Individual Healthcare Mandate Was a Republican Idea

SUMMARY

There has been much controversy about the Patient Protection and Affordability Care Act (PPACA or ACA) that became law in 2010. Some concern is over how it was passed, though that is more about form than substance.

Regarding substance, critics have claimed that this is a government takeover of healthcare and an over-reach into private affairs. One item getting particular attention is a mandate that all people buy health insurance or pay a fine. Some, including judges, say this is unconstitutional, others say it is not. Insurers are not happy either, not because there is a mandate, but because the mandate does not go far enough to deter potential abuse.

The purpose of this analysis is not to debate whether the ACA is unconstitutional or an over-reach into private affairs. Its purpose is to highlight that much of ACA was actually promoted and supported by Republicans in years past. In some respects, Democrats "stole" Republican ideas, not once, but twice.

In 1973, President Nixon proposed a health reform bill that is eerily similar to the Affordable Care Act. Then in 1993, Republicans again introduced the "Health Equity and Access Reform Today Act of 1993", a health reform bill that is even closer to the ACA. Neither became law.

As for the mandate that is now the subject of much controversy, this is what the 1993 bill proposes:

"Requires each citizen or lawful permanent resident to be covered under a qualified health plan or equivalent health care program by January 1, 2005. Provides an exception for any individual who is opposed for religious reasons to health plan coverage, including those who rely on healing using spiritual means through prayer alone." (title I, subtitle F)

Now compare this wording to that of the ACA law:

"An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage". [section 5000A(a)]

The term "applicable individual" …shall not include any individual …of a recognized religious sect …or…a member of a health care sharing ministry" [section 5000A(d)(2)]

Such term shall not include an individual …if …not a citizen or national of the United States or an alien lawfully present in the United States.[section 5000A(d)(3)]

Save for the dates, these two mandates sound virtually identical in substance though slightly different in form.

This is not the only similarity. Below is the Congresional summary of that Republican proposal. A careful reading reveals that an overwhelming number of provisions are found in the current law with two key exceptions.

One is the 1993 proposal included federal malpractice reform while the ACA encourages States to set or improve malpractice reforms. The other is the 1993 proposal allows 100% deductibility of health insurance costs for self-employed. Ironically, Republicans proposed 11 major provisions in 1993 that they are against today.

This highlights not that Democratic ideas are so far left, but that Republican ideas have moved so far right.

CRS SUMMARY OF REPUBLICAN "HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993"

Title I: Basic Reforms to Expand Access to Health Insurance Coverage and to Ensure Universal Coverage

Subtitle A: Universal Access - Provides access to health insurance coverage under a qualified health plan for every citizen and lawful permanent resident of the United States.

(Sec. 1003) Establishes a program under which persons with low incomes (and who are not eligible for Medicaid) will receive vouchers to buy insurance through purchasing groups.

(Sec. 1004) Requires each employer to make available, either directly, through a purchasing group, or otherwise, enrollment in a qualified health plan to each eligible employee.

Subtitle B: Qualified General Access Plan in the Small Employer and Individual Marketplace- Requires the National Association of Insurance Commissioners to develop specific standards to implement requirements

concerning: (1) guaranteed eligibility, availability, and renewability of health insurance coverage; (2) nondiscrimination based on health status; (3) benefits offered; (4) insurer financial solvency; (5) enrollment process; (6) premium rating limitations; (7) risk adjustment; and (8) consumer protection.

(Sec. 1119) Requires each qualified general access plan to: (1) establish and maintain a quality assurance program and a mediation procedures program; and (2) contain assurances of service to designated underserved areas.

(Sec. 1141) Provides for the formation of purchasing groups by individuals and small employers.

(Sec. 1161) Requires brokers or insurers to provide specified information to prospective enrollees.

(Sec. 1162) Prohibits insurers from creating improper financial incentives and from selling duplicate coverage.

Subtitle C: Qualified Health Plans in the Large Employer Marketplace - Requires the Secretary of Health and Human Services, in consultation with the Secretary of Labor, to establish standards for large employer plans similar to requirements applicable to small employer plans.

(Sec. 1203) Requires large employers to offer to employees at least a standard package and a catastrophic package.

(Sec. 1205) Allows two or more large employers to form purchasing groups, but not through an individual or small employer purchasing group.

(Sec. 1206) Requires a semi-annual review of each large employer plan to determine whether requirements are being met and what corrective actions need to be taken.

