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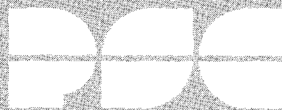

HEALTH POLICY BULLETIN

FOCUS: FEDERAL ACCESS TO CARE PROPOSALS— THE REPUBLICANS

The number of proposals to increase access to health care in the present session of Congress is fast becoming legion. Republican proposals focus on providing the opportunity for coverage through insurance market reform, while Democratic proposals tend to stress either a Canadian-style system funded by tax dollars and administered by the federal government or a "play or pay" program in which employers who do not provide health care benefits pay a special payroll tax.

➤ ***The Chafee Proposal*** Senate Bill 1936 (S. 1936) sponsored by Senator John Chafee (R-RI) and twenty other Republican senators contains six titles that include provisions for tax incentives, health care and medical liability reform, public health, medically underserved areas, and incentives for preventive services.

The tax incentives offer four forms of relief to individuals, families, employers, and providers: (1) A health expenses tax credit for out-of-pocket medical expenses that would be capped at $600 for individuals with incomes up to $16,000 and $1,200 for families with incomes up to $32,000; (2) full deductibility for health insurance premiums paid by the taxpayer; (3) a maximum 25-percent tax credit for eligible small employers providing health insurance—the credit would decline by 5 percent a year; and (4) tax credits of $1,000 per month for physicians and $500 a month for nurse practitioners and physician assistants who provide primary health services on a full-time basis to persons, 80 percent of whom are living in rural health manpower shortage areas.

Under the health care reform provisions, the secretary of the U.S. Department of Health and Human Services (HHS) would ask the National Association of Insurance Commissioners (NAIC) to develop a model health insurance benefits plan. The plan would contain standards to be met by all health insurance providers, including coverage for basic hospital, medical, and surgical services, cost sharing by beneficiaries, and copayments and deductibles. A Managed Care Advisory Committee would be created within one year to advise the secretary on standards for managed care plans. All state legislation (1) limiting financial incentives to beneficiaries to use particular providers, (2) restricting the ability of managed care plans to negotiate with providers, (3) imposing particular requirements for licensed personnel in review agencies and standards for utilization review, (4) requiring disclosure of review standards, and (5) mandating benefits beyond those set by the secretary would be preempted. The secretary would be the final arbiter of benefit coverages.

Small employers could band together into purchasing groups, each composed of at least 100 small employers. Health plans chosen by the groups would have to comply with state laws and the model benefit plans developed by the NAIC. Insurance carriers would be required to provide quality review, utilization review, and access to services; they also would be required to employ community rating. State-mandated coverages that are outside the recommendations of the model benefit plan would be preempted.

Insurers would be required to offer the plans to any small employer, unless doing so would violate financial solvency standards or result in inability of the insurer to serve previously enrolled groups and individuals. Coverage of every eligible employee and his/her dependents is guaranteed; preexisting conditions exclusions would apply for the first six months of the contract and then only to conditions that appeared within three months before the first date of coverage. Contracts would be renewable; premiums could not exceed the premium rate for any other class of business by more than 20 percent.

Medical liability reform would emphasize development of a model alternative dispute resolution (ADR) mechanism by an Alternative Dispute Resolution Board of Advisors established by the secretary; states would be encouraged to adopt such processes. In states where ADRs exist, parties would proceed under those rules; the party refusing to do so could be subject to an assessment for attorney's fees and costs. Claimants and defendants rejecting offers of settlement that prove to be equal to or in excess of the settlement offer would be assessed the loser's attorney fees and costs; attorney fees would be calculated on the basis of hourly charges acceptable in the community. The maximum fee for a plaintiff's attorney would be 25 percent of the first $150,000 of an award or settlement plus 15 percent of any amount over $150,000. Joint and several liability is abolished for noneconomic damages; liability for such damages is limited to a total of $250,000 and apportioned on the basis of the degree of fault of each defendant.

States would be required to direct fees from health practitioner licensing and certification to those state agencies responsible for licensure and disciplinary actions; at least one-fourth of the membership of each disciplinary board would have to consist of public members; states also would be required to establish risk management programs

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and health professional disciplinary trust funds to provide extra funds to the disciplinary boards.

