DOWNLOAD PDF PROPOSALS TO STIMULATE HEALTH CARE COMPETITION

Chapter 1 : Competition in the Health Care Marketplace | Federal Trade Commission

Proposals to stimulate health care competition: hearings before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-sixth Congress, second session, on S. , a bill to amend the Internal Revenue code of to encourage competition in the health care industry, to encourage the provision of catastrophic health insurance by employers, and for other purposes.

As of June , only 3. One simple step to smooth the functioning of the APTC and avoid burdensome reconciliations would be to improve the accuracy of the credits by providing coverage applicants with a clearer and more comprehensive explanation of how their APTC was calculated. Currently, applicants receive a statement when they become eligible that tells them the amount of their APTC and the amount of income on which APTC were based. Eligibility may be calculated based on the income reported by the applicant or on income drawn from prior tax records or other sources. A more transparent explanation could explain how the income was computed, including what income was considered in calculating the amount. The current notice informs the taxpayer that changes in income, available coverage alternatives, or household composition must be reported and that failure to do so may result in the taxpayer having to pay back overpayments, but the notice could include examples of how changes in household income or size might affect the amount the taxpayer would have to pay back. Taxpayers could also be sent quarterly notices including the income projections on which their tax credits are calculated and advised to report any changes in income to avoid over- or under-payment of their APTC. Monthly premium statements from insurers could also remind enrollees of their obligation to keep enrollment information current. The issuance of the A form that enrollees are sent to assist with tax reconciliation could be moved up to mid-January to ensure that taxpayers received early notice of their need to file taxes and the amount of APTC on which their taxes would be calculated. The reconciliation process could also be adjusted to ease the burden of reconciliation. Taxpayers could be excused from having to pay back tax credits if their final household income were within a certain percentage perhaps 10 percent of their projected income, as long as the taxpayer did not intentionally underreport income. Taxpayers who were determined to have received less in APTC than they were entitled by the same percentage of variation would not receive an additional payment unless they had intentionally foregone advance payment of the full tax credit. If they fail to do so, however, the IRS could simply perform the reconciliation calculation for them, assuming the information on form A to be correct. Taxpayers could be notified on the form A that the IRS will perform the reconciliation calculation for them if they fail to file a form No one should lose access to premium tax credits simply because they fail to file this form. Assisting Moderate and Middle-Income Uninsured Individuals and Families Although Medicaid, tax credits, and cost-sharing reduction payments help make insurance affordable, health insurance is still so costly for many moderate- and middle-income Americans that they refuse coverage. Download Current tax credits require individuals and families with incomes below percent of FPL to pay too much before tax credits take over. One consequence is that many low-income workers are declining subsidized employer-based and marketplace-based coverage. Affordability is also a problem among those with higher incomes. More than 15 million uninsured Americans have incomes in excess of percent of FPL, while 5. The full schedule of ACA subsidies could potentially particularly in combination with income limits of other federal and state anti-poverty programs create adverse work incentives. They also impose significant burdens on middle-income Americans who lack access to employer-sponsored coverage. Blumberg and Holahan also propose allowing individuals with incomes above percent of FPL to gain access to tax credits, as long as the premiums they would have to pay for the second-lowest-cost gold plan cost more than 8. Thus assistance would not be linked only to the amount of income but also to the cost of coverage. Adoption of this proposal would improve access to affordable health insurance for moderate- to middle-income households. Yet its cost would not be open ended, as the number of households that would be eligible for coverage would rapidly

