S362-27

96th Congress
1st Session

[COMMITTEE PRINT]

SUMMARY AND COMPARISON OF PRINCIPAL FEATURES OF HEALTH INSURANCE PROPOSALS

CP 96-18

GENERAL CONCEPT AND APPROACH

S. 350 (Senators Long, Ribicoff, et al.) S. 351 (Senator Long, Talmadge, et al.)	S. 748 (Senators Dole, Domenici, and Danforth)	S. 760 (Senator Long)	(Administration)	[1] S. 1014 (Senator Hart)	[2] (Senator Kennedy)	[3] (Senator Schweiker)
Provides a catastrophic illness insurance program for the entire population provided through 1) a federally administered plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage, and 2) a private catastrophic insurance plan allowed as an option for employers and the self-employed, or alternatively under approved private plans. S. 350 also provides for establishment of a uniform national program of basic benefits for low-income persons and families.	Would create a system of catastrophic health insurance protection by 1) amending medicare to provide for catastrophic benefits; 2) establishing employer-based private catastrophic health insurance plans; 3) establishing a residual market catastrophic insurance program for those with no other coverage; and 4) requiring State Medicaid programs to provide catastrophic coverage equal to that or the residual plan or to buy into the residual plan. The type of benefits would be the same as those provided under current State medicaid program.	Requires by Federal mandate that employers provide workers and their families with qualified catastrophic health insurance coverage, assists others, including the self-employed and their dependents, in the purchase of qualified individual catastrophic protection; establishes a new health program for low-income persons and families; and, establishes a voluntary certification program to assure the universal availability of basic health insurance.	Provides for 1) a Federal insurance program (Health Care) providing comprehensive coverage for the aged, disabled, and poor, and offering insurance against major medical expenses to other individuals and small employers; and 2) a system of mandated employer-based coverage for workers and their families through approved private insurance plans. Public Plan incorporates Medicare and acute care portions of Medicaid.	Provides catastrophic insurance coverage of expenses for certain health services in excess of specified income levels, administered by DHEW through contracts with private insurance carriers, and financed through general revenues.	Provides for a national health insurance program covering the entire population, financed through employer-employee wage-related premiums, Medicare payroll taxes and premiums, State payments for the poor, and Federal general revenues. Would be administered primarily by certified private health insurers and HMOs, with the Federal government continuing to administer Medicare. A national budget would be established for all services covered under the program, with increases limited to rates of increase in the GNP.	Provides a minimum level of catastrophic health insurance protection for all Americans utilizing a combination of (1) additional prerequisites for tax deductible employer-based health insurance plans, (2) State-administered insurance pooling arrangements, and (3) increased Medicare benefits. Minimum catastrophic coverage would be defined as a complete coverage, without copayments, of medical expenses incurred annually by an individual and his family in excess of 20 percent of the family's adjusted gross income.

COVERAGE OF THE POPULATION

Provides coverage for all U.S. residents under the public plan except for employees (and their families) of employers and the self-employed who elect to purchase private plans. Low-income plan coverage would be available to all individuals and families whose incomes were at or below certain specified levels. Families with incomes above these levels would qualify for medical assistance under the plan, if they spent enough on medical care to reduce their incomes to the eligibility levels (S. 350 only).	Medicare could continue to cover current beneficiaries. Employer-based plans would: 1) offer coverage to full-time employees, spouses and dependent children; 2) permit widows, widowers, divorced spouses, or orphaned children to continue coverage for 3 months; 3) offer open enrollment to individuals meeting specified changes in circumstances; 4) permit conversion to individual policies prior to termination of group coverage; and 5) coverage would commence shortly after entering the workforce and continue for up to 3 calendar months following separation from employment. Residual program would be available to those with no other catastrophic insurance.	Employment-based plans and plans for the self-employed would cover full-time employees dependent family members. Coverage would commence shortly after entering the workforce and continue for up to six months following separation from employment due to layoff or death. Low-income plan coverage would be available to all individuals and families whose income were at or below certain specified levels. Families with incomes above these levels would qualify for medical assistance under the plan, if they spent enough on medical care to reduce their incomes to the eligibility levels.	The public plan would cover the aged, disabled, poor, certain near-poor, and certain other individuals and small groups. Employers could also purchase public coverage in lieu of a private plan. All full-time employees and their dependents would be covered through mandated employer-provided insurance. The self-employed would be treated like any other employer.	Provides coverage for all U.S. citizens and resident aliens in the country for at least three months as long as benefits provided are secured through participating health insurance carriers.	Would cover all U.S. citizens and permanent resident aliens, and certain nonpermanent aliens if appropriate agreements were entered into. All employers would be required to offer employees a choice of health insurance plans (including an HMO option). All individuals aged 65 or older, the disabled, and persons with end-stage renal disease would be covered under Medicare. Premiums would be paid to private insurers and HMOs for AFDC and SSI recipients and for certain institutional populations. All others, such as the self-employed would enroll individually with insurers. All individuals would be issued a health insurance card. Eligibility for benefits would continue whether or not premiums were paid, and whether or not the individual was actually enrolled in an insurance plan.	Provides catastrophic coverage for employees and their families by requiring all health plans offered by employers with more than 50 full-time employees to contain a minimum level of catastrophic protection. Employees would remain covered for at least six months after termination of employment if they were on the job and enrolled in the plan for at least 30 days. In addition, spouses and children under age 25 would have to be covered for at least six months after death of the employer-policyholder. Employees of small employers (fewer than 50 employees), uninsurable risks, self-employed, and those without private or government insurance would be covered through State-administered private insurance pools. Medicare beneficiaries would receive coverage through an expanded Medicare program.

