TO: Ira Magaziner

FROM: David Nexon

DATE: 6/25/94

SUBJECT: Coverage of all children by July 1, 1995

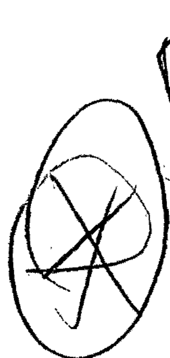
Attached is a draft of the proposal with suggestions as to how to get it in place immediately. Obviously, we would want to work on this further with Gary, Larry, and others, but we are convinced it can get started on a fast track. I understand that CBO has completed costing of the comparable Finance provision, although without the additional layering-on of a percent of income cap.

– Clarification!

* Kids & Pregnant women → 5%
* cost containment
* Trigger – no commission → What also does the Governor say
* no new program

Parker doesn't [illegible]

[illegible] LTC [illegible]



DRAFT

1:00 pm
7/25

A "FAST START" ON HEALTH INSURANCE COVERAGE FOR UNINSURED CHILDREN

Overview

The Riegle amendment adopted by the Finance Committee by a bi-partisan vote of 11-8 provides subsidies for private health insurance coverage of uninsured children. A maintenance of effort provision was also included for private employment-based coverage.

The amendment provides for full subsidies for children up to 185% of poverty, phasing out at 240% of poverty. This proposal would add to the amendment capping the percent of income that any family would have to pay for coverage of its children, e.g., at five percent. This limit would be layered on top of the Riegle subsidy schedule.

With this addition, enactment of the proposal would guarantee affordable coverage for every child in America as of the effective date of the provision. Currently, there are an estimated 5.9 million uninsured children under 18 years of age below185 percent of poverty. There are 1.1 million between 185 percent and 245 percent of poverty, and there are an additional 1.3 million with incomes above 245 percent of poverty.

Steps needed to start the program by July 1, 1995

--Establish a system to verify eligibility. The core administrative structure for establishing eligibility for this population already exists in state Medicaid programs. All states already have Medicaid extensions for pregnant women and young children to 133% of poverty, and 34 states already provide coverage to 185% of poverty. This system would be transitional, pending a non-welfare-based income verification system for low-income people generally. New York has the private insurance plans doing income verification under its program, although there has been some concern that the plans have not enforced income limits aggressively enough.

--Establish benefit package. The basic benefits will likely be established by the statute, with fleshing out of benefits by the National Board. It

seems unlikely that the National Board could be appointed, confirmed, and produce regulations that could be implemented by insurers by July 1, 1995 (although a possible fast-track procedure is described below). For child-only coverage, the Secretary of HHS could issue rules, consistent with the law, for interim community-rated coverage. Special rules would be established, as described below, for existing employment-based coverage.

--Assure availability of private coverage.

Option 1: General insurance reforms in place by July 1 (open enrollment, community-rating, pre-existing limits, guaranteed offer by businesses, etc.). Under this circumstance, the only additional requirement would be that all insurers offer a separately priced, child-only policy. If Option 2 is used, many of the special provisions would terminate at the same time as the general insurance reforms were phased-in.

Option 2: General insurance reforms not in place until January 1, 1996 or later.

--Community-rated coverage. Two approaches would be allowed. (a) would be the default if a state did not indicate it wanted option (b) and could get it going within a specified time frame:

a. All insurers currently selling policies in the small group and individual market would be required to make child-only coverage available on a community-rated basis. Child-only coverage would have to be priced at a specified fraction of the community-rated price for a single adult, based on the insurer's existing line of business (e.g., 50% of a single adult policy). Pricing would have to be certified by an actuary as representing a valid community rate, given the pricing of existing business. The people running the current New York state program felt this would be preferable to option b, which was the one they implemented.

b. States could issue an RFP and contract with one or more carriers to provide the standard coverage within a community-rating area. A number of states have already established such programs, and Blue Cross already makes child-only coverage available in 31 states.

--Employment-based coverage. Where an employer has offered

worker-only coverage or family coverage with no employer contribution, the employer would be required to establish a child-only category of coverage with the same benefits as the more general policy. Individuals who have not previously insured their children through the employer would be allowed to use their voucher to contribute to the cost of this coverage, if they preferred to do so rather than go through the community-rated pool.

--Establishment of community-rating pricing areas. Many states already have established such areas as part of their insurance regulation of the individual or small group market, or for Blue Cross rate-setting. There would be three interim options available:

o States elect to use existing community rating areas.

o States elect to establish new areas consistent with the requirements of the Act by the target date.

o Default would be to use Medicare carrier areas, which are large areas that conform roughly to current insurance company practices.

--Other health plan standards. Other health plan standards would be included in the act. While implementing regulations may not be fully developed, private plans would be expected to meet relevant standards of the Act during the interim period. As a practical matter, we can expect enforcement to be relatively minimal--but this is not crucial during the start-up phase.

--Pricing of vouchers. Vouchers would be priced based on the average of community-rated plans (under the default option) or based on the negotiated bids (under the alternative). We might consider, as a means of protecting Federal dollars, capping the voucher based on a projected price for each community rating area (in addition to whatever fall-back budget safeguards will be included in the overall bill).

--Make payments of voucher amounts to plans. States would generally perform this function. In most cases, this should not be difficult, since it essentially involves paying a bill submitted by an insurance company based on an eligibility determination already made by the state. Medicare carriers or FEHBP could perform this function as a default.

--Maintenance of effort/interaction with current Medicaid.

o Maintenance of effort. Employers would be required to maintain their current family plan offerings and contributions, consistent with the Riegle amendment. Individuals who currently accept employment-based policies for their children or where employers contribute more than 50 percent of the cost of coverage would not be eligible for the new program. This should be coupled with a non-discrimination requirement as an additional incentive for employers not to drop coverage.

This will obviously create some inequities, and there could be some erosion of current coverage over time, but it seems a reasonable approach for a transition program.

o Interaction with current Medicaid. Individuals currently receiving Medicaid would be required to stay with Medicaid until the program is integrated into the new system. Individuals qualifying for Medicaid under current standards could be given a choice or required to go to Medicaid first, depending on the cost implications.

Fast-tracking government. Independent of what is done on the children's initiative, the whole process of implementing reform could be speeded up by adoption of special procedures. Specifically:

o National Health Board. The healthcare reform statute can provide for naming an "interim" National Health Board (e.g. Cabinet Secretaries) as soon as the bill is signed or delegate interim regulatory authority to the Secretaries of HHS and Labor.

o Federal regulations. The reform statute can also provide for implementation under expedited procedures permitted by the Federal Administrative Procedures Act, i.e. issuance of immediately-effective "interim final" regulations.

FAX TO CHRIS JENNINGS

RE: ESTIMATES OF SENATE DRUG PROVISION

In reviewing the estimate of the monthly premium for the Senate drug provision, I discovered a problem with the estimate that we previously cleared.

Under HSA, beneficiaries will pay 25 percent of the cost of the new drug benefit. This 25 percent is computed the same way that it is determined for the rest of Part B -- the premium equals 25 percent of average per capita costs for <u>aged</u> beneficiaries. As you may recall, when the President's budget was prepared the actuary discovered that because of higher per capita use of drugs for the disabled compared to the elderly, a premium based on 25 percent of aged costs would finance approximately 22 percent of total costs. Up to this point, the model had been determining the premium based on 25 percent of total costs. As a result of this change our estimate of Federal costs went up and our estimate of premium revenues went down by the same amount.

I discovered today that the actuary had not adjusted the model to estimate premium revenues based on 22 percent of total costs instead of 25 percent. When this was corrected, the estimate increased from $91.1 billion to $95 billion. The attached table has the corrected estimate.

In reading through the specifications for the Senate benefit, I saw that they were not proposing to use the indexing methodology proposed in HSA (maintaining a constant percentage of beneficiaries meeting the deductible and cap) but instead were planning to index both to CPI-U. As indicated on the table, this would increase costs by approximately $5 billion over 98 - 2004.

Please give a call if you have any questions (528-0297).

Peter Hickman

Senate Drug Proposal with Two Indexing Options for Deductible And Out-of-Pocket Limit

Assumptions:
- Starts 1/1/98.
- Deductible=$500 in 1998.
- 20% coinsurance
- Out-of-pocket limit=$1200 in 1998.
- Dispensing fee=$5 in 1998. Indexed as in President's plan.

Net program cost - in billions

Fiscal Year	1998	1999	2000	2001	2002	2003	2004	1998-99	2000-4	98-2004
Constant % of Beneficairies Indexing	6.2	12.6	13.3	14.2	15.2	16.2	17.2	18.8	76.1	95.0
CPI Indexing	6.2	12.7	13.7	14.8	16.1	17.4	18.8	18.9	80.9	99.8

July 27, 1994 - HCFA OACT

DRAFT (7/26/94 #1)
BREAUX-LIEBERMAN PROPOSAL

PURPOSE: Attached is a proposal to ensure that the goal of universal coverage is met in the event that Congress fails to act on Commission recommendations under the process set forth in the Senate Finance Committee bill. The proposal would require the states to achieve universal coverage and would give them flexibility and resources to do so.

CONTEXT: The Finance Committee bill sets up a national commission that would report to Congress every two years on the status of the uninsured and suggest ways to expand coverage.

If less than 95% of the U.S. population is insured in 2002, the Commission would send recommendations to Congress on how those parts of the country that have not achieved 95% coverage could do so. These recommendations would be considered by Congress under fast-track procedures that would allow for relevant amendments but which would ultimately require that Congress take a vote. The following proposal would apply only if, at the end of fast-track procedures, Congress failed to pass legislation to reach universal coverage.

SUMMARY OF PROPOSAL: This proposal would set up a default process in the event that Congress fails to approve legislation (based on Commission recommendations) in the year 2002. States with less than 95% coverage would be required to submit a plan to the Department of Health and Human Services that would bring them to universal coverage.

The proposal was written with the following guiding principles in mind: (1) states should be given a reasonable amount of flexibility and resources so that they can act to expand coverage within their borders, (2) states should not be presented with an unfunded federal mandate, (3) the federal government should not promise the states more resources than can realistically be provided, and (4) any new commitment of federal resources must be fully financed.

The proposal would establish:

- **1995 TO 2002:** incentives and flexibility for states to encourage and enable states to act aggressively to reach 95% coverage;

- **BEGINNING IN 2002:** additional authorities that states can use to reach 95% coverage (should Congress fail to enact legislation based on Commission recommendations); and

- **CONSEQUENCES OF STATE INACTION AFTER 2002:** limited federal interventions in states that fail to make substantial progress within a reasonable period of time after the year 2002 (if Congress has failed to act).

DRAFT

Add new section II (E) to Senate Finance Committee mark:

E. DEFAULT STRATEGY FOR ASSURING UNIVERSAL COVERAGE

In the event that Congress fails to act on the recommendations of the Commission as described in section II (D), any state in which fewer than 95% of residents are insured must submit a plan of action to the Secretary of Health and Human Services for achieving 95% coverage. Flexibility will be permitted for states that have extremely high rates of uninsured.

Such plans shall address all relevant parties, including State and local governments, employers, employees, unemployed and low income individuals, beneficiaries of public programs, etc.

1995 TO 2002: The following provisions are designed to give states the resources and flexibility they need in order to reach the goal of universal coverage before the year 2002:

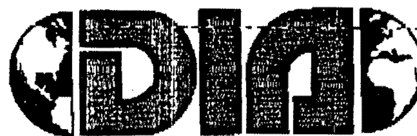
o Allow limited flexibility under ERISA: under a waiver process, states will be given limited authority to impose requirements on ERISA plans if they can demonstrate that these requirements would significantly increase coverage.

o Provide funding for state outreach efforts to low-income and other populations at risk of remaining uninsured. (Funds are intended for administrative and technical support.)

o Allow states to impose additional "risk adjustments" among health plans based on factors other than health status (such as geography) that are designed to encourage health plans to cover populations that are at risk of remaining uninsured.

o Provide funding and additional flexibility to states to encourage the development of provider networks in rural and urban underserved areas. (Funds are intended for administrative and technical support.)

o Provide funding for state planning and reporting requirements.



Talk to C. Jennings
Keep will be there

Drug Information Association

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June 21, 1994

Post-it® Fax Note 7671	Date 7-14	# of pages ▸ 5
To Gary Cohen	From Dr. Al Giovenella	
Co./Dept.	Co.	
Phone #	Phone #	
Fax # 202-456-6115	Fax #	

Hillary Rodham Clinton
Office of the First Lady
Old Executive Office Building
Room 100
Washington, D.C. 20500

Dear Mrs. Clinton:

Key members of the pharmaceutical industry, the biotechnology industry and other health care stakeholders such as Managed Care, Pharmacy Management Companies and those academicians involved in shaping medical school curricula will be meeting at the J. W. Marriott in Washington D.C. on July 26 and 27, 1994.

The purpose of this symposium will be to consider strategies and affects of innovation and regulation for each stakeholder Many innovative strategies that offer a wide variety of alternatives for delivery of health care will be demonstrated.

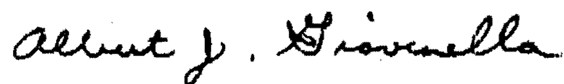
Some examples of the threshold presentations will include Pharmaceutical Research Manufacturers Association President, Gerald Mossinghoff, speaking on "The New Direction for the Industry", Managed Prescription Services (PBM Co.) Vice President, Dr. Arthur Shinn, speaking on "Bringing Access to the Underserved and Underinsured", and Dr. Michael Wilkes of U.C.L.A. will be talking on "The Curriculum Changes Necessary to Increase the Number of Primary Care Physicians".

There is no pharmaceutical money involved in this conference. The Drug Information Association is a nonprofit organization.

This conference would be tremendously enhanced and it would please all of us to hear your visions of what we need to do toward a better health care system. Please consider being a part of our symposium at this crucial time and give us your response as quickly as your busy schedule will allow.

Thank you for your consideration.

Sincerely,



Dr. Albert J. Giovenella
Health Alliance Executive
MHHD

University of Pennsylvania
School of Dental Medicine

sb/AJG

Drug Information Association

SYMPOSIUM

HEALTH CARE REFORM THROUGH INNOVATION

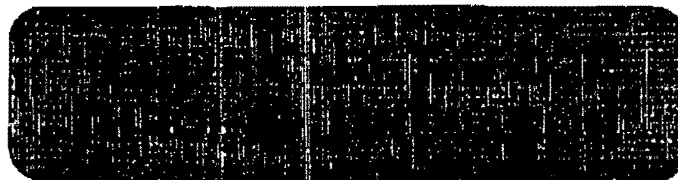
July 26-27, 1994
J. W. Marriott Hotel, Washington, D.C.

Program Chairperson
Albert Giovenella, Ph.D.
Health Alliance Executive
Merck Human Health Division
University of Pennsylvania
School of Dental Medicine

The pharmaceutical industry, the biotechnology industry, and other health care stakeholders are facing great challenges that will offer the opportunity to gain control of costs and benefits, and that will ultimately provide quality health care to all people in the United States.

This symposium will consider the strategies and effects of innovation and regulation for each stakeholder. Many innovative strategies that offer a wide variety of alternatives for the delivery of health care will be demonstrated. The many meaningful reforms that have already been accomplished will be highlighted during these discussions.

Drug Information Association



July 26 - 27, 1994
J. W. Marriott Hotel
Washington, DC

Program Chairman
Albert Giovenella, Ph.D.
Health Alliance Executive
Merck Human Health Division
University of Pennsylvania
School of Dental Medicine

Monday, July 25, 1994

4:00-6:00pm **Registration**

Tuesday, July 26, 1994

7:30am **Registration**

8:30am **Welcome and Introduction**
Dr. Albert Giovenella
Health Alliance Executive
Merck Human Health Division
Instructor, University of Pennsylvania School of Dental Medicine

9:00am Keynote Speaker
Pharmaceutical Industry's Leadership in Health Care Reform
Gerald J. Mossinghoff, Esq.
President, Pharmaceutical Research Manufacturers of America (formerly PMA)

Economic Effects of Reform on Innovation
Alan Hillman, M.D., M.B.A.
Director, Center for Health Policy
Leonard Davis Institute of Health Economics
University of Pennsylvania

9:30am Current Legislation Impacting the Industry
Michael Hudson
Senior Vice President
Strategic Management Associates Inc.

10:00am **Coffee Break**

10:30am The Crushing Effects of Reform on Biotechnology
Carl B. Feldbaum, Esq. (invited)
President, Biotechnology Industry Organization

11:00am Effects on Pharmacists
Dr. William Zellner
Vice President of Professional and Government Affairs
American Society of Hospital Pharmacists

11:30am Panel Discussion

12:00pm **Luncheon**

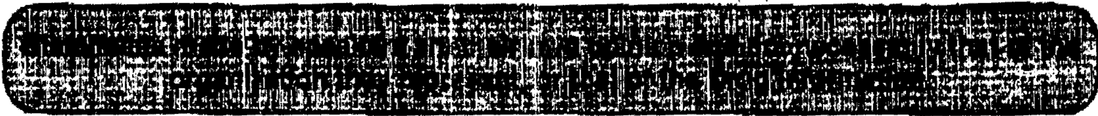
1:30pm The Newly-Empowered Consumer
Dr. Heather Paul
Executive Director
National Safe Kids Campaign

2:00pm The Ethics of Health Care Reform
Dr. Dan Brock
Professor, Department of Philosophy and Center for Biomedical Ethics
Brown University

2:30pm	The Necessity of Partnerships for Survival **Dr. Richard Goodstein** Senior Director, Medical Partnering Merck Human Health Division
3:00pm	**Coffee Break**
3:30pm	Managed Care and Mental Health Care **Dr. Ian Shaffer** Medical Director Value Behavioral Health
4:00pm	Diversity: An Important Ingredient in Any Reform Plan **Mr. Michael A. Caso** Executive Vice President Vanderveer Group
4:30pm	Panel Discussion
5:00pm	**Tuesday Meeting Adjourned**

Wednesday, July 27, 1994

8:30am	The Role of the Medical School in Health Care Reform **Dr. Michael Wilkes** UCLA School of Medicine, Director of UCLA Doctoring, Curriculum Division of General Internal Medicine
9:00am	The Inroads of Innovations by PBM's **Dr. Arthur F. Shinn** Vice President Managed Prescription Services
9:30am	**Coffee Break**
9:45am	Outcomes Research: Economic vs Medical Benefits **Dr. Robert Epstein** Executive Director, Outcomes Research, Merck & Co.
10:15am	Closing - **Dr. Albert Giovenella**



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225-3147

Bill Schultz -
Marc Childress - 224-7675
Teresa Forster 224-5364
Marc Hayes -
G Sen. Bonds

July 26, 1994

POST-MANDATE PAYMENTS

1. **Employer Payment Responsibility.** In general, employers (other than exempt employers) are required to make a premium payment on behalf of all qualifying employees.

   a. **Definitions:**

      i. "Contributing employer" means an employer with 25 or more employees or an employer with fewer than 25 employees that elects to be a contributing employer.

         A self-employed person with at least one full-time employee could elect to be treated as a contributing employer. *Note: Senate Labor bill does not require full-time employee.* If the self-employed person makes such an election, the person is treated as an employee of him or herself and is deemed to pay wages to him or herself equal to self-employment income. See Senate Labor bill for details (including closely held businesses, etc.).

      ii. "Exempt employer means an employer with less than 25 employees that does not elect to be a contributing employer. A self-employed person without at least one full-time employee is treated in the same manner as a worker in an exempt firm.

      Note: This is essentially the construct of the Senate Labor bill; a key definition is he definition of "qualifying employee" because it does not include an employee working for an exempt firm.

   b. **Community-rated employers.** For full-time employees, the employer is required to pay at least 50% of the weighted average premium of the HIPC chosen by the employer ("HIPC weighted average premium") for the employee's class of family enrollment. For part-time employees, the employer pays a pro-rated share of the HIPC weighted average premium.

      Note: May need to add large employer opt-in credit and potentially excess premium credit if premium caps are used.

   c. **Experience-rated employers.** For full-time employees, the employer is required to pay at least 50% of the weighted average premium of the plans offered by the employer. For part-time employees, the employer pays a pro-rated share of the HIPC weighted average premium.

      An experience-rated plan sponsor may establish premium areas (consistent with regulations of the Secretary of ?). Experience-rated employers may base

their contributions on the premiums of the plans offered in each premium area.

d. **Non-enrolling Employee Credit.** A non-enrolling employee credit is calculated as follows:

i. **Non-enrolling employee credit for couples.**

(1) For couples, the credit is equal to:

(a) The total of employer payments (without regard to any subsidies) made on behalf of non-enrolling employees in the couples class of enrollment in an HCCA minus the amount described in (2), divided by

(b) The number of families in the couple class of enrollment, plus the number of "additional workers" within the couple class in the HCCA.

(2) The amount described in this paragraph is the credit earned by couples with more than a years worth of work in a year (and provided as a family credit to these families for a period of time in which they do not have full-time work).

ii. **Non-enrolling employee credit for single-parent and two-parent families.**

(1) For single-parent and two-parent families, the credit is equal to:

(a) The total of employer payments (without regard to any subsidies) made on behalf of non-enrolling employees in the two-parent family class of enrollment in an HCCA, minus the amount in described in (2), divided by

(b) The number of families in the single-parent and two-parent classes of enrollment, plus the number of "additional workers" within such classes in the HCCA.

(2) The amount described in this paragraph is the credit earned by two-parent families with more than a years worth of work in a year (and provided as a family credit to these families for a period of time in which they do not have full-time work).

iii. Definitions:

A "non-enrolling employee" is an employee of an employer that does not enroll in a health plan offered by that employer (i.e., the employee

enrolls in a plan offered by a spouse's employer)

"Additional workers" are as defined in the HSA.

e. **Exempt employers:** Exempt employers are not required to make payments on behalf of their employees.

f. **Self-employed:** Are treated as workers in exempt firm.

2. **Employer subsidies.** In general, the 50% required payment for contributing employers for an employee is capped at 8% of the employee's wage, limited to the reference premium (as described below).

a. **Reference premium.** A reference premium is defined for each HCCA (See specifications for High Cost Plan Assessment).

b. **Subsidy amount.** (Same for community-rated and experience-rated employers). Contributing employers receive a subsidy with respect to the payment for an employee equal to the following:

Subsidy = the lower of (i) the applicable employer premium obligation for an employee (net of the non-enrolling credit) or (ii) 50% of the reference premium for the class of family enrollment for the area, minus 8% of the employee's wages, but in no case less than zero.

c. Self employed person (with at least one full-time employee) that elects to be a contributing employer receives a subsidy as in b.

d. State and local governments are not eligible for employer subsidies.

3. **Family Payment Responsibilities.** In general, families are required to enroll in an applicable health plan and make payments towards the premium for the plan.

a. **Family Share of the Premium.** Each family enrolled in a community-rated or experience-rated health plan is responsible for payment of the family share.

i. **Community-rated health plans.** The family share for a family enrolled in a community-rated health plan is the sum of the amounts in (1) reduced by the amounts in (2).

(1) (a) The applicable plan premium. (!<u>See</u> Senate Labor bill for details!)

(b) 20% of the family collection shortfall add-on for the applicable class and HCCA. Families with no payment responsibility are exempt from paying the family

collection shortfall add–on.

(c) Any applicable marketing of HIPC fees.

(2) (a) The family credit.

(b) Any income–related subsidies.

(c) *[?NOTE: large group sponsor opt–in and the potentially excess premium credit may need to be added if premium caps are included.?]*

(3) (a) The family credit for a month for a family that enrolls through an employer is equal to the employer's required premium payment for the family.

(b) The family credit for a month for a family that is not enrolled through an employer is equal to 50% of the estimated weighted average of the employer premium payments (without regard to subsidies) made by community–rated employers in the HCCA for the month.

ii. **Experience–rated health plans.** The family share for a family enrolled in an experience–rated health plan is the amount described in (1) reduced by the amounts in (2).

(1) The applicable plan premium. (!See Senate Labor bill for details!)

(2) (a) The family credit.

(b) Any income–related subsidies.

(3) The family credit for a month for a family that enrolls through an employer is equal to the employer's required premium payment for the family.

iii. The family share for a family cannot be less than zero.

4. **Subsidies for the Family Share of the Premium.** In general, families receive subsidies which cap their premium payment responsibility for the family share of the premium as a percentage of adjusted gross income, limited to the reference premium (as described below).

a. **Amount of subsidy.** The subsidy toward the family share of the premium is equal to:

i. 50% of lesser of (1) the weighted average community-rated premium in the HCCA for the applicable class of family enrollment; (2) the reference premium in the HCCA for the applicable class of family enrollment and (3) ??the applicable employer premium obligation for the employee (without regard of the non-enrolling credit)??, reduced, but not below zero by

ii. The sum of (1) the family obligation amount and (2) the amount of any voluntary employer payment (in excess of the required employer premium obligation).

b. **Definition of the family obligation amount.**

i. The family obligation amount is zero if the family's adjusted income is less than the income threshold amount ($1000 initially, indexed as in Senate Labor Bill);

ii. If a family's adjusted income is above the threshold, the family obligation amount is the sum of the following:

(1) The product of (a) the initial marginal rate for the applicable class of family enrollment and (b) the amount by which the family adjusted income (not including any portion that exceeds the applicable poverty level) exceeds the income threshold amount, and

(2) The product of (a) the final marginal rate for the applicable class of family enrollment and (b) the amount by which the adjusted income exceeds 100% of the poverty level but is less than 200% of the poverty level.

iii. The initial marginal rate is the ratio of 4% of the applicable poverty level for the class of enrollment to the amount by which such poverty level exceeds the income threshold amount.

iv. The final marginal rate is 12%.

v. In no case shall a family's obligation amount exceed 8% of the family's adjusted income. For families with adjusted income in excess of 200% of the applicable poverty level for the class of family enrollment, the family obligation amount is equal to 8% of income.

vi. !The dollar amounts and percentages are indexed as in Senate Labor Bill.!

5. **Repayment of the family credit.** In general, families without a year of full-time

employment are required to repay all or a portion of the family credit they receive.

a. **Repayment liability.** The repayment liability for a family for a month is the amount of the family credit for a month.
!Note: Since self-employed are treated as exempt workers, there is no need for special provision as in Senate Labor!

b. **No liability for full-time employment; reduction in liability for part-time employment.** [!See Section 6111 of Senate Labor Bill for details!]. The repayment liability is reduced (consistent with regulation established by the Secretary of ?) based on employer premiums payable for a family member that this a qualifying employee. In no case shall the reduction result in any payment owing to a family.

The net is the "repayment amount."

c. **Subsidy based on income for repayment of family credit.** In general, a family with wage-adjusted income of income of less than 200 percent of the applicable poverty is eligible for a subsidy for any repayment amount under this [section].

i. **Amount of subsidy.** The subsidy toward the repayment amount is equal to:

(1) Reference-adjusted repayment amount, reduced by, but not below zero,

(2) The family credit repayment obligation amount.

ii. **Definition of the family credit repayment obligation amount.**

(1) The amount is zero if the family's adjusted income is less than the income threshold amount ($1000 initially, indexed as in Senate Labor Bill);

(2) If a family's adjusted income is above the threshold, the amount is the sum of the following:

(a) The product of (i) the initial marginal rate for the applicable class of family enrollment and (ii) the amount by which the family adjusted income (not including any portion that exceeds the applicable poverty level) exceeds the income threshold amount, and

(b) The product of (i) the final marginal rate for the applicable class of family enrollment and (ii) the amount

by which the adjusted income exceeds 100% of the poverty level but is less than 200% of the poverty level.

iii. The initial marginal rate is the ratio of 4% of the applicable poverty level for the class of enrollment to the amount by which such poverty level exceeds the income threshold amount.

iv. The final marginal rate for a year for a class of family enrollment is the ratio of:

(1) The amount by which the reference-adjusted repayment amount exceeds 4% of the applicable poverty level for the applicable class of family enrollment for a year, to

(2) 100% of such poverty level.

Note: the reference adjusted repayment amount is used to limit the subsidies to the reference premium level.

v. The reference-adjusted repayment amount is the repayment amount multiplied by the ratio of:

(1) The reference premium for the class of family enrollment for the HCCA, to

(2) Estimated weighted average of the employer premium payments (without regard to subsidies or non-enrolling employee credits) made by community-rated employers in the HCCA. [!Note: this is the same amount as the family credit for nonworking families, except that it is without regard to the non-enrolling employee credit.]

vi. !The dollar amounts and percentages are indexed as in Senate Labor Bill!

vii. !See the definition of wage-adjusted income in Senate Labor Bill!

List of stuff to be worried over:

1. Bad debt; need to correct the calculation of the collection shortfall add-ons.
2. Calculate how premiums build up.
3. Effect of the trigger; clarify to whom mandates apply; boundry issues. Talk to Parashar about conforming applicable plan definitions, etc.
4. Define enroll through an employer
5. adjustment/errors and borrowing issues
6. Think about this where contiguous states are not using same years.

Managed Prescription Services®

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Vice President, Clinical Services
General Manager

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FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

TO: Mr. Chris Jennings

FROM: Len Nichols

Fax Destination
Organization:
Phone Number:

Number of Attached Pages: 1

Notes:

This is based on conversation last night about "step-down."
Please call Ashish Sahni at 5-3844 if problems.

HD Fax Number: 202/395-3910
Voice Confirmation: 202/395-4922
202/395-4926
202/395-3844

DRAFT

Compared to Baseline Private Health Insurance Premiums:

	1997		2004	
	HSA	Senate	HSA	Senate
Benefit Package	5	-3	5	-3
Medicaid Cost Shift	3	1	3	2.4
Risk Adjustment	1.8	0	1.8	0
High Cost Plan	na	0	na	2
Uncompensated Care	-8	-5	-8	-8
Small firm exemption	-6	0	-6	0
Administrative load	1.2	0	1.2	0
Academic Health Centers	1.5	1.75	1.5	1.75
NET Effect on Private Premiums	**-1.5**	**-5.25**	**-1.5**	**-4.85**

DRAFT

DRAFT

ID: JUL 27'94 9:16 No.003 P.02

B. ADDITIONAL SUBSIDIES FOR UNINSURED KIDS

1996

1. **Eligibility** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Infants who are currently covered to 133 percent of poverty, with an option to 185 percent of poverty, would be covered up 185 percent of poverty.

   b. Children up to age 6 who are currently covered up to 133 percent of poverty would be covered up to 185 percent of poverty.

   c. Children between ages 6 and 19 who are currently covered up 100 to percent of poverty on a phased-in basis would be covered up to 185 percent of poverty.

   d. Children in 1115 waiver states who are currently covered to various degrees would be covered up to 185 percent of poverty. States that currently use 1902(r)(2) to cover children at higher income levels could continue to cover these persons, but with 100% Federal financing only for those with income up to 185 percent of poverty.

2. **Coverage through Private Plans** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, State options include:

   a) Family option of employer plan: A state may elect to enroll children in a family option within the option of the group health plans offered to the caretaker relative.

   b) Family option of state employee plan: a state may elect to enroll the children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c) Health Maintenance Organizations: a state may elect to enroll the children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To JENNINGS From THORPE

Dept./Agency Phone #

d) A state may elect to enroll children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for the services covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

3. **Financing** The Federal government would provide the following Federal matching through Medicaid.

   a. All current eligibility categories would continue to matched at the state's regular Medicaid matching rate (FMAP), except as noted below.

      1) Coverage for infants with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

      2) Coverage for children up to age 6 with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

      3) As of 1/1/96, coverage for children born after 10/1/83 up to age 19 (children ages 14 through 18) with family incomes above AFDC but below 100 percent of poverty would be 100 percent Federally financed.

      4) Coverage for children age 7 up to age 19 with family incomes between 100 percent and 185 percent of poverty would be 100 percent Federally financed.

      5) Coverage for children in 1115 waiver states who are currently covered at various levels of income would be 100 percent Federally financed up to 185 percent of poverty. Individuals covered through the 1115 waiver above the 185 percent threshold would no longer be eligible for Federal financing; i.e., all Statewide waivers would be terminated.

      6) Children in states that use more liberal eligibility rules under 1902(r)(2) in families with incomes up to 185 percent of

poverty would be covered at the levels indicated above. Children covered with family income above the 185 percent threshold would no longer be covered; i.e., all 1902(r) changes would be terminated.

1997

1. Eligibility In general, children up to age 19 who have not been covered by health insurance for at least six months (could be a year if dropping employer coverage is an issue) and who are in families with incomes up to 240 percent of poverty would be eligible for a voucher toward insurance coverage.

    a. Children in a family would not be eligible for this program if the children are eligible for coverage under an employer's plan where the employer offers to contribute at least 80 percent (could make it a lower level if there would be an assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a single-parent or two-parent family policy.

    b. To be eligible for the program, families would be required to enroll all eligible dependent children.

    c. Children who were covered under a state's Medicaid program (cash or noncash) as of December 1996 would not be required to meet the six month previously-uninsured test.

2. Amount of Subsidy

    a. Eligible children in families with income up to 185 percent of poverty would receive a voucher for the full premium for the appropriate children's policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA).

    b. Eligible children in families with incomes between 185 percent and 240 percent of poverty would receive a voucher for a portion of the premium (calculated on a sliding scale, phasing out at 240 percent of poverty) for the appropriate children's policy (limited as in a. above).

3. Use of subsidies Community-rated health plans would accept vouchers toward payment of coverage.

    a. Community-rated health plans would create two categories of children's coverage; single child and multiple child.

b. These categories would be tied to the premiums charged for two-parent family coverage. The National Board (or HCFA) would determine the average cost of insuring children and would express it as a national percentage for family coverage. For example, the single child policy might be one-third of the premium for the two-parent family policy and the multiple child policy might be one-half of the two-parent family premium.

c. Eligible children with a parent covered by a community-rated or experience-rated plan could use their voucher to be covered under the parent's policy.

4. Nondiscrimination To protect the subsidy program from the incentives for employers to drop coverage (and/or contributions) for dependent children, nondiscrimination rules would apply to employer's decisions to offer coverage and the amount they contribute for dependent children. Nondiscrimination rules would apply by class of employee (i.e. full-time or part-time).

5. Dual Eligibility For families that are eligible for a subsidy under the kids program and under the low income or unemployed voucher program:

a. The family would receive the sum of: the voucher amount for the kids and the applicable low-income (or unemployed) voucher amount for the family.

b. The voucher for the low income voucher program would be calculated using the poverty level based on the entire family, but the premium would be the applicable premium for the entire family minus the premium applicable for the kids alone.

c. A family may use the children's voucher and the low-income voucher to purchase separate policies or combine their value toward one policy.

6. Wrap-around Benefits Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

C. ADDITIONAL SUBSIDIES FOR PREGNANT WOMEN

<u>1996</u>

1. **Eligibility** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Pregnant women who are currently covered to 133 percent of poverty, with an option to 185 percent, would be covered up 185 percent of poverty.

   b. Pregnant women in 1115 waiver states who are currently covered to various degrees would be covered up to 185 percent of poverty. States that currently use 1902(r)(2) to cover pregnant women at higher income levels could continue to cover these persons, but with 100 percent Federal financing only for those with income up to 185 percent of poverty.

2. **Coverage through Private Plans** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a) <u>Family option of employer plan</u>: A state may elect to enroll pregnant women in a family option within the option of the group health plans offered to the caretaker relative.

   b) <u>Family option of state employee plan</u>: a state may elect to enroll pregnant women in a family option within the options of the group health plan or plans offered by the state to state employees.

   c) <u>Health Maintenance Organizations</u>: a state may elect to enroll pregnant women in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

   d) A state may elect to enroll pregnant women in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

3. **Financing** The Federal government would provide the following Federal matching through Medicaid.

   a. All current eligibility categories would continue to matched at the State's regular Medicaid matching rate (FMAP), except as noted below.

      1) Coverage for pregnant women with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

      2) Coverage for pregnant women in 1115 waiver states who are currently covered at various levels of income would be 100 percent Federally financed up to 185 percent of poverty. Individuals covered through the 1115 waiver above the 185 percent threshold would no longer be eligible for Federal financing; i.e., all Statewide waivers would be terminated.

      6) Pregnant women in states that use more liberal eligibility rules under 1902(r)(2) in families with incomes up to 185 percent of poverty would be covered at the levels indicated above. Individuals covered with family income above the 185 percent threshold would no longer be covered; i.e., all 1902(r) changes would be terminated.

<u>1997</u>

1. <u>Eligibility</u> In general, pregnant women who have not been covered by health insurance for at least six months (could be a year if dropping employer coverage is an issue) and who are in families with incomes up to 240 percent of poverty would be eligible for a voucher toward insurance coverage.

   a. Pregnant women would not be eligible for this subsidy if they have available an employer's plan where the employer offers to contribute at least 80 percent (could make it a lower level if there would be an assumption that employers would reduce coverage for dependents;

note nondiscrimination rule!) toward the cost of a policy covering the women.

b. Pregnant women who are covered under a state's Medicaid program (cash or noncash) as of December 1996 would not be required to meet the six-month previously uninsured criteria.

c. Eligibility would continue for three months after delivery.

d. Pregnancy would not be treated as a pre-existing condition.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

2. Amount of Subsidy

a. Eligible women in families with income up to 185 percent of poverty would receive a voucher for the full premium for a single policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA.)

b. Eligible women in families with incomes between 185 percent and 240 percent of poverty would receive a voucher for a portion of the premium (calculated on a sliding scale, phasing out at 240 percent of poverty) for the single policy (limited as in a. above).

3. Use of Subsidies Community-rated health plans would accept vouchers toward payment for coverage. A pregnant woman could use the voucher toward the purchase of a single policy or toward the purchase of a couple, single-parent or two-parent policy, as appropriate.

4. Dual Eligibility For families that are eligible for a subsidy under the pregnant women program and under the low-income voucher or unemployed program:

a. The family would receive the sum of: the voucher amount for the pregnant woman and the applicable low income (or unemployed) voucher for the family.

b. The voucher for the low-income program would be calculated using the poverty level based on the entire family, but the premium would be the applicable premium for the entire family minus the premium applicable for the pregnant woman alone.

c. A family may use the pregnant woman voucher and the low-income voucher to purchase separate policies or combine their values toward one policy.

d. A family eligible for the low income (or unemployed), pregnant woman, and kids subsidy programs would be treated in the same way as described above, except that the applicable premium for the low-income (or unemployed) voucher program would be the applicable premium for the entire family minus the premiums applicable for the pregnant woman alone and the kids alone.

The applicable premium for the low-income (or unemployed) voucher program could not be less than zero.

D. SUBSIDIES FOR PEOPLE LEAVING WELFARE FOR WORK

<u>1996</u>

1. **Policy** To provide subsidies for people leaving welfare for work, the existing Medicaid transition benefit would be extended to cover eligible individuals for 24 months.

2. **Duration of Coverage** Current law allows for a simple 6-month extension, and then a more complex second 6-month extension. We recommend eliminating the second extension and lengthening the first by 18 months to create a single 24-month transition benefit.

3. **Eligibility** Currently, the two-phased extension terminates if the family no longer has a dependent child. In the health reform context, family policies are provided to various family configurations, not just to couples with dependent children. For this reason, as well as to provide additional work incentives, we recommend striking the "termination for no dependent child" provision.

   In addition to those who have been off of welfare for work for one year, those who are in their second year off of welfare for work and who are currently uninsured would be eligible for this program.

4. **Coverage through Private Plans** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a) <u>Family option of employer plan</u>: A state may elect to enroll a caretaker relative and dependent children in a family option within the option of the group health plans offered to the caretaker relative.

   b) <u>Family option of state employee plan</u>: a state may elect to enroll the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c) <u>Health Maintenance Organizations</u>: a state may elect to enroll the caretaker relative and dependent children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d) A state may elect to enroll the caretaker relative and dependent children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

5. **Financing** The Federal government would cover 100 percent of the expense related to this expansion.

<u>1997</u>

1. **Eligibility** Welfare recipients who return to work would receive subsidized coverage for two years.

2. **Amount of Subsidy** Instead of receiving Medicaid coverage, welfare recipients returning to work would receive a full premium subsidy for the entire family (i.e. the family would receive a low-income voucher as if it had income below 75 percent of the poverty level).

3. **Wrap-around Benefits** Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans. Because Medicaid is a secondary payer when a recipient has private coverage, the program would provide coverage for supplemental services for low income groups currently entitled to Medicaid.

DRAFT

MEMORANDUM

TO: The President

FROM: Senator Mitchell

SUBJECT: Follow up on July 21 Health Meeting

DATE: July 22, 1994

DRAFT

During our meeting last night you asked for additional information about (1) why an employer mandate system costs more than a system without a mandate, and (2) how a system without a mandate could achieve 95 percent coverage. Outlined below is some further information on these two issues.

DRAFT

Costs of a Mandate:

A mandatory system is more expensive than a system without a mandate for a couple of reasons.

First, since virtually all Americans would have health care insurance under a mandatory system, the federal government would be subsidizing more individuals and employers than it would under a non-mandate system. We hope, for example, that a system of targeted subsidies would expand coverage to about 95 percent of the population. While this represents a substantial increase over current levels, it would still be less than the 98 or 99 percent coverage that would be achieved under a mandatory system. This extra three or four percentage points represents 8-10 million people, most of whom would be eligible for federal subsidies. Providing these subsidies under a mandatory system would increase federal costs substantially. For example, adding a mandate to one voluntary plan currently under review would increase the plan's ten year costs by $138 billion.

A second reason why a system with an employer mandate is more expensive relates to the efficiency and generosity of employer subsidies typically available in a mandatory system. Most mandatory proposals include subsidies for employers which would cap employers' premium payments at a certain percent of each worker's income. While these employer subsidies tend to target lower income workers, they are available to all employers, including those currently offering insurance to their lower wage workers. Such a subsidy regime tends to be less efficient than employer subsidies under a voluntary system, which are usually limited to currently uninsured workers.

DRAFT

DRAFT DRAFT

95 Percent Coverage under a Voluntary System:

The proposal which I am now considering includes additional targeted subsidy programs that should bring the percentage of the population with insurance up to at least 95 percent. That legislation would include the following targeted subsidy programs:

- o Low-income subsidies for the general population that phase out between a range of 75 percent and 200 percent of poverty. This would include an outreach program whereby individuals presumptively eligible for full subsidies (those at less than 75 percent of poverty) would be signed up for health insurance at the point of service. This subsidy is estimated to reduce the number of uninsured by about 10-12 million people, raising the percentage of the population covered by about 4-5 percent.

- o The purchase of health insurance for AFDC recipients that find work would be fully subsidized for two years. Currently they are fully subsidized for one year. It is estimated that this would increase coverage by about 2 million people, raising the percentage of the population insured by a little less than 1 percent.

- o The income of insured working individuals who become unemployed would be calculated by disregarding unemployment insurance income and 75 percent of their job income. This would make more unemployed individuals eligible for the low income subsidies, thus increasing coverage. It is estimated that this would increase the number of insured by about 4 million people, raising the percentage of the population insured by a little less than 2 percent.

- o The Riegle amendment to the Finance-reported bill would be included to provide higher subsidies to pregnant women and children. It is estimated that this would increase the number of insured by about 4 million people, raising the percentage of the population insured by about 2 percent.

- o Two employment based subsidies would be provided to encourage employers to expand coverage. The first would provide employers of any size a subsidy on their share of the premium up to 50 percent so that such premium does not exceed 8 percent of an individual employee's wages. This would only be available for those employees not now covered, where health insurance is offered to all workers in the firm. The second program would be targeted to firms with under 25 employees who do not now provide coverage. It would permit the employer to share in both the low income household subsidies and the 8 percent of wage employer subsidies where insurance coverage is offered to all employees. It is estimated that these programs together would increase the number of insured by about 4 million people, raising the percentage of the population insured by somewhat less than 2 percent.

DRAFT

In total these targeted subsidy programs would increase the number of insured by about 25-27 million people, leaving about 13 to 15 million people uninsured. The percentage of the population with insurance would rise to about 95 percent.

These numbers are consistent with the work of CBO on the Cooper bill. That legislation provides for a system of household subsidies that pay for the full cost of health insurance for families below poverty. The subsidies are phased out between 100 and 200 percent of poverty. CBO estimated that this would result in an increase in the percentage of the population with insurance from 85 percent to 91 percent.

The Finance Committee reported bill includes the same subsidies, plus a program added in a Riegle amendment that provides more generous subsidies for the purchase of health insurance by pregnant women and children. Under this provision, full subsidies for this population would be provided up to 185 percent of poverty, phased out by 240 percent of poverty. Although CBO has not yet released its analysis of the Finance bill, the Riegle provision should increase coverage by another 2 percent. That would mean the Finance Committee bill would increase the percentage of the population with insurance to 93 percent.

DRAFT

TO: HAROLD ICKES, DEPUTY CHIEF OF STAFF
ALEXIS HERMAN, ASSISTANT TO THE PRESIDENT
IRA MAGAZINER, SENIOR ADVISOR TO THE PRESIDENT
GREG LAWER, DIRECTOR OF THE DELIVERY ROOM
JACK LEW, SPECIAL ASSISTANT TO THE PRESIDENT
✓CHRIS JENNINGS, SPECIAL ASSISTANT TO THE PRESIDENT

FROM: CAREN WILCOX

DATE: JULY 26, 1994

RE: NACDS

I've attached the following for your information.

Activities Conducted to Support President Clinton's Health Care Reform Initiative
By the Community Retail Pharmacy Health Care Reform Coalition

- The Community Retail Pharmacy Coalition, consisting of the National Association of Chain Drug Stores (NACDS) and the National Association of Retail Druggists (NARD) was one of the first groups to endorse the President's health care reform plan and has consistently been highly vocal and active in generating support among its members, its pharmacy customers and the elderly.

- The Coalition is particularly supportive of the pharmacy-related provisions of the HSA, especially the Medicare Outpatient Drug Benefit. The Coalition's primary issue is the provision requiring drug manufacturers to give equal access to discounts for purchasers meeting the same terms and conditions established by the manufacturer.

- Currently, manufacturers give significant discounts to preferred purchasers of prescription drugs (mail order pharmacy, HMOs, etc.). The cost of these discounts are shifted to retail consumers. Consequently, every consumer who purchases prescription products in a local pharmacy -- including senior citizens -- subsidizes the lower prices given to the preferred buyers. The President's proposal ends this practice by requiring that the discounts be offered to retail pharmacies if they meet the terms and conditions set by the manufacturer. The Coalition does not seek favorable treatment, only equitable treatment. All consumers -- especially senior citizens -- will benefit from this provision and costs to the federal government will be lower.

- The Coalition took the lead in establishing the Small Business Coalition for Health Care Reform, which today consists of 29 national organizations representing more than 625,000 small businesses employing more than 5.5 million Americans. The Small Business Coalition actively supports universal coverage with a shared responsibility between employer and employee, and actively counters the misinformation and opposition activities of the National Federation of Independent Business. Activities undertaken by the Small Business Coalition include letter writing campaigns, and an aggressive program of editorial board visits and media interviews.

- Additionally, the Community Retail Pharmacy Coalition has testified several times in support of the President's bill, and provided numerous sites for pro-Clinton health care reform rallies and events.

- Leadership of NACDS also independently developed strong corporate support from other large corporations both within and outside of the retail chain drug store industry for the President's plan.

- The Community Retail Pharmacy Coalition of NACDS and NARD have been a true supporter the White House could always count upon as a supporter of the President's health care reform objectives and continues to work for a successful conclusion.

FUNDING SOURCE	1995	1996	1995-1996	1997
Tobacco	1.8	2.4	4.2	3.5
Medicare revenue provisions	0	1.9	1.9	3.1
Medicare savings	1.4-1.7	6.6-7.1	8 - 8.8	9.6-10.1
Medicaid savings	0	0	0	
TOTAL	3.2-3.5	10.9 - 11.4	14.1 - 14.9	

1996 Make sure the program is for previously uninsured children and pregnant women.

1997 Two concerns:

- Not realistic to have an employer mandate without some subsidies for low-wage large employers. Very large marginal tax on employers.
- Not really fair to subsidize large employers and not smaller ones that are offering coverage.
- An individual mandate for some employees, without universal coverage, does not really work. For example, people that lose their job would lose their subsidy, which is very strange. Also, we would subsidize the worker but not his or her spouse?

Suggest: Mandate all firms to cover workers as of 1998. Employer subsidies in 1998.

No individual mandate until everyone is required to have coverage. No individual subsidies until universal coverage.

2000 Suggest: Mandate all individuals to have coverage in 2000. Provide individual subsidies. Mandate employers to contribute toward family coverage.

Cost Containment: Suggest triggering premium caps for community rated market. Consider allowing large employers to join community rated market, with 10-year demographic adjustment.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 8, 1994

The Honorable Albert Gore, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

Enclosed for consideration by the Congress is a draft bill "To make changes in Medicare and Medicaid data collection requirements."

The draft bill would postpone by 18 months the requirement for employers to collect health plan enrollment data for the Medicare and Medicaid Coverage Data Bank. The draft bill would also require Medicare intermediaries and carriers to collect and match data from their private lines of business with Medicare data for the purpose of carrying out the Medicare secondary payer provisions, and would require us to send questionnaires concerning private health plan coverage to individuals shortly before their Medicare coverage begins.

Delaying the implementation of the data bank provisions would allow us to work with Congress and the business community to ensure that the data bank minimizes the burden on employers and is consistent with health care reform. The requirement that Medicare intermediaries and carriers collect and match private data with Medicare data would prevent the inappropriate payment of Medicare funds, would reduce conflict of interest problems, and would lessen the workload for recoveries that utilize matches with Social Security and Internal Revenue Service data. The initial enrollment questionnaire would identify many secondary payer situations before a beneficiary filed claims and would also help to prevent mistaken primary payments.

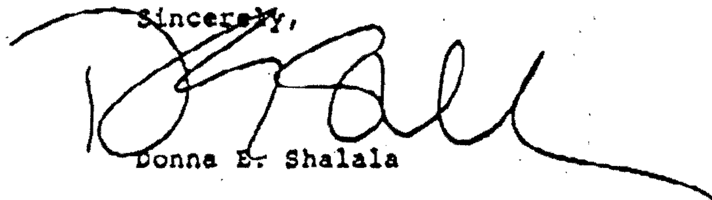
The 18 month delay in collecting health plan enrollment data would result in an increase of $348 million in entitlement spending over fiscal years 1995 through 1999, but this increase would be offset by savings of $350 million for the same period resulting from intermediary and carrier data collection and matching, producing a net five year savings of $2 million.

The provisions of the draft bill are described in detail in the enclosed section-by-section summary.

We urge the Congress to give the draft bill its prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of the draft bill would be in accord with the program of the President.

Sincerely,



Donna E. Shalala

SUMMARY OF PROPOSED MEDICARE AND MEDICAID
DATA COLLECTION AMENDMENTS OF 1994

Section 1 assigns the draft bill the short title "Medicare and Medicaid Data Collection Amendments of 1994".

Section 2 postpones by 18 months the requirement for employers to collect data for the Medicare and Medicaid Coverage Data Bank.

Section 3 requires Medicare intermediaries and carriers to collect and maintain data (as may be specified by the Secretary) from their private lines of business, and match those data with Medicare data, for the purpose of carrying out the Medicare secondary payer provisions.

Section 4 requires the Secretary to send a questionnaire concerning private health plan coverage to individuals at least two months before they become entitled to Medicare Hospital Insurance (HI) benefits (or at the time of application for Medicare benefits by individuals not entitled to HI coverage).

A BILL

To make changes in Medicare and Medicaid data collection requirements.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND REFERENCES IN ACT.

(a) Short Title.--This Act may be cited as the "Medicare and Medicaid Data Collection Amendments of 1994".

(b) References in Act.--The amendments in this Act apply to the Social Security Act.

SEC. 2. DELAY IN IMPLEMENTATION OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

Section 1144(c)(1)(A) is amended--

(1) by striking "1994" and inserting "1996", and

(2) by inserting "for the six month period beginning on July 1, 1995 and" after "paragraph (5)".

SEC. 3. DATA MATCHING BY INTERMEDIARIES AND CARRIERS.

(a) In General.--The last sentence of section 1816(c)(1) and the last sentence of section 1842(b)(2)(A) are each amended--

(1) by striking "may not" and inserting "shall", and

(2) by striking "match data obtained other than in its activities under this part with data used in the administration of this part" and inserting "collect and maintain data (as may be specified by the Secretary) related to its activities (or the activities of any other entity under common ownership or control) other than its activities

under this part, and match those data with data used in the administration of this part,".

(b) Technical Amendment.--The last sentence of section 1816(c)(1) and the last sentence of section 1842(b)(2)(A) are each further amended by striking "1871" and inserting "1874".

(c) Effective Date.--The amendments made by subsection (a) apply to agreements and contracts, entered into or renewed after 30 days after the date of enactment of this Act.

SEC. 4. MEDICARE INITIAL ENROLLMENT QUESTIONNAIRES.

(a) In General.--Section 1862(b)(5) is amended by adding at the end the following:

"(D) Obtaining information from beneficiaries.--At least two months before an individual will become entitled (upon application) to benefits under part A (or when the Secretary is first informed of that entitlement, if later), or at the time an individual applies for enrollment under part B (or applies under section 1818 for enrollment under part A), the Secretary shall provide the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and on the nature of that coverage.".

(b) Effective Date.--The amendment made by subsection (a) applies to entitlements under part A of title XVIII of the Social Security Act that begin after, and to enrollments under that title that occur after, 1994.

CHRIS J.

7/25

The HCFA proposed additions have not been cleared by Nancy-Ann.

John R.

July 25, 1994

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Route to: Nancy-Ann Min
Chris Jennings
Barry Clendenin BC

Decision needed	___
Please sign	___
Per your request	___
Please comment	___
For your information	X

With informational copies for:
L. Nichols, HFB/HD Chrons

Subject: HCFA Additional Medicare Savings Proposals of July 24

From: John Richardson

We have prepared three tables (attached) that show the effects of HCFA's July 24th proposed additions to the Senate Medicare savings package. As with HCFA's July 21st "$25 billion additional savings" packages, the new alternatives put almost all of the additional savings after FY 2000. If our proposed additions (high-cost medical staffs and full lab coinsurance) are not included, none of the three packages will raise the FY 1995-2000 total to $80 billion -- Option D1 is closest at $79.7 billion.

Option D is Building Block. HCFA's packages are proposed as additions to Option D. HCFA proposes three versions of further hospital market basket update reductions:

Option D1: MB minus 2% (FY 1998-2004) for urban hospitals
MB minus 1% (FY 1998-2004) for rural hospitals

Option D2: MB minus 2% (FY 1999-2004) for urban hospitals
MB minus 1% (FY 1999-2004) for rural hospitals

Option D3: MB minus 2% (FY 2001-2004) for all hospitals
MB minus 2% (FY 2000) for urban hospitals only

Because of these specifications, most of the savings in these proposals come from reductions in payments to urban hospitals.

Note: The first page of the attached tables is unchanged since Friday -- it should serve as page 1 for all three additional packages.

Attachments

OPTION D - Page 1

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

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PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PART A - Savings/Receipts													
Hospital Update at MB-1.0 (1997-2000)	0	0	-277	-1,005	-1,918	-2,986	-3,318	-3,798	-4,158	-4,554	-3,200	-6,186	-22,014
DO NOT Reduce Indirect Med. Educ. Payments	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
Part A Interactions	0	0	26	134	228	336	408	449	495	573	388	724	2,649
Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
PART A - Costs													
Medicare Dependent Hospitals (ends FY99)	40	50	50	50	10	0	0	0	0	0	200	200	200
Rural Transition Grants (authorization; non-add)	30	30	30	30	30	0	0	0	0	0	150	150	150
Part A Sub-total	20	-2,629	-3,450	-5,007	-6,443	-8,027	-8,584	-9,443	-10,097	-10,790	-17,509	-25,536	-64,450
PART B - Savings/Receipts													
Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
Cut 1995 Physician Update (-3%; PC exempt)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
Eliminate Formula Driven Overpayment	-480	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-6,931	-10,112	-35,959
Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
Lab Coinsurance (MD+OPD)*	-411	-687	-761	-866	-970	-1,086	-1,219	-1,358	-1,545	-1,744	-3,695	-4,781	-10,647
Prohibit Certain Physician Self-Referrals	0	0	0	0	0	0	0	0	0	0	0	0	0
Resource-Based Practice Expenses for Physicians	0	0	0	0	0	0	0	0	0	0	0	0	0
Extend Part B Premium at 25% of Costs (net)	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
PART B - Costs													
Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
Payments to Eye/Ear Specialty Hospitals	2	3	3	0	0	0	0	0	0	0	8	8	8
Payments for MD Assistants/Nurse Practitioners	0	0	100	170	210	250	310	380	470	580	480	730	2,470
Part B Sub-total	-1,219	-1,853	-3,173	-4,871	-8,042	-10,782	-14,925	-19,940	-25,943	-32,164	-19,158	-29,940	-122,912

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PARTS A and B - Savings													
10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
Home Health Copay - no 30 day window	-52	-578	-688	-775	-837	-908	-985	-1,068	-1,159	-1,257	-2,930	-3,838	-8,307
Extend OBRA93 Medicare Secondary Payer	0	0	0	0	-1,219	-1,788	-1,906	-2,131	-2,163	-2,303	-1,219	-3,007	-11,510
HMO Payment Improvements	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
PARTS A and B - Costs													
Repeal Medicare/Medicaid Data Bank	57	154	347	388	---	---	---	---	---	---	946	946	946
Parts A and B Sub-total	-129	-1,770	-2,283	-2,828	-4,829	-5,703	-6,130	-6,711	-7,135	-7,717	-11,839	-17,542	-45,235
<u>HCFA Proposed Changes (7/21/94):</u>													
Lower MSP threshold from 100 to 20 employees	0	0	0	-176	-236	-303	-342	-266	-392	-420	-412	-715	-2,135
Extend ESRD Secondary Payer to 24 Months	0	-84	-119	-127	-140	-154	-169	-186	-205	-225	-470	-624	-1,409
Cut 1995 Phys Fee Update add'l -1%; incl. PC	-100	-225	-240	-250	-240	-250	-250	-250	-255	-255	-1,055	-1,305	-2,315
Increase DSH Phase-down from 20% to 33%	0	-74	-246	-669	-730	-795	-867	-946	-1,038	-1,125	-1,719	-2,514	-6,490
HI Interaction	0	2	7	20	22	24	26	28	31	34	51	75	194
Correct MVPS Upward Bias (eff. FY95 MVPS)	0	0	-20	-210	-910	-1,880	-2,770	-3,600	-4,490	-5,480	-1,140	-3,020	-19,360
TOTAL with HCFA 7/21 Changes	**-1,428**	**-6,633**	**-9,599**	**-12,393**	**-19,223**	**-26,370**	**-32,386**	**-39,464**	**-47,549**	**-55,942**	**-49,276**	**-75,646**	**-250,987**
<u>Possible Additions to Reach Savings Targets</u>													
Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
Coinsurance for Independent Lab Services*	-273	-458	-527	-578	-646	-724	-812	-926	-1,030	-1,162	-2,482	-3,206	-7,136
TOTAL with All Additions as of 7/21	**-1,701**	**-7,091**	**-10,126**	**-13,495**	**-20,673**	**-27,857**	**-34,018**	**-41,327**	**-49,550**	**-58,056**	**-53,086**	**-80,943**	**-263,894**

*These proposals could be combined into one lab coinsurance proposal, as in the HSA and SFC Chairman's Mark. If not combined, savings from MD+OPD provision by itself could be substantially reduced (up to 50%).

Option D1:

HCFA Proposed Additions (7/24/94):	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
URBAN Hospital Update at MB-2.0 (1998-2004)	0	0	0	-583	-1,335	-2,226	-4,124	-6,608	-9,302	-12,451	-1,918	-4,144	-36,629
RURAL Hospital Update at MB-1.0 (1998-2004)	0	0	0	0	0	0	-123	-281	-463	-677	0	0	-1,544
Part A Interactions	0	0	0	17	40	67	127	207	293	394	57	124	1,145
Sub-total, 7/24 HCFA Additions	0	0	0	-566	-1,295	-2,159	-4,120	-6,682	-9,472	-12,734	-1,861	-4,020	-37,028
TOTAL with HCFA 7/24 additions	**-1,701**	**-7,091**	**-10,126**	**-14,061**	**-21,968**	**-30,016**	**-38,138**	**-48,009**	**-59,022**	**-70,790**	**-54,947**	**-84,963**	**-300,922**

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PARTS A and B - Savings													
10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
Home Health Copay - no 30 day window	-52	-578	-688	-775	-837	-908	-985	-1,068	-1,159	-1,257	-2,930	-3,838	-8,307
Extend OBRA93 Medicare Secondary Payer	0	0	0	0	-1,219	-1,788	-1,906	-2,131	-2,163	-2,303	-1,219	-3,007	-11,510
HMO Payment Improvements	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
PARTS A and B - Costs													
Repeal Medicare/Medicaid Data Bank	57	154	347	388	---	---	---	---	---	---	946	946	946
Parts A and B Sub-total	-129	-1,770	-2,283	-2,828	-4,829	-5,703	-6,130	-6,711	-7,135	-7,717	-11,839	-17,542	-45,235
<u>HCFA Proposed Changes (7/21/94):</u>													
Lower MSP threshold from 100 to 20 employees	0	0	0	-176	-236	-303	-342	-266	-392	-420	-412	-715	-2,135
Extend ESRD Secondary Payer to 24 Months	0	-84	-119	-127	-140	-154	-169	-186	-205	-225	-470	-624	-1,409
Cut 1995 Phys Fee Update add'l -1%; incl. PC	-100	-225	-240	-250	-240	-250	-250	-250	-255	-255	-1,055	-1,305	-2,315
Increase DSH Phase-down from 20% to 33%	0	-74	-246	-669	-730	-795	-867	-946	-1,038	-1,125	-1,719	-2,514	-6,490
HI Interaction	0	2	7	20	22	24	26	28	31	34	51	75	194
Correct MVPS Upward Bias (eff. FY95 MVPS)	0	0	-20	-210	-910	-1,880	-2,770	-3,600	-4,490	-5,480	-1,140	-3,020	-19,360
TOTAL with HCFA 7/21 Changes	**-1,428**	**-6,633**	**-9,599**	**-12,393**	**-19,223**	**-26,370**	**-32,386**	**-39,464**	**-47,549**	**-55,942**	**-49,276**	**-75,646**	**-250,987**
<u>Possible Additions to Reach Savings Targets</u>													
Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
Coinsurance for Independent Lab Services*	-273	-458	-527	-578	-646	-724	-812	-926	-1,030	-1,162	-2,482	-3,206	-7,136
TOTAL with All Additions as of 7/21	**-1,701**	**-7,091**	**-10,126**	**-13,495**	**-20,673**	**-27,857**	**-34,018**	**-41,327**	**-49,550**	**-58,056**	**-53,086**	**-80,943**	**-263,894**

*These proposals could be combined into one lab coinsurance proposal, as in the HSA and SFC Chairman's Mark. If not combined, savings from MD+OPD provision by itself could be substantially reduced (up to 50%).

Option D2:

<u>HCFA Proposed Additions (7/24/94):</u>	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
URBAN Hospital Update at MB-2.0 (1999-2004)	0	0	0	0	-667	-1,484	-3,300	-5,664	-8,268	-11,319	-667	-2,151	-30,702
RURAL Hospital Update at MB-1.0 (1999-2004)	0	0	0	0	0	0	-123	-281	-463	-677	0	0	-1,544
Part A Interactions	0	0	0	0	20	45	103	178	262	360	20	65	968
Sub-total, 7/24 HCFA Additions	0	0	0	0	-647	-1,439	-3,320	-5,767	-8,469	-11,636	-647	-2,086	-31,278
TOTAL with HCFA 7/24 additions	**-1,701**	**-7,091**	**-10,126**	**-13,495**	**-21,320**	**-29,296**	**-37,338**	**-47,094**	**-58,019**	**-69,692**	**-53,733**	**-83,029**	**-295,172**

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MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PARTS A and B - Savings													
10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
Home Health Copay - no 30 day window	-52	-578	-688	-775	-837	-908	-985	-1,068	-1,159	-1,257	-2,930	-3,838	-8,307
Extend OBRA93 Medicare Secondary Payer	0	0	0	0	-1,219	-1,788	-1,906	-2,131	-2,163	-2,303	-1,219	-3,007	-11,510
HMO Payment Improvements	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
PARTS A and B - Costs													
Repeal Medicare/Medicaid Data Bank	57	154	347	388	---	---	---	---	---	---	946	946	946
Parts A and B Sub-total	-129	-1,770	-2,283	-2,828	-4,829	-5,703	-6,130	-6,711	-7,135	-7,717	-11,839	-17,542	-45,235
HCFA Proposed Changes (7/21/94):													
Lower MSP threshold from 100 to 20 employees	0	0	0	-176	-236	-303	-342	-266	-392	-420	-412	-715	-2,135
Extend ESRD Secondary Payer to 24 Months	0	-84	-119	-127	-140	-154	-169	-186	-205	-225	-470	-624	-1,409
Cut 1995 Phys Fee Update add'l -1%; incl. PC	-100	-225	-240	-250	-240	-250	-250	-250	-255	-255	-1,055	-1,305	-2,315
Increase DSH Phase-down from 20% to 33%	0	-74	-246	-669	-730	-795	-867	-946	-1,038	-1,125	-1,719	-2,514	-6,490
HI Interaction	0	2	7	20	22	24	26	28	31	34	51	75	194
Correct MVPS Upward Bias (eff. FY95 MVPS)	0	0	-20	-210	-910	-1,880	-2,770	-3,600	-4,490	-5,480	-1,140	-3,020	-19,360
TOTAL with HCFA 7/21 Changes	**-1,428**	**-6,633**	**-9,599**	**-12,393**	**-19,223**	**-26,370**	**-32,386**	**-39,464**	**-47,549**	**-55,942**	**-49,276**	**-75,646**	**-250,987**
Possible Additions to Reach Savings Targets													
Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
Coinsurance for Independent Lab Services*	-273	-458	-527	-578	-646	-724	-812	-926	-1,030	-1,162	-2,482	-3,206	-7,136
TOTAL with All Additions as of 7/21	**-1,701**	**-7,091**	**-10,126**	**-13,495**	**-20,673**	**-27,857**	**-34,018**	**-41,327**	**-49,550**	**-58,056**	**-53,086**	**-80,943**	**-263,894**

*These proposals could be combined into one lab coinsurance proposal, as in the HSA and SFC Chairman's Mark. If not combined, savings from MD+OPD provision by itself could be substantially reduced (up to 50%).

Option D3:

HCFA Proposed Additions (7/24/94):	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
Hospital Update at MB-2.0 (2001-2004)	0	0	0	0	0	0	-1,896	-4,340	-7,128	-10,408	0	0	-23,772
URBAN Hospital Update at MB-2.0 (2000)	0	0	0	0	0	-742	-825	-944	-1,034	-1,132	0	-742	-4,677
Part A Interactions	0	0	0	0	0	22	82	159	245	346	0	22	854
Sub-total, 7/24 HCFA Additions	0	0	0	0	0	-720	-2,639	-5,125	-7,917	-11,194	0	-720	-27,595
TOTAL with HCFA 7/24 additions	**-1,701**	**-7,091**	**-10,126**	**-13,495**	**-20,673**	**-28,577**	**-36,657**	**-46,452**	**-57,467**	**-69,250**	**-53,086**	**-81,663**	**-291,489**

COMMENTS REGARDING CBO QUESTIONS (7/24/94)

1. Subsidies are not really a fixed percentage of the average premium. They are a fixed percentage of the applicable premium for plan chosen by the individual (up to the fixed percentage of the average community-rated premium for the HCCA).

2. Prior to the mandate, the self-employed would be treated like non-workers.

   After the mandate: [to be determined]

3. Prior to the mandate, dual earners can choose coverage through either employer. The non-enrolling employer pays nothing. Alternatively, dual earners can split coverage between the two employers. In other words, status quo.

   Suggestion for after the mandate:

   - Dual earner families enroll as a unit with either employer.

   - The enrolling employer pays at least 50% of the premium for the family.

   - A non-enrolling employer pays 50% of the appropriate policy based on the reference premium for the HCCA. Payments from non-enrolling employers are converted into "dual earner credits" separately for couples and for single-parent/two-parent families.

   - Any entity (an employer or a non-worker) paying an employer share of a family (or couple) policy receives the "dual earner credit."

   - Employer subsidies are calcuated on the net premium obligation (i.e., after the "dual earner credit"). For an employer receiving a subsidy on behalf of a worker, the government in effect receives the "dual earner credit."

4. Cost sharing subsidies cannot work quite like the HSA because of employer choice.

   Possible structure:

   For people who are under 150% of poverty and are not receiving AFDC:

   - People who are working for community-rated employers:

     -- No cost sharing subsidy is available if the

person could enroll in a lower or combinaion cost sharing plan with a premium at or below the weighted average premium of the HIPC offered by the employer through which they enroll.

-- Otherwise, the person may enroll in a higher cost sharing plan and have their cost sharing reduced to the lower cost sharing level.

- People who enroll in a plan through an experience-rated employer are not eligible for cost sharing subsidies (unless there is no lower or combination cost-sharing plan in the area (i.e., their employer has to offer a lower and/or combination cost-sharing plan if one is available).

- People who are not working:

  -- No cost sharing subsidy is available if the person could enroll in a lower or combinaion cost sharing plan with a premium at or below the weighted average premium for community-rated plans in the HCCA.

  -- Otherwise, the person may enroll in a higher cost sharing plan and have their cost sharing reduced to the lower cost sharing level.

People who are AFDC recipients:

- To be eligible for a cost-sharing reduction, an AFDC recipient must enroll in a lower or combinaion cost sharing plan with a premium at or below the weighted average premium for community-rated plans in the HCCA if one is available.

- If no such plan is available, the AFDC recipient would be eligible for a cost-sharing reduction in a higher cost sharing plan.

- An AFDC recipient that is eligible for cost-sharing reduction would have their cost sharing reduced to 20% of the lower cost sharing level.

5. Suggestion from BR: Leave employer subsidies uncapped for now.

6. An employer who does not now offer coverage at all should be able to claim subsidies.

7. Employer subsidies should not depend on coverage available through a spouse.

8. Employer subsidies available for expansion within a class (class is full-time or part-time). Test of coverage is $500, not what type of coverage is offered. To get a subsidy, employer has to offer to pay for employee and dependents.

9. Class of worker is just full-time or part-time.

10. Self-employed treated like non-workers and would not be eligible for employer subsidy. A sole proprietor with a minimum number of employees (suggest: three) that reports a specified minimum amount of wages paid would be eligible for the subsidy.

11. Employer subsidy would not be available to employee leasing firms.

12. [We need to check what numbers reflect for employer subsidies for state and locals] Suggestion from BR: Do not give subsidies to them.

13. Confirmed with BR: Want to use finance-type nondiscrimination rules.

14. Plan can do pure community rating or use standard age factors, but nothing in between.

15. Assumption: HIPCs can negotiate lower rates, but the lower rate become a plan's community rate.

16. The internal risk adjustment system takes into account the payments from the cross-pool (i.e., XR) risk adjustment. The cross-pool risk adjustment is essentially a per capita assessment. Why is this hard?

17. XR to CR risk adjustment is just for the higher expected health care expenditures, not administrative costs.