(Sec. 1221) Amends the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to revise provisions to conform to this Act.

Subtitle D: Benefits; Benefits Commission - Requires each qualified health plan to provide a standard package and a catastrophic package. Specifies items and services to be covered.

(Sec. 1311) Establishes the Benefits Commission to develop and propose legislation that provides a clarification of covered items and services and includes specifications for cost sharing.

(Sec. 1314) Provides for congressional consideration and implementation of such legislation.

Subtitle E: State and Federal Responsibilities in Relation to Qualified Health Plans - Requires each State to establish a program to: (1) certify insured health plans; (2) disseminate information on health care coverage areas; (3) establish procedures for purchasing groups; (4) prepare information concerning plans and purchasing groups; (5) provide for a risk adjustment program, including an adjustment for differences in nonpayments among qualified insured health plans; (6) develop a binding arbitration process; and (7) specify an annual general enrollment period.

(Sec. 1421) Allows the waiver of specified requirements.

(Sec. 1431) Provides preemptions of certain State laws.

(Sec. 1441) Specifies the Federal responsibilities with respect to multi-State employer plans and in case of State defaults.

Subtitle F: Universal Coverage - Requires each citizen or lawful permanent resident to be covered under a qualified health plan or equivalent health care program by January 1, 2005. Provides an exception for any individual who is opposed for religious reasons to health plan coverage, including those who rely on healing using spiritual means through prayer alone.

Subtitle G: Definitions - Defines terms used in this Act.

Title II: Tax and Enforcement Provisions

Subtitle A: General Tax Provisions - Amends the Internal Revenue Code to exclude from an employee's gross income employer-provided coverage under a qualified health plan or employer-provided contributions to the employee's medical savings account. Includes excess employer contributions in such gross income.

(Sec. 2002) Allows a business expense deduction for employer costs of qualified health plans or contributions to an employee's medical savings account.

Increases the allowable deduction (from 25 percent to 100 percent) for the qualified health insurance costs of self-employed individuals. Makes such deduction permanent.

(Sec. 2003) Allows individuals a tax deduction for contributions made to a medical care savings account established for the benefit of an eligible individual.

Allows such deduction whether or not an individual itemizes deductions.

Disallows distributions from such accounts as medical expense deductions.

Excludes employer contributions to such accounts from employment taxes.

Establishes an excise tax for excess contributions to medical care savings accounts.

(Sec. 2004) Eliminates the commonality of interest and geographic location requirements with respect to group purchasing by large tax-exempt organizations.

(Sec. 2005) Revises and repeals provisions concerning continuation coverage requirements of group health plans upon implementation of this Act.

Subtitle B: Provisions Relating to Acceleration of Death Benefits - Requires payment under a life insurance contract on the life of an insured who is terminally ill to be treated as a death benefit, making such payment eligible for tax exclusion from gross income.

(Sec. 2102) Provides that any reference to life insurance shall be treated as referring to a qualified terminal illness rider.

Subtitle C: Long-Term Care Tax Provisions - Treats qualified long-term care services as medical care for purposes of the medical expense deduction.

(Sec. 2202) Provides for the treatment of long-term care insurance as accident and health insurance.

(Sec. 2301) Sets forth consumer protection provisions to be satisfied by qualified long-term care insurance contracts, including the model regulation and Act promulgated by National Association of Insurance Commissioners (NAIC). Requires NAIC to promulgate standards for the use of uniform language and definitions in such policies, with certain variations permitted.

Subtitle D: Enforcement Provisions - Amends part A (General Provisions) of Social Security Act title XI to establish the Health Insurance Coverage Data Bank to: (1) further the purposes of coverage requirements under this Act; and (2) collect certain information reported by employers about individual employee group health plan coverage for purposes of identifying and collecting from responsible third parties any amounts owed to reimburse Medicare or Medicaid for health care items and services furnished to their beneficiaries. (Replaces the Medicare and Medicaid Coverage Data Bank.)

(Sec. 2402) Amends the Internal Revenue Code to impose excise taxes on failures by employers and insurers to comply with provisions of this Act.

(Sec. 2411) Amends the Employee Retirement Income Security Act of 1974 to make conforming changes regarding enforcement of employer failures.

Title III: Quality Assurance and Simplification

Subtitle A: Quality Assurance - Directs the Secretary of Health and Human Services, in consultation with relevant agencies, to develop and publish standards for quality assurance programs and ensure that appropriate performance measures are established. Requires the standards to contain provider risk programs to prevent or provide early warning of practices that may result in injury.