BENEFIT STRUCTURE

Provides institutional benefits (hospital care, 100 days of post-hospital services, and home health services) after an individual had been hospitalized for a total of 60 days within one year. Medical benefits (similar to those provided under medicare part B with some limits placed on mental health services) would be offered after an individual or family had incurred medical expenses of $2,000 for services similar to those provided under Part B. Low-income plans benefits (S. 350 only) would be substantially the same as those that are now required or can be provided under the medicaid program. Benefits would be provided generally without limits on the amount of services or cost-sharing requirements.	Medicare—Catastrophic benefits would be provided for Part A-type services through elimination of current copayment requirements for hospital care and skilled nursing facility services and durational limits on hospital services. For part B services, medicare would pay 100% of reasonable costs or charges for covered services (plus drugs listed in a special formulary) once catastrophic coverage has been triggered (when individual incurs expenses of $5,000 in a year or out-of-pocket expenses equal to 20 percent of that amount for covered Part B-type services (plus certain drugs). Employer based catastrophic plan would cover substantially the same kinds of services that are covered under the medicare program. Institutional benefits would be covered after an individual or family unit has been hospitalized for 60 days. Also covers medicare part B-type physician and medical services without cost-sharing after an individual or family incurs $5,000 in medical expenses for such services. Residual plan—Same benefits as mandated under employer-based plans. In addition, coverage for medicare part B-type services would be provided once individual has incurred $5,000 in medical expenses or has out-of-pocket costs for such services (not less than $200) equal, to 15 percent of income.	Employment-based catastrophic plans would cover substantially the same kinds of services that are covered under the medicare program. Institutional benefits would be paid after an individual had been hospitalized for a total of 60 days in one year. A $2,000 medical expense deductible (individual or family) would apply in the case of all other covered expenses. The medical expense deductible would be adjusted annually to reflect changes in the price of covered services and other factors. Low-income plans benefits would be substantially the same as those that are now required or can be provided under the medicaid program. Benefits would be provided generally without limits on the amount of services or cost-sharing requirements.	The public plan includes the following: unlimited inpatient hospital services; unlimited physician and other ambulatory service, including laboratory and x-ray (but excluding dental and psychiatric care); 100 days per year of skilled nursing services; 100 home health visits per year; mental health, alcoholism and drug abuse services (20 days of inpatient care and $1,000 in ambulatory services); for all mothers and children—complete prenatal, delivery and total infant care; scheduled preventive services for children to age 18. Cost sharing for the aged and disabled—medicare's current cost-sharing requirement with following changes: substitution of annual hospital deductible rather than spell-of-illness deductible; no cost-sharing after individual pays $1,250 in out-of-pocket expenses; no cost-sharing for low-income aged or for aged and disabled with expenses exceeding 100 percent of difference between their income, and a national low-income standard. No cost—no cost-sharing required for persons eligible through entitlement to welfare assistance or because their income is less than low-income standard. Individuals who purchase private plan coverage through premiums would be subject to $2,500 deductible for all services; except no cost-sharing imposed for prenatal services, delivery and total preventive and treatment costs for infants to age one. Private plans would cover the same services as under the public plan, subject to a $2,500 limit on annual out-of-pocket payments. No cost-sharing on prenatal and infant care would be imposed.	In general, covers (1) 50 percent of expenses for covered services exceeding 10 percent of an individual's annual income but less than 20 percent of his annual income, and (2) 100 percent of expenses for covered services exceeding 20 percent of individual's annual income. Covers allowable expenses for appropriate hospital services; surgical services; medical services; dental services, prescribed drugs, medicines, and prosthetic devices; other medical supplies and services determined to be appropriate for complete physical and mental health care; and premiums for health insurance covering one or more of the above (including supplements to Medicare Part B).	The program would cover the following without cost-sharing or limits (except as noted); hospital care (limited to 45 days for inpatients psychiatric care); 100 days of skilled nursing facility services; physician visits (limited to 20 if for psychiatric services); preventive services; 100 home health visits; medical and other health services, such as x-rays, lab tests, outpatient physical therapy, rural health clinic services, medical equipment, ambulance, prosthetic devices; outpatient drugs for chronic illness (Medicare beneficiaries only); certain limited mental health day care and community mental health center services; speech and short-term occupational therapy; hearing exams and aids. The existing Medicare benefit package would be amended to make it consistent in most respects (except for the additional drug benefit and retention of Medicare's special limits on inpatient and outpatient mental health care) to the mandated benefits above.	All plans offered by employers with more than 50 full-time employees would contain a minimum level of catastrophic protection. The minimum level would be full payment of all medical expenses incurred annually in excess of 20 percent of annual adjusted gross family income. Medical expenses would be defined as those currently included under Medicare, excluding long term nursing home care. At least one plan offered would require the employee to pay 25 percent of his hospital costs until they exceed 20 percent of family income. Under State-administered pools, insurance carriers would be required to offer a minimum level of catastrophic protection equal to that offered under employer-based plans. Under Medicare, all limits on the number of covered days of hospital care would be eliminated. Deductible and co-insurance rates would be revised to require beneficiaries to pay 20 percent of the costs of hospital care regardless of the number of days spent in the hospital. Once part A and B copayments reached 20 percent of annual net income in any one year, all copayment requirements would cease.