diminish as income increased. Middle-income taxpayers without access to employer coverage would at least be entitled to a fixed-dollar tax credits even if their incomes were too high to qualify for income-based credits. From both a substantive and a political perspective, such proposals merit consideration. Fixed-dollar tax credits have long been proposed as an alternative to the current employer-sponsored insurance tax exclusion. These proposals have come primarily from conservative or libertarian advocacy groups, but have also been put forward by many economists across the political spectrum. Under one proposed alternative, taxpayers who do not have employer-sponsored coverage could choose between income-based tax credits, which could continue to phase out at percent of FPL based on the cost of coverage, as described above, and fixed-dollar tax credits, which could be more generous than income-based tax credits at the percent of poverty level. The amount of the credits should be set high enough to have a significant effect on affordability, but would still leave most of the responsibility for the cost of insurance with enrollees at higher income levels. Credits should be age-adjusted to ensure that they reflect age-related premium differences. However, individuals offered coverage through their work should be able to decline that coverage and purchase coverage through the marketplace and claim tax credits if this alternative is more affordable. This program structure may lead some employers to stop offering coverage, as firms and workers compare the value of the fixed credit to the value of the tax exclusion. As long as marketplaces offer good coverage, we regard this as an acceptable policy tradeoff. Fixed-dollar tax credits for higher-income individuals would not require reconciliation based on actual income or to repayment to the Treasury, as long as total household income remained below the maximum eligibility level. Fixed dollar tax credits would thus be more predictable and simpler than income-based tax credits. It may not even be necessary to pay them in advance, as taxpayers could reduce withholding or estimated tax payments in anticipation of the credits and use the savings to help pay for health insurance. A fixed-dollar tax credit such as that proposed here would come at some cost. Since it would only be available to individuals who do not enroll in employer coverage and who did not qualify for income-based credits, it would be much less costly than a universal tax credit. One attractive pathway to finance this system would be to cap the employer-sponsored coverage tax exclusion, a proposal that has wide support in the policy research community. Further research is needed to determine the amount of tax credits, their total cost, and how they would be financed. Making Health Care Affordable The ACA has reduced the financial burdens associated with injury and illness, and has made health care more affordable for millions of Americans. Although ACA provides valuable limits on total out-of-pocket spending, it has not restrained the long-term trend toward higher deductibles and copayments in employer-sponsored coverage. Higher cost-sharing indisputably reduces the volume of care received by consumers, and thus overall expenditures. Yet there is considerable and growing evidence that such cost-sharing does so indiscriminately, reducing consumption of high-value as well as low-value care. Covered individuals increasingly seek care from narrow provider networks and find medications listed on limited or tiered formularies. In-network providers are not always easily identified, and out-of-network providers are not easily avoided. People served by out-of-network providers may therefore face large and unexpected bills. This section addresses problems raised by excessive cost-sharing and networks and formularies that are too restrictive. Moderating Costs for Insured Households Although the ACA implements stop-loss provisions that reduce the risk of catastrophic financial loss, out-of-pocket medical costs continue to be a major concern for many Americans. The ACA is sometimes wrongly blamed for increasing consumer out-of-pocket spending, so far the new law appears to have neither aggravated nor slowed the long-term trend toward higher deductibles and copayments in private coverage see Figure 8. Download High cost-sharing is having a real impact on American families. A recent Commonwealth Fund study finds that half of underinsured adults report being contacted by collection agencies or having to change their way of life because of medical bills. Download The ACA has a confusing array of rules governing the adequacy of coverage that can, in some circumstances, leave care essentially unaffordable. Large employers with more than fifty full-time equivalent employees are required to provide minimum essential coverage to their full-time employees or to pay a penalty for each full-time employee if any

