payments to State health security programs (that provide	No provision.	Current financing of GME would be replaced with a national fund established through assessments on AHPs and Medicare. The Health Care Standards Commission (Board under S. 1579) would be required to approve residency positions in medical residency training programs and determine funding levels, allocate the entry (first-year) positions among programs, and determine the appropriate total number of entry residency positions allocated to the training programs. The Commission (or Board) would establish the amount of reimbursement per resident, and would be	No provision.	The Secretary would be required to establish demonstration projects in no more than 7 States and in no more than 7 health care consortia (in other States). The demos would test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to nonprimary care practice through the use of Medicare's funding for direct GME payments. The Secretary would be required to pay States or consortia an amount equal to the medical education payments participating hospitals would otherwise have received under Medicare.	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
The Council would be required to consider the historical distribution of approved physician training programs and the underrepresentation of minority groups in medicine generally and in the various medical specialties. Primary health care would include the medical specialties of family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology. Funding for GME programs would be determined by Federal formulas. The Secretary would also be required to make payments to qualified academic health centers (AHCs) or qualified teaching hospitals to assist these institutions with costs that are not routinely incurred by other providers, but are the result of the academic nature of such institutions. These	for payments to medical residency education programs) that failed to meet the primary care goals established by the Board. Primary care residencies would include programs of family practice, general practice, general internal medicine, or general pediatrics. The Board would be required to establish an Advisory Committee on Health Professions Education to advise the Board on health professions education.		allowed to vary payments depending on whether a resident was in a primary care or some other medical specialty. The Commission (or Board) would be required to fund a physician retraining program that would provide physician retraining in primary care for physicians who completed training in a nonprimary care residency. Funding for residency training would come from an assessment against gross premiums of AHPs of one percent and a Medicare payment equal to one percent of the prior year Medicare program expenditures. These funds would be entered into the National Medical Education Fund in the Treasury and be used to fund medical residency training and physician retraining programs beginning July 1, 1995.		Primary care would include the medical specialties of family medicine, general internal medicine, and general pediatrics, and could also include obstetrics and gynecology if the care was person-centered, comprehensive care that was not organ or problem specific.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
costs would include the costs resulting from the reduced productivity of the faculty due to teaching responsibilities, uncompensated costs of clinical research, and the exceptional costs associated with the treatment of health conditions that teaching facilities would have specialized expertise including rare diseases, unusually severe conditions, and other specialized care. Qualified institutions would be required to submit a request for payment to the Secretary, and the Secretary would determine if the payment was necessary. Funding for GME and AHC payments would be drawn from (a) an assessment on regional alliance health plans and on multi-employer corporate alliances equal to 1.5 percent of premiums; (b) transfers from the Treasury of a portion of 1 percent payroll tax on corporate						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
alliances; and (c) transfers from the Medicare trust funds. Direct Medicare payments for GME would be eliminated.						
B. Health Professions Education and Training	**B. Health Professions Education and Training**	**B. Health Professions Education and Training**	**B. Health Professions Education and Training**	**B. Health Professions Education and Training**	**B. Health Professions Education and Training**	**B. Health Professions Education and Training**
In addition to current appropriations authority, the National Health Service Corps (NHSC) program authorizations of appropriations would be increased by $50 million for FY 1995; $100 million in FY 1996; $200 million for each year from FY 1997-FY 2000. Of the amount appropriated for the NHSC, the Secretary of HHS would be required to reserve such amounts as necessary to ensure that the number of nurses being educated or serving in the NHSC be increased to 20 percent of the total number of individuals participating in the NHSC scholarship and	The Board would be responsible for reaching the national goal of assuring an adequate supply of midlevel primary care practitioners (clinical nurse practitioners, certified nurse midwives, physician assistants, or other nonphysician practitioners as authorized to practice under State law) employed in the health care system by January 1, 2000. In order to meet the national goal for midlevel practitioners, the Board would be required to advise the PHS on funding allocations for programs under titles VII and VIII of the PHS	No provision.	Authorizations of appropriations for the National Health Service Corp scholarship and loan repayment programs would be: $150 million for FY 1995; $175 million for FY 1996; $200 million for FY 1997; $225 million for FY 1998; and $250 million for FY 1999. Authority for appropriations for the Area Health Education Center Program would be increased to $30 million for each year from FY 1995-FY 1999. Program authority would be extended for the following PHS Act grant programs through FY 1999: Public Health	No provision.	Funding for the NHSC program would be specified at $120 million for FY 1993-FY 1994, and continue to be for such sums as may be necessary for each year from FY 1996-FY 1998. One-third of total appropriated funds would be required to be made available to the NHSC Grants for State Loan Repayment Program. Program authority and appropriations authority would be extended and increased, respectively, for specified programs under titles VII and VIII of the PHS Act supporting primary care physicians, nurse practitioners and	No provision.

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
loan repayment programs. The National Council on Graduate Nurse Education would be required to authorize graduate nurse training programs (nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists), and positions, as well as allocate funding for institutional costs of graduate nurse training. Authorizes $400 million in appropriations for additional funding of programs authorized in titles VII and VIII of the PHS Act. These funds would support the training of additional primary care physicians and physician assistants, including projects to enhance community-based generalist training for medical students, residents, and practicing physicians; retraining mid-career physicians previously certified in a nonprimary care medical specialty; to	Act and the NHSC, in order to increase the supply of health care providers. The Board would also be required to commission a study of the potential benefits and disadvantages of expanding the scope of practice authorized under State laws for midlevel practitioners. Funding for health professions education and training would be made by the Board from the Trust Fund to PHS, with 50 percent of funds allocated to the NHSC.		and Preventive Medicine; Family Medicine; General Internal Medicine and General Pediatrics; Physician Assistants; Allied Health Project Grants and Contracts; Allied Health Project Grants and Contracts; Nurse Practitioner and Nurse Midwife Programs. The Secretary would be required to obligate not less than 15 percent of annual appropriations for the Agency for Health Care Policy and Research to conduct and support research in primary care.		physician assistants. A program for physician assistant scholarships would be created to award grants to individuals, with preference given to individuals who are residents of health professions shortage areas. The Secretary would also be required to award grants to States or nonprofit entities to fund not less than 10 demonstration projects to evaluate one or more of the following: State mechanisms, including changes in the scope of practice laws, to enhance the delivery of primary care by nurse practitioners or physician assistants; the feasibility of re-training subspecialist physicians to deliver primary care services; and State mechanisms to increase the supply or improve the distribution of primary care providers.	

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
expand the supply of physicians trained to serve in rural areas, community settings, managed care, cost-effective practice management, continuous quality improvement, and for other purposes. These programs would also support projects to increase the number of underrepresented minority and disadvantaged persons in medicine and other health professions, and projects to support midlevel provider training and address nursing workforce needs. In addition, $200 million would be authorized to be appropriated for programs carried out by the Secretary of Labor, including retraining and upgrading the skills of health care workers, and other workforce adjustment programs. Jointly, the Secretaries of HHS and Labor would be required to						

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellstone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3704/S. 1770 (W. Thomas/Chafee)	H.R. 3918/S. 1807 (Santorum/Gramm)
establish an office, the National Institute for Health Care Workforce Development, to make recommendations on the supply of health care workers and on the impact of health reform on such workers and the need for education, training, and other career development needs.						

crspphgw