A new program called Basicare would be created under the Social Security Act that would provide basic health benefits to persons with incomes below 200 percent of the poverty line who are neither covered by an employer plan nor eligible for Medicaid. States would receive a matching percentage identical to their Medicaid percentage. As an incentive to enroll people, states would receive a 3-percent bonus for each person enrolled in a managed care plan. Federal payments are capped at $10,000 per covered individual; cost sharing requirements not to exceed 5 percent of gross income would be imposed on persons whose incomes fall between 100 and 200 percent of the poverty level.

As an incentive to individuals to purchase preventive services that may not be reimbursed by health plans, tax credits up to $250 for persons in the 15-percent tax bracket and $200 for all other brackets would be available. Providers could receive the tax credit based on the number of preventive services delivered without charges to persons whose incomes are below 150 percent of the poverty line. Preventive services would include cancer screening tests, immunizations for children, and well-child care.

➤ ***The Working Americans Access to Health Care Act*** Introduced by Rep. John Rhodes III (R-AZ), H.R. 3478 creates MedEquity plans, which would provide basic hospital, medical, and surgical benefits as defined in model policies developed by the NAIC. Any insurer offering a small employer health benefit plan would have to offer a MedEquity plan; premiums for the plans could not vary by more than 25 percent from premiums for similar plans. Carriers could neither exclude persons nor refuse to renew a policy because of the health status of members of the group. The NAIC would be asked to develop models for reinsurance for persons and employers for whom the carriers might incur very high costs. Self-employed persons would be eligible for tax deductions for health insurance expenses. Rhodes's bill also would preempt state laws restricting the ability of managed care plans to contract with providers and to use utilization reviews as well as those mandating specific benefits.

Significant omissions in both bills are financing mechanisms; the Chafee bill carries an estimated price tag of $150 billion over five years and Rhodes's bill is silent on funding. Both bills give the NAIC the basic responsibility for developing model plans and make the HHS secretary the chief designer of the plans. States would retain supervisory authority over the plans and the carriers. There are no tort reform provisions in the Rhodes bill.

Of concern to policy makers are the bills' retention of the current chaotic system of multiple payers, the absence of a common claim form, and the assumptions that employers will continue to pick up the costs of the plans once the tax credits have expired, that tax credits will be a meaningful inducement to low-income individuals and families to purchase health insurance, and that copayment and coinsurance requirements will be affordable for low-income persons and families.

➤ ***Alain Enthoven: The Father of Reform*** Both bills reflect the thinking of Alain Enthoven. In his view, competition in the classical sense does not work in health care because the buyer does not possess the same degree of knowledge about or of the need for the product as the seller. The ability of sellers to select risks, segment the market, and engage in relatively meaningless product differentiation guarantees the failure of a market based on classical competition. Enthoven points out that competition needs to be managed by allowing buyers to coalesce into groups capable of offsetting the power of the sellers. He favors the creation of what he calls "sponsors," which he defines as groups consisting of at least 500 persons or entities; only an entity of that size could take on a powerful provider of health care. The role of government is to make rules to see to it that the playing field is fair or, to use his phrase, "to manage competition": This is an active not a passive role. In short, he is at odds with much of the laissez-faire regulatory philosophy that has dominated government thinking in the past decade.

For Enthoven, the small employer purchasing groups called for in Chafee's bill and composed of at least 100 small employers would approach being an adequate size to negotiate with a provider of health insurance coverage. The government's role of assuring an adequate supply of comparable products would be filled through the NAIC and the HHS secretary, who is charged specifically to set benefits. Sponsors, he believes, have an active duty to manage benefit plans in the interests of efficiency and equity not of profit and survival. Both bills recognize another of Enthoven's conditions: Coverage must be universal. Both the Basicare and MedEquity plans proposed in the bills would meet requirements for universal coverage. The use of the tax credits by individuals would probably further cost-conscious choices by consumers.

It has been suggested that tax credits to help people buy insurance, an emphasis on HMOs, and tort reform will be part of the president's State of the Union address on January 28. It is our belief that Enthoven's ideas will have a profound effect upon the direction eventually taken by the administration.

OF INTEREST

The legislature is back in session with a light work schedule for January. Unresolved budget issues and the no-fault auto insurance reform will dominate the first three months of the year.

—Frances L. Faverman, Editor

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