ADMINISTRATION

Provides that HEW would administer the public plan; and qualified private insurance companies of the employer's choice would administer the private plan. HEW would approve employer plans and the self-employed plans which would be required to comply with Federal standards. Exemptions from antitrust laws would be provided to permit carriers to enter a pool, reinsurance, or residual market arrangement.	For employer-based program, provides for civil penalty for employers who fail to comply with catastrophic coverage provisions. Also provides for employee private right of action against employer who fails to make available required coverage for amounts that would have been payable. For residual program, plans would be certified by the Secretary. HEW would administer premium subsidies for low-income persons and families, and would make income determinations and direct payments to insurance carriers. Insurance carriers would establish community rated premiums. Carriers would be permitted to establish insurance pools.	Employment-based plans would be subject to approval by the Secretary of HEW. Insurers offering qualified plans would also be subject to certain requirements regarding policies, claims procedures, etc. Low-income benefits would be administered in a manner similar to the present medicare program, including the use of carriers as fiscal agents for the processing of claims and making payments to providers of services.	Public plan—Similar to Medicare's process of claims administration with use of fiscal agents, including insurance companies, data processing firms and others. Federal government would determine eligibility for aged and disabled. States would determine eligibility of categorically needy persons. Federal government (or States meeting performance standards) would determine eligibility for other low-income enrollees. Establishes national minimum standards for all health insurance plans offered under the employer mandated program. Plans would be Federally-certified to assure adequacy and uniformity. Federal government would also offer a voluntary reinsurance program to HMOs, employers, and small insurance companies, covering 80 percent of costs of a policyholder when costs exceed $25,000.	Federal government would contract with health insurance carriers to administer benefits. Participating carriers would be required to enter into a reinsurance pool with other insurers or develop an internal pool among their affiliates. Carriers must also agree to certain other conditions including conditions for reimbursement for services and enrollment of eligible individuals. Carriers are to be paid a uniform per capita amount for each enrollee reflecting the costs of benefits provided and administration of the program. In areas with no participating carriers, HEW would operate program. Creates a national Catastrophic Medical Expense Reimbursement Board to advise the Secretary, and Area Advisory Boards in each administrative area to advise the National Board. Also establishes a Catastrophic Medical Expense Reimbursement Office in each health service area to provide information on program.	A Federal-level National Health Insurance Board, appointed by the President, would establish policy and standards, set national and State budgets for national health insurance purposes, negotiate premiums with private insurers, certify insurers for participation, and conduct other activities. Within each State, a State Health Insurance Board would submit and implement the State health insurance budget, negotiate budgets and fee schedules with health providers, certify qualified providers, and carry out other administrative functions. Much of the day-to-day administration would be handled by certified private insurers and HMOs. Insurers would have to make mandated benefits available at negotiated community-rated premiums. Insurers would be grouped into four national consortia for purposes of premiums collections and claims payment and other functions.	For employer-based plans, provides that employers not offering required coverage would no longer be able to deduct from gross income for Federal tax purposes the premium contribution paid for health insurance benefits. Employers, including government employers, with more than 200 employees would be required to offer at least three health insurance plans, each sponsored by a different organizational entity. The definition of health plans that must be offered would include all standard health insurance arrangements certified under State laws, as well as HMOs and prepaid group practices. The rights of collective bargaining would be preserved by requiring that health plan choices would be offered through employee collective bargaining agents. Under State pooling arrangements, insurance carriers would be required, as a condition of participating in Federal health programs, to enroll individuals for catastrophic protection in proportion to the carriers' business in any State. States would be encouraged to monitor carriers' performance and to assign individuals to be enrolled. Small employers would be required to assist their enrollees in contacting the State agencies administering the assignment program.