(Sec. 3002) Provides for the standardization of information through a national health data system.

(Sec. 3003) Requires the Secretary to establish measures to determine quality of care in specialized centers of care.

(Sec. 3004) Authorizes appropriations to examine the feasibility of creating an Agency for Clinical Evaluations by consolidating the responsibilities of specified other offices.

(Sec. 3005) Requires the Secretary to report annually to the Congress on factors affecting universal coverage and make recommendations for increasing such coverage.

(Sec. 3006) Requires the Secretary to monitor the reinsurance market for qualified health plans and periodically report to the Congress on the financial implications.

(Sec. 3101) Amends the Public Health Service Act to establish within the Agency for Health Care Policy and Research a clearinghouse for information and research data concerning clinical trials. Requires the appointment of a fund investigator for the Agency.

(Sec. 3201) Amends the Internal Revenue Code to establish the National Fund for Medical Research and provide for the designation of tax overpayments to such fund.

Subtitle B: Administrative Simplification - Establishes a health care data interchange system to make data available on a uniform basis to all participants in the health care system.

(Sec. 3302) Requires the Health Care Data Panel to develop regulations for the operation of an integrated electronic health care data interchange system.

(Sec. 3304) Sets forth requirements for such system including: data and transaction standards, uniform working files, code sets, unique identifiers, standards for confidentiality, rules for the transfer of information, and periodic reviews.

(Sec. 3313) Establishes the Health Care Data Panel and a National Health Informatics Commission to advise the Panel on its activities.

Title IV: Judicial Reforms

Subtitle A: Medical Liability Reform - Requires a qualified health plan to provide effective mediation procedures for hearing and resolving health care malpractice claims.

(Sec. 4013) Requires each State to adopt an alternative dispute resolution method for the resolution of health care malpractice claims and consumer grievances.

(Sec. 4021) Establishes provisions with respect to liability under health care malpractice actions brought in State or Federal courts.

(Sec. 4022) Limits attorney contingency fees and award amounts for noneconomic damages.

(Sec. 4024) Establishes a two-year statute of limitations for health care malpractice claims, except in the case of minors.

(Sec. 4025) Requires each State to establish a set of specialty clinical guidelines. Allows the use of such guidelines as a rebuttable presumption in a claim or action, if the service provided was the appropriate standard of medical care.

(Sec. 4026) Prohibits the award of punitive damages against the producer of a drug or device that is approved by the Food and Drug Administration.

(Sec. 4027) Requires a report to the appropriate congressional committees on the operation of this subtitle.

Subtitle B: Anti-Fraud and Abuse Control Program - Requires the Secretary to establish in the Office of the Inspector General of the Department of Health and Human Services a program to control fraud and abuse under the universal health care plan. Establishes the Anti-Fraud and Abuse Trust Fund.

(Sec. 4102) Amends title XI of the Social Security Act (SSA) to provide for the application of the penalties for Medicare and Medicaid fraud to all health care programs.

(Sec. 4103) Requires the Secretary to establish a program through which Medicare-eligible individuals may report instances of suspected fraud under Medicare.

(Sec. 4111) Revises current SSA title XI sanctions for fraud and abuse involving Medicare and State health care programs, with changes providing for: (1) program exclusion for individuals convicted of a felony relating to fraud or the unlawful manufacture or dispensing of a controlled substance; (2) new offenses under civil monetary penalty provisions, such as the offering of inducements to program-eligible individuals; (3) establishment of a minimum period of exclusion for practitioners and persons who fail to meet statutory obligations; (4) intermediate sanctions on eligible health maintenance organizations for program violations; and (5) procedures for imposing such sanctions.

(Sec. 4121) Directs the Secretary to establish a national health care fraud and abuse data collection program for

the reporting by each government agency and health care plan of final adverse actions against health care providers, suppliers, and practitioners. Requires program information to be made available to the public for a reasonable fee.

(Sec. 4122) Amends SSA title XI to require the Secretary to publish in the Federal Register a listing of all final adverse actions taken during the quarter.

(Sec. 4131) Amends the Federal criminal code to set penalties for knowingly executing a scheme or artifice to: (1) defraud any health care plan in connection with the delivery of, or payment for, health care benefits, items, or services (benefits); and (2) obtain, by means of false or fraudulent pretenses, representations, or promises, money or property owned by, or under the custody or control of, any health care plan or person in connection with the delivery of, or payment for, health care benefits.