employee receives premium tax credits for non-group coverage through the marketplace. As applied to employer coverage, the minimum essential coverage definition requires vanishingly little. Minimum value employer coverage is somewhat more comprehensive than minimum essential coverage. Minimum value employer plans must have an actuarial value of at least 60 percent that is, they must cover at least 60 percent of the costs of a standard self-insured-plan population and they must cover substantial hospitalization and physician servicesâ€”but minimum value plans can still impose substantial cost-sharing on employees. It must cover ten essential health benefits and provide coverage after cost-sharing set at one of four actuarial value levelsâ€”bronze 60 percent , silver 70 percent , gold 80 percent , and platinum 90 percent. Premium tax credits are keyed to the premium of the second lowest-cost silver plan in a market. Most marketplace enrollees who depend on premium tax credits choose to purchase bronze or silver plans. But high cost-sharing can impose significant burdens, particularly those with modest incomes or costly health challenges. Lower-income families may face a choice between affordable coverage and affordable care. Insurers and group health plans can cover services from out-of-network providers but are not required to do so except for emergency services and often impose higher caps on out-of-network out-of-pocket expenditures. Out-of-pocket caps also do not apply to services that do not qualify as essential health benefits. Although a standard silver plan is one that covers 70 percent of the actuarial value of covered services, the ACA also provides cost-sharing subsidies that boost the total value of a silver plan for marketplace enrollees with incomes below percent of the FPL. The ACA requires the federal government to reimburse health plans for the amounts they provide modest-income consumers in reducing cost-sharing. Litigation is now pending challenging the legality of this reimbursement in the absence of explicit congressional appropriation. Urban Institute researchers Linda Blumberg and John Holahan propose that the premium tax credits be set to cover the cost of 80 percent actuarial value gold plans rather than the 70 percent silver plans. Health care could also be made more affordable by reducing out-of-pocket limits. As noted above, the ACA imposes an out-of-pocket limit on all forms of health coverage. The ACA provided, however, that these reductions in out-of-pocket limits should not increase the actuarial value of plans above the limits set for cost-sharing reduction payments. Thus, while out-of-pocket limits are reduced by two-thirds for enrollees with incomes below percent of FPL, out-of-pocket limits are reduced by less than a third for individuals with incomes between and percent of FPL, and not at all for those with higher incomes. Significant cost-sharing relief could be afforded individuals with moderate incomes by effectuating the out-of-pocket limits imposed by the ACA without regard to actuarial value. If the actuarial value of ACA benchmark plans were increased from 70 to 80 percent, as Blumberg and Holahan suggest, the out-of-pocket limit could be decreased across the board to the levels found in the original ACA, since insures could pay a larger share of total covered costs. Finally, the ACA employer responsibility regulations should be amended to improve coverage. Minimum value coverage should include substantial coverage for pharmacy and diagnostic tests as well as hospitalization and physician services. Minimum essential coverage should require coverage of hospital, physician services, pharmacy, and diagnostic tests as well. Employers who fail to provide these services should be subject to the employer mandate penalties. Employees who are not offered minimum value coverage as redefined should have access to marketplace coverage with premium tax credit support. As noted below, principles of value-based insurance design may prove helpful in defining the scope of coverage in these areas. Improving Coverage for Some Individuals Whose Incomes Exceed Percent of the Federal Poverty Line Cost-sharing reduction payments are only available to individuals who purchase individual qualified health plans through the marketplaces and who are otherwise eligible for APTC assistance. This leaves millions of individuals with coverage through their employment or through the individual market with incomes above percent of FPL exposed to levels of cost-sharing that may still make health care a significant economic burden. Increase Use of Health Savings Accounts for Moderate-Income Americans One way of increasing affordability for middle-income populations is through account-based programs such as health savings accounts HSAs , health reimbursement accounts, flexible spending plans, and Archer medical savings accounts. These accounts permit tax subsidies for amounts set aside to cover medical costs, including

cost-sharing imposed by health plans. HSAs are sometimes touted as an all-purpose solution to health policy problems. In fact, HSAs provide one of the most heavily subsidized investment vehicles available and are used disproportionately by affluent taxpayers, who use them to maximize retirement savings rather than simply paying for health care, as money can be withdrawn from HSAs after age 65 for non-health care expenses without a penalty. HSAs can, however, be of value to marketplace enrollees. While it would be preferable to increase APTC and cost-sharing reduction eligibility levels and generosity, if this is not politically possible, HSA investments can provide some relief for individuals with moderate incomes or individuals who underestimate their income and are faced with high APTC repayments at tax filing time. Some legislative changes could make HSAs even more helpful for those who actually use them to cover health care costs. First, the out-of-pocket limits under the ACA could be amended to align them with out-of-pocket maximums for HSA-linked high-deductible health plans. Although the limits were initially aligned, they increase under different inflation adjustment rules, making it possible that ACA compliant plans would not be HSA eligible. These rules could be easily aligned. Modest direct federal contributions to HSAs for moderate-income Americans could also be considered. These could be paid as a refundable tax credit at the time of tax filing based on actual taxable income, avoiding the need for reconciliation. As with retirement accounts, modest subsidies could be implemented with a well-designed choice architecture that could overcome behavioral inertia to encourage greater savings. Government or private plans could also assist consumers with the logistical practicalities of establishing such accounts.

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Chapter 2 : NHC Policy Proposals for Reducing Health Care Costs | National Health Council

The Resource Description of proposals to stimulate competition in the financing and delivery of health care / Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives.