FINANCING

Provides for financing through a one percent tax on the payroll of employers and the income of the self-employed subject to the Social Security tax with 50 percent of the amount paid allowed as a tax credit. No employee contribution would be allowed. Private-insured employers and self-employed persons would also be eligible for a 50 percent tax credit on the amount paid for premiums and any additional amount paid to meet the payroll tax liability. Low-income plan protection (S. 350 only) would be financed from general revenues and also with State medical assistance funds.	For employer-based plans, financing through employer and employee premium contributions, with employee share limited to 25 percent of catastrophic insurance costs. For residual program, financing through premium payments from individuals and families. General revenues would be used to finance premium subsidies for the low-income population. Provides initial Federal subsidy for employers whose payroll costs increase more than two percent as a result of compliance with the program.	Employment-based plans would be premiums financed, with employers paying the full costs of private catastrophic insurance coverage. Small employers and public and non-profit employers would be entitled to tax credits for up to 50 percent of premium costs. Low-income plan protection would be financed from general revenues and also with State medical assistance funds.	The public plan would be financed through a combination of current medicare payroll taxes, premiums equal to current medicare part B premiums paid by the aged and disabled above the public plan low-income standards, premiums set at a national community rate for individuals and employer-groups with fewer than 10 employees, and additional subsidies from Federal general revenues. Any employer could purchase public coverage at premiums equal to 5 percent of payroll. State and local governments would share in costs for the low-income enrollees. Private plan — employer-employee premium payments with employer paying at least 75 percent of cost of plan meeting Federal standards. Includes Federal subsidies to protect employers and low-wage workers from undue hardship.	The plan would be financed through appropriations from Federal general revenues. Also, the current income tax deduction for medical expenses and tax preference for health insurance expenses would be repealed.	Financing would be based on wage-related premiums, premiums on substantial amounts of nonwage income, State and Federal payments for welfare and institutionalized individuals, voluntary payments on behalf of U.S. residents employed by foreign governments, Medicare taxes and premiums, and general revenues. Employees would pay on a set amount of income. Employers would pay based on their total payrolls. Employees could be required to pay from 25 to 30 percent of the premium amount. Tax credits would be available to employers who are severely impacted by the program.	For employer-based plans, financing would be through employer and employee premium contributions. Employers would be required to contribute the same dollar outlay for health benefits per employee. Outlays per employee could not be lowered after the bill's effective date. Outlays per employee could not exceed the amount of the highest costs plan selected by 25 percent of employees. If an employee chose a plan whose premium cost was less than the employer outlay per employee, he would be entitled to receive a tax free rebate equal to the difference between the outlay and the cost of the plan. For State pools, financing would be through premium contributions which could not exceed 125 percent of comparable large group rates for similar protection in the same geographic area.