(Sec. 4132) Directs the court, upon a finding that a Federal health care offense is of a type that poses a serious threat to the health of any individual or has a significant detrimental impact on the health care system, to order a person convicted of that offense to forfeit property that was used in the commission of the offense or that constitutes or was derived from proceeds traceable to the offense that is of a value proportionate to the seriousness of the offense.

(Sec. 4133) Authorizes the Attorney General to commence a civil action in Federal court to enjoin a violation constituting a Federal health care offense.

(Sec. 4134) Makes commission of a Federal health care offense a predicate to a violation of the Racketeer Influenced and Corrupt Organizations Act.

(Sec. 4141) Makes provisions of the Civil False Claims Act applicable to the use of false records or statements made to a health care plan. Includes within the definition of "claim" for purposes of such Act any request or demand for money or property which is made or presented to a health care plan.

Subtitle C: Treatment of Certain Activities Under the Antitrust Laws - Exempts from the antitrust laws specified "safe harbor" activities related to the provision of health care services. Sets forth provisions regarding the award of attorney fees and costs of suit to the prevailing party in an action based on a claim involving activity found to be exempt.

(Sec. 4202) Lists as safe harbors specified: (1) activities relating to health care services of combinations of health care providers with market share below a specified threshold; (2) activities of medical self-regulatory entities relating to standard setting or enforcement activities not conducted for purposes of financial gain; (3) participation of a health care provider in a written survey of the prices of services, reimbursement levels, or the compensation and benefits of employees and personnel; (4) activities relating to health care joint ventures for high technology and costly equipment and services; (5) activities relating to hospital mergers; (6) joint purchasing arrangements; and (7) negotiations.

(Sec. 4203) Directs the Attorney General to publish a notice in the Federal Register soliciting proposals for additional safe harbors and to review and report to the Congress on proposed safe harbors. Sets forth criteria in establishing safe harbors, including: (1) the extent to which a competitive or collaborative activity will accomplish an increase in health care access and quality, the establishment of cost efficiencies, and increased ability of health care facilities to provide services in medically underserved areas or to underserved populations; and (2) whether designation as a safe harbor will result in specified desirable outcomes.

(Sec. 4204) Directs the Attorney General to issue certificates of review for providers of health care services and assist persons in applying for such certificates. Sets forth provisions regarding applications for, revocation of, and review of determinations regarding such certificates. Limits the disclosure of information.

(Sec. 4205) Sets forth provisions regarding notifications providing for a reduction in certain penalties under the antitrust laws for health care cooperative ventures.

(Sec. 4206) Directs the Attorney General to: (1) review the safe harbors and certificates of review periodically; and (2) promulgate such rules, regulations, and guidelines as necessary to carry out provisions of this subtitle.

(Sec. 4208) Establishes within the Department of Health and Human Services an Office of Health Care Competition Policy.

Title V: Special Assistance for Frontier, Rural, and Urban Underserved Areas

Subtitle A: Frontier, Rural, and Urban Underserved Areas - Amends the Public Health Service Act to establish a program of allotments to States for grants for community-based primary health services to low-income or medically underserved populations regarding infant mortality and referrals for the health management of infants and pregnant women. Earmarks for the allotments specified percentages of appropriations under certain provisions added by this Act.

(Sec. 5002) Mandates grants to federally qualified health centers (FQHCs) and other entities for providing access to services for medically underserved populations or in high impact areas not currently being served by a FQHC. Authorizes appropriations. Directs the Secretary to report to the appropriate congressional committees on the relationship and interaction between community health centers and hospitals in providing services to such populations.

(Sec. 5003) Amends the Internal Revenue Code to: (1) allow a nonrefundable credit for certain primary health services providers for mandatory service periods in health professional shortage areas; (2) exclude from gross income qualified loan repayments to the National Health Service Corps; (3) increase the dollar limitation allowed for expensing medical equipment used in rural health shortage areas; and (4) allow a deduction for student loan payments by medical professionals practicing in rural areas.

(Sec. 5004) Amends title XVIII (Medicare) of the Social Security Act (SSA) to provide for: (1) establishment of rural emergency access care hospitals under Medicare; and (2) coverage of and payment for rural emergency access care hospital services under Medicare part B (Supplementary Medical Insurance).