Private Payers News Early Health Insurance Premium Proposals Indicate Hikes for Health insurance companies in several states have proposed their premium prices, which could increase between 10 and 90 percent over rates. A challenging regulatory landscape, complicated by policy changes that have altered the Affordable Care Act, have led payers to request significant premium increases for many of their plan offerings. As a result of federal actions in the health insurance marketplace, payers are anticipating decreasing enrollment and shifts in the beneficiary risk pool, which are likely to continue to push premiums upward in and beyond. Virginia likely to see double-digit premium increases for individual plans Private payers in Virginia offering individual health plan products are requesting premium increases between 8 and 69 percent. Cigna, the largest individual health plan provider with more than , beneficiaries, is requesting an average increase of 15 percent. Group Hospitalization and Medical Services Inc. In one instance, the payer requested premium increases of In contrast, small group health plan prices are likely to remain stable or even shrink. CareFirst BlueChoice is decreasing small group health plan premiums by an average of 1. Some individual plan premium rates in Maryland will almost double Payers in the state of Maryland have requested premium increases between 24 and 98 percent for individual health plans, citing expected growth in their medical loss ratios for Kaiser Foundation individual health plans requested increases of 48 percent, and CareFirst BlueChoice plans requested an increase of 24 percent. Small group market health plans remained more stable than individual market products, with payers anticipating increases between 6 and 25 percent. Pros and Cons of High Cost Sharing for Employer Health Plans Payers offering individual health plans in Oregon requested average rate hikes between 5 and 16 percent, while small group plan increases range between 0 and 9. Health Net Health Plan of Oregon requested an average rate increase of Kaiser Foundation Health Plan of the Northwest proposed increases of Conversely, PacificSource Health Plans decreased their proposed rates for individual plans by 9. Payers only requested minimal premium increases for small group health plans, since expected costs held steady or decreased slightly. Health Net requested a 4 percent decrease in small group plan premiums, Moda Health Plan requested a 1. Four out of the nine payers offering small group plans in the state requested premium increases between 0 and 1. Consumers and stakeholders can comment on the rate changes here until July 9, Small group plans are also requesting similar increases. Tufts Health plan proposed increases of Neighborhood Plan of Rhode Island a 0. UnitedHealthcare also requested a 0. By Rhode Island law, premium rate requests over 10 percent are subject to an additional review.

Chapter 3 : Research Proposal: Antitrust Laws and Competition in the Health Care Market â€¦ | 6 Pages

Proposals to stimulate health care competition: Hearings before the Subcommittee on Health of the Committee on Finance, United States Senate, session, on S. March 18 and 19, [United States.

Overview[edit] Chart showing life expectancy at birth and health care spending per capita for OECD countries as of These range from increased use of health care technology through changing the anti-trust rules governing health insurance companies and tort-reform to rationing of care. Different overall strategies have been suggested as well. He mentioned electronic record-keeping, preventing expensive conditions, reducing obesity, refocusing doctor incentives from quantity of care to quality, bundling payments for treatment of conditions rather than specific services, better identifying and communicating the most cost-effective treatments, and reducing defensive medicine. He argued that the U. He articulated four "pillars" of such a strategy: Writing in The New Yorker , surgeon Atul Gawande further distinguished between the delivery system, which refers to how medical services are provided to patients, and the payment system, which refers to how payments for services are processed. He argued that reform of the delivery system is critical to getting costs under control, but that payment system reform e. Gawande argued that dramatic improvements and savings in the delivery system will take "at least a decade. He argued this would be an iterative, empirical process and should be administered by a "national institute for healthcare delivery" to analyze and communicate improvement opportunities. These options included increased use of health information technology, research and incentives to improve medical decision making, reduced tobacco use and obesity, reforming the payment of providers to encourage efficiency, limiting the tax federal exemption for health insurance premiums, and reforming several market changes such as resetting the benchmark rates for Medicare Advantage plans and allowing the Department of Health and Human Services to negotiate drug prices. The authors based their modeling on the effect of combining these changes with the implementation of universal coverage. The authors concluded that there are no magic bullets for controlling health care costs, and that a multifaceted approach will be needed to achieve meaningful progress. Health insurance premiums for employer-provided family coverage Health spending accounted for Following the United States were the Netherlands at Americans spent more than twice as much as relatively rich European countries such as France, Sweden and the United Kingdom. The causes are disputed, ranging from recession-related delays in visiting doctors to more long-term trends in moderating insurance premiums and reduced spending on structures and equipment. However, costs per capita continue to rise. Per capita cost increases have averaged 5. Costs relative to GDP have risen from Reasons include, among others: Higher unemployment due to the recession, which has limited the ability of consumers to purchase healthcare; Rising out-of-pocket payments; Deductibles the amount a person pays before insurance begins to cover claims have risen sharply. Workers must pay a larger share of their own health costs, and generally forces them to spend less; and The proportion of workers with employer-sponsored health insurance enrolled in a plan that required a deductible climbed to about three-quarters in from about half in Bloomberg reported in January If health insurance were cheaper, or the marketplace were structured so that most people bought health coverage for themselves rather than getting it with their jobs, people would be paid more and raises would be higher. Comparative effectiveness research would be one of many tools used by the IMAC. And ultimately, without a structure in place to help contain health care costs over the long term as the health market evolves, nothing else we do in fiscal policy will matter much, because eventually rising health care costs will overwhelm the federal budget. Washington Post columnist David Ignatius has also recommended that President Obama engage someone like Cortese to have a more active role in driving reform efforts. Several treatment alternatives may be available for a given medical condition, with significantly different costs yet no statistical difference in outcome. Such scenarios offer the opportunity to maintain or improve the quality of care, while significantly reducing costs, through comparative effectiveness research. According to economist Peter A. He described how the U. With a central oversight