STANDARDS FOR REIMBURSEMENT OF PROVIDERS OF SERVICES

Requires that payments to and standards for providers would be the same under the public plan as that for medicare. Payments to skilled nursing and intermediate care facilities would be on a cost-related basis. Medicare reimbursement and other standards would not be applicable to employer plans.	No explicit provisions.	No explicit provisions.	Provider participation standards would generally be similar to medicare's. Permits reimbursement of services provided by nurse practitioners, physicians assistants or similar trained personnel, even if State law are more restrictive. Organized ambulatory care) settings would also be considered reimbursable providers. HEW would certify providers, although HEW could enter contracts or agreements with private organizations or States to conduct certification review. Payment for hospital services would be governed by Administration's hospital cost containment program. Fee-for-service physicians would be paid on basis of a fee schedule, based initially on medicare physician payment levels. Insurance carriers may at their option, use health fee schedule in paying physicians. All physicians accepting public plan patients would be required to accept assignment of claims. Organized providers of ambulatory services could be reimbursed on basis of prospectively-set, all-inclusive rate per visit or a per capita rate for covered services provided to enrolled beneficiaries. HMOs would be reimbursed on basis of "average adjusted per capita community cost."	Services provided must be medically necessary and meet PSRO criteria. States may agree to perform health care provider qualification services. Reasonable costs and charges for services would be determined in accordance with Medicare criteria.	The National Board would establish an annual budget based on all expenditures for health services and program administration, and all revenues from premiums and other financing sources. Total annual increases in expenditures over the preceding year would be limited to a maximum of the average rate of increase in the GNP over the last three years. The budget would establish expenditure levels for each State, premium rates to be paid to insurers, and the amounts needed to be appropriated from government sources. Hospitals, home health agencies, neighborhood and other health centers and skilled nursing facilities would be reimbursed on the basis of negotiated prospective budgets. Physicians and podiatrists would be paid on the basis of negotiated fee schedules, as would lab services and medical equipment. HMOs would be paid on a capitation basis, with developing HMOs paid approved budget costs in excess of capitation payments. Physicians and other professionals eligible for fee schedule reimbursement could also be paid by salary or fee-for-time payments. Providers would send elected representatives to negotiate with committee convened by the National and State boards for establishing prospective budgets, fee schedules, other payment mechanisms.	No explicit provisions.

OTHER MAJOR PROVISIONS

Private insurers could obtain Federal certification that their basic health insurance policies that meet certain minimum standards of adequacy of coverage, eligibility and reasonableness of premiums. Health insurance facilitation programs would be established to assure that such basic coverage would be available to the general public.	Expands medicare benefits by deleting prior hospitalization requirement and numerical limits on home health services, adding occupational therapy as a primary home health service, increasing coverage of out-patient psychiatric benefits to $750 a year; and recognizing community mental health centers as providers.	Private insurers could obtain Federal certification that their basic health insurance policies that meet certain minimum standards of adequacy of coverage, eligibility and reasonableness of premiums. Health insurance facilitation programs would be established to assure that such basic coverage would be available to the general public.	Also includes various incentives designed to encourage health system reform and competition, including among other things, a new process for accessing health needs and determining adequacy of Federal programs, and a system for limiting hospital capital growth.	S. 1014 also establishes a separate national program of comprehensive health care services for children and pregnant women.	Provides for National Board to be served by an Ombudsman, an Advocate, and an Inspector General to ensure proper program operation. Would establish Commissions on Benefits, Quality, Access, and Health Care Organization. Would authorize a National Health Resources Distribution Fund to improve health delivery system, assist in closure or conversion of underused health facilities. Would authorize State Boards to undertake consumer health education programs.	All employer-based tax deductible health plans would be required to include a range of preventive health benefits, as well as minimum levels of catastrophic coverage. Preventive benefits would include: comprehensive maternal care, well baby clinic services, childhood immunizations, hypertension screening every three years up to age 80 and annually thereafter, pap smears every five years after three annual checks, periodic physical examinations. If plans did not include these benefits employers would be unable to deduct costs of health insurance premiums or employees to exclude employer contributions from taxed income. Individuals covered under State-administered pooling arrangements would also receive these benefits with the same 125 percent premium cap that applies to catastrophic benefits.

[1] Referred to the Committee on Labor and Human Resources.
[2] Information contained in summary taken from briefing materials supplied by Senator Kennedy at a press conference on May 14, 1970.
[3] Information contained in summary taken from statement in June 12, 1070 Congressional Record (pp. S7417-S7423), and press release issued from Senator Schweiker's office on June 9, 1970.
Source: Prepared by the Congressional Research Service.