(Sec. 5005) Amends the Public Health Service Act to direct the Secretary to make grants to States to assist in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments. Sets forth provisions regarding: (1) application and State plan requirements; (2) considerations in awarding grants; (3) State administration and use of grants; (4) the number of grants; and (5) reporting requirements. Authorizes appropriations.

(Sec. 5006) Authorizes the Secretary to conduct a demonstration project and grant program to encourage the development and operation of rural health networks. Authorizes appropriations.

(Sec. 5007) Requires the Secretary to report to the Congress on improving access to benefits under qualified health plans for individuals residing in rural areas.

Subtitle B: Primary Care Provider Education - Requires the Secretary to provide for the establishment of demonstration projects to evaluate mechanisms to increase the number and percentage of medical students entering primary care practice through funds otherwise available for direct graduate medical education costs under the Medicare program.

(Sec. 5102) Allows funding under Medicare for training in nonhospital-owned facilities.

(Sec. 5103) Increases authorized funding for the National Health Service Corps Scholarship and Loan Repayment Programs. Authorizes funding through FY 1998.

(Sec. 5104) Increases and extends through FY 1997 authorized funding for training for certain health service providers.

Subtitle C: Programs Relating to Primary and Preventive Care Services - Authorizes appropriations for a grant program to improve coordination of maternal and infant care.

(Sec. 5202) Amends the Elementary and Secondary Education Act of 1965 to authorize appropriations to carry out a comprehensive school health education and prevention program for elementary and secondary school students.

(Sec. 5203) Allows frontier States (including Alaska, Wyoming, and Montana) to implement proposals and

participate in demonstration projects which give special consideration to their diverse needs.

Title VI: Treatment of Existing Federal Programs

Subtitle A: Medicaid Program - Gives States the option of allowing the enrollment of Medicaid-eligible individuals (including a limited number of AFDC- and SSI-eligible individuals) in the standard benefit package under a qualified health plan, instead of enrollment in the State's Medicaid program.

(Sec. 6001) Sets forth requirements for States exercising such option. Places a cap on Federal payments for acute medical services furnished under a State's Medicaid programs.

(Sec. 6011) Discontinues reimbursement standards for inpatient hospital services.

Revises the Federal medical assistance percentage for certain States.

Modifies Federal requirements to allow States more flexibility in contracting for coordinated care services under Medicaid.

(Sec. 6021) Provides for waivers from requirements on coordinated care programs.

Gives States the option to guarantee the continued Medicaid eligibility of individuals enrolled with risk contracting and other managed care entities.

(Sec. 6031) Provides for phased-in elimination of Medicaid hospital disproportionate share adjustment payments.

Subtitle B: Medicare - Requires the Secretary to: (1) submit to the Congress a proposal for legislation which provides for the enrollment of Medicare beneficiaries in qualified health plans; and (2) provide for a monthly payment to a qualified health plan on behalf of enrolled Medicare beneficiaries.

(Sec. 6111) Amends the Omnibus Budget Reconciliation Act of 1990 (OMBRA '90) to revise provisions for a modified payment methodology for risk contractors.

(Sec. 6112) Requires the Secretary to provide for adjustment in Medicare capitation payments to take into account secondary payer status.

Authorizes the Secretary to make additional payments to eligible organizations with risk-sharing contracts.

(Sec. 6121) Amends OMBRA '90 to: (1) make permanent the Medicare select policy program; and (2) allow access to Medicare select policies in all States.

Amends Medicare to revise the Medicare select policy program and provide for a civil penalty for misrepresentations made in connection with such a policy.

(Sec. 6131) Makes specified changes with regard to monthly Medicare part B premium determinations for part B enrollees.

(Sec. 6132) Amends the Internal Revenue Code to provide for an increase in the Medicare part B premium for individuals with high income.

(Sec. 6133) Makes permanent certain payment reductions relating to outpatient hospital services furnished under Medicare.

(Sec. 6135) Imposes copayments for laboratory services and certain home health visits provided under Medicare.

(Sec. 6137) Provides for phased-in elimination of Medicare disproportionate share hospital payments.

(Sec. 6138) Directs the Secretary to discontinue hospital reimbursements for costs relating to the recovery of bad debts.

(Sec. 6139) Makes specified changes with regard to Medicare as a secondary payer.

Title VII: Patient's Right to Self-Determination Regarding Health Care

Provides for the treatment of advance directives and other measures, including a study by the Secretary on issues relating to health care decisions by the patient, in addressing the patient's right to self-determination regarding health care.