panel the U. Medicare and Medicaid currently pay clinicians the same amount regardless of results. But there is a pilot program to increase payments for doctors who deliver high-quality care at lower cost, while reducing payments for those who deliver low-quality care at higher cost. Still another would test a system of penalties and rewards scaled to the quality of home health and rehabilitation care. Other experiments try moving medicine away from fee-for-service payment altogether. A bundled-payment provision would pay medical teams just one thirty-day fee for all the outpatient and inpatient services related to, say, an operation. This would give clinicians an incentive to work together to smooth care and reduce complications. These groups would be permitted to keep part of the savings they generate, as long as they meet quality and service thresholds. The bill has ideas for changes in other parts of the system, too. Some provisions attempt to improve efficiency through administrative reforms, by, for example, requiring insurance companies to create a single standardized form for insurance reimbursement, to alleviate the clerical burden on clinicians. There are tests of various kinds of community wellness programs. The legislation also continues a stimulus-package program that funds comparative-effectiveness researchâ€"testing existing treatments for a condition against one anotherâ€"because fewer treatment failures should mean lower costs. Official budget scores of universal health care proposals state that most of its savings would be from providing preventative care to the uninsured. Nearly half of these costs were paid for by the government via Medicare or Medicaid. State obesity rates ranged from Obesity rates were roughly equal among men and women. The study was performed by researchers at Cornell and Emory universities. One study in the Netherlands indicated that: At older ages, the highest yearly costs were incurred by the smoking group. However, because of differences in life expectancy life expectancy at age 20 was 5 years less for the obese group, and 8 years less for the smoking group, compared to the healthy-living group , total lifetime health spending was greatest for the healthy-living people, lowest for the smokers, and intermediate for the obese people. This was done at the urging of a Dr. Howard Brody, who published this recommendation in a article. The nine groups medical societies developed the lists after months of analyses and reviews of the medical literature by expert committees. The New York Times editorial board wrote: It is sound medicine and sound economics. These high-cost beneficiaries, compared with beneficiaries in the bottom 75 percent in terms of their spending, were slightly older, more likely to suffer from chronic conditions, such as coronary artery disease and diabetes, and more likely to die in a given year. Peter Orszag wrote in May His January version of the plan includes the transition of Medicare to a voucher system, meaning individuals would receive a voucher which could be used to purchase health insurance in the private market. This would not affect those near retirement or currently enrolled in Medicare. The median market share of the largest carrier was about 33 percent, with a range from about 14 percent in Texas to about 89 percent in North Dakota. The five largest carriers, when combined, represented three-quarters or more of the market in 19 of the 34 states supplying information, and they represented more than 90 percent in 7 of these states. Twenty-five of 37 states supplying information identified a Blue Cross and Blue Shield BCBS carrier as the largest carrier offering health insurance in the small group market, and in all but one of the remaining 12 states, a BCBS carrier was among the five largest. The median market share of all the BCBS carriers in the 34 states supplying information was about 34 percent, with a range from about 3 percent in Vermont to about 89 percent in North Dakota; in 9 of these states BCBS carriers combined for half or more of the market. The median market share of the largest carrier in the small group market was about 47 percent, with a range from about 21 percent in Arizona to about 96 percent in Alabama. In 31 of the 39 states supplying market share information, the top carrier had a market share of a third or more. The five largest carriers in the small group market, when combined, represented three quarters or more of the market in 34 of the 39 states supplying this information, and they represented 90 percent or more in 23 of these states. Thirty-six of the 44 states supplying information on the top carrier identified a Blue Cross and Blue Shield BCBS carrier as the largest carrier, and in all but 1 of the remaining 8 states, a BCBS carrier was among the five largest carriers. The median market share of all the BCBS carriers in the 38 states supplying this information was about 51 percent, with a range of less than 5 percent in Vermont and Wisconsin and more

