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	Decision needed	___
		Please sign	___
		Per your request	___
		Please comment	___
		For your information	X
Subject:	HCFA Additional Medicare Savings Proposals of July 24	With informational copies for: L. Nichols, HFB/HD Chrons	
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

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OPTION D - Page 1

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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
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
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 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**

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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
<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**

MEDICARE OPTION - SAVINGS AND COSTS

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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
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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**

Trigger Proposal

- On January 15, 2000, the Health Care Coverage Commission would determine whether the voluntary system has achieved 95 percent coverage nationwide.

- First Alternative -- Coverage Target Achieved: If the Commission determines that at least 95 percent of all Americans had health coverage, they would send recommendations to the Congress on how to expand coverage to the same levels as achieved in Social Security and Medicare. No further action would be required.

- Second Alternative -- Coverage Target Not Achieved: If coverage is below 95 percent, the Commission would send to Congress by May 15, 2000 one or more legislative proposals on how to expand coverage to the same levels as achieved in Social Security and Medicare.

- Such legislation would be referred to the relevant committee(s) and would be considered in both the House and the Senate under the expedited process provided for in the Finance Committee bill. The legislation would be fully amendable and require the President's signature.

- In order for the legislation to be eligible for this expedited procedures, GAO would have to certify that the legislation would in fact accomplish its objective in a deficit neutral manner. Prior to the bill being brought up on the Senate floor, prior to third reading, and prior to final passage of the conference report, a 60 vote point of order would lie against such legislation if it does not have the GAO certification.

- If such legislation is not enacted by December 31, 2000, an employer mandate would go into effect on January 1, 2002 in those states where coverage is below 95 percent.

- Under the mandate, employers with 25 or more employees would have to pay 50 percent of their employees' premium costs, with the employee paying the remainder. Firms employing fewer than 25 workers would be exempt from the employer mandate. Individuals would be required to have health insurance.

- Subsidies would be available to reduce both employer and individual costs:

  - Employers would pay the lesser of 50 percent of the premium or 8 percent of each employee's wage.

  - Employees with Adjusted Gross Income under 200 percent of poverty would be subsidized on their 50 percent share of the premium on a sliding scale basis. However, no individual would pay more than 8 percent of their Adjusted Gross Income for the 50 percent share of their premium.

  - Non-workers and those in exempt firms would receive the same subsidies for their 50 percent share of the premium as employees in covered firms. They would also be subsidized on the "employer" share of the premium according to a different sliding scale that phases out by 200 percent of poverty.

一等書記官

樽見英樹

在アメリカ合衆国
日本国大使館
(二〇二)九三九—六七〇〇

8/1/94

FAX TO CHRIS JENNINGS

RE: POSSIBLE POLICY FOR THE DEDUCTIBLE UNDER THE DRUG BENEFIT

The deductible amount for 1998 (first year of the benefit) would not be set in statute. Instead, the bill would require that the Secretary determine the deductible consistent with a spending target.

- o Before September 30, 1997, the Secretary would determine a deductible that would result in incurred spending for benefits and administrative costs (before rebates and premiums) under the drug benefit that would equal the spending target. All other aspects of the benefit would be specified -- that is, the out of pocket cap, payment methodology and rebate levels (consistent with the current draft).

- o The spending target would be specified in statute as $18.3 billion. This target is consistent with a stream of fiscal year outlays that would total $95 billion over ten years (95 - 2004).

- o The deductible would be updated for 1999 so as to maintain the same percentage of beneficiaries who met the deductible in 1998.

- o In updating the deductible for 2000, the Secretary would look back to the actual experience for 1998 and determine what the deductible should have been in order to have met the target. The Secretary would then determine the percentage of beneficiaries that would have met that deductible in 1998 and would establish the deductible for 2000 and subsequent years so as to maintain that percentage.

I spoke with Scott Harrison at CBO. He indicated that CBO

would have no problem with this deductible policy. He also said that the $18.3 billion target for 1998 would be scored by CBO as generating an outlay stream of $98 billion over ten years. The difference between our $95 billion and CBO's $98 billion is due to higher rate of growth assumptions by CBO. Both our $95 billion and CBO's $98 billion are before <u>any savings from the maintenance of effort provision</u>.

Peter Hickman

Deductible Policy for Drug Benefit

- The Deductible amount for the first year of the program would not be provided for in the statute, instead it would be determined by the Secretary.

- Before September 30, 1997 (assuming a benefit that would start 1/1/98), the Secretary would establish the deductible level such that projected incurred spending for benefits and administrative costs under the drug benefit [before rebates and premiums] would be equal to the spending target. This target would be specified in statute as $18.3 billion (This $18.3 billion in incurred costs for 1998 is consistent with a stream of fiscal year outlays estimates that would total $95 billion over 10 years).

- The deductible would be updated for 1999 so as to maintain the same percentage of beneficiaries who met the deductible in 1998.

- In determining the deductible for 2000, the Secretary would look back to the experience in 1998. The Secretary would determine at what level the deductible should have been set in 1998 so that actual incurred spending would have been equal to the spending target. The Secretary would then determine the percentage of beneficiaries who would have met such a deductible and would establish the deductible for 2000, and for subsequent years, so as to main that same percentage.

Three Forks

Bobby

224 6603

Craig Obey - highroad consultants - collect L.I.F. from Iowa

Labor?

Margaret

2000 2002

Atrec

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.

- Universal coverage
- something less certain