than 90 percent in Alabama and North Dakota The result would be to afflict the afflicted, to make the lives of Americans with pre-existing conditions even harder. Two of these include: This provides a financial incentive to increase the costs of treatment provided. Patients that are fully insured have no financial incentive to minimize the cost when choosing among alternatives. The overall effect is to increase insurance premiums for all. He contrasted this with lower-cost areas that used salaried doctors and other techniques to reward value, referring to this as a "battle for the soul of American medicine. The provider network would also purchase insurance for catastrophic extremely high cost cases. Please consider splitting content into sub-articles, condensing it, or adding or removing subheadings. November Critics have argued that medical malpractice costs insurance and lawsuits, for example are significant and should be addressed via tort reform. And the reason tort reform is not on the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on. That is the plain and simple truth. For example, the current contingent fee system skews litigation towards high-value cases while ignoring meritorious small cases; aligning litigation more closely with merit might thus increase the number of small awards, offsetting any reduction in large awards. Bush Administration and members of Congress; CBO concluded that "the evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Such courts exist in other disciplines. In administrative health courts, an expert judge would decide cases based on best medical practice, writing an opinion that is subject to appeal to an appellate health court. There would also be a requirement of full disclosure by hospitals, and all facts would be fed back into the health care system so providers learn from their mistakes. Such an approach has been opposed by trial lawyer lobbyists. Writing in the Washington Post , cardiologist Arthur Feldman cited various studies that indicate the U. Writing in Forbes, a physician argued that this is a "tiny band-aid at best," advocating full loan repayments and guaranteed positions upon graduation. This drives some doctors into higher paying specialties as opposed to primary care. As specialists, they prescribe more expensive treatments. Making medical school free would help address the shortage in their view. Germany and France had approximately 3. A study by Price Waterhouse advanced several strategies for addressing the nursing shortage, including developing more public-private partnerships, federal and state-level grants for nursing students and educators, creating healthy work environments, using technology as a training tool, and designing more flexible roles for advanced practice nurses given their increased use as primary care providers. Although both theory and evidence suggest that workers ultimately finance their employment-based insurance through lower take-home pay, the cost is not evident to many workers According to the OECD, it "encourages the purchase of more generous insurance plans, notably plans with little cost sharing, thus exacerbating moral hazard". These two needs create cost-efficiency challenges for health care. The researchers found that only 3.

Chapter 4 : Key Proposals to Strengthen the Affordable Care Act

Proposals to Stimulate Competition in the Financing and Delivery of Health Care. September 30, Report.

Chapter 5 : Health care reforms proposed during the Obama administration - Wikipedia

Summary of Testimony Received on Proposals to Stimulate Competition in the Financing and Delivery of Health Care ï»¿ Unknown creator (United States. Congress.

Chapter 6 : Early Health Insurance Premium Proposals Indicate Hikes for

Full text of "Proposals to stimulate competition in the financing and delivery of health care: hearings before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, Ninety-seventh Congress,

first session, September 30, October 1, 2, ".

Chapter 7 : Medical Technology Under Proposals To Increase Competition in Health Care

Proposals to stimulate competition in the financing and delivery of health care: hearings before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, Ninety-seventh Congress, first session, September 30, October 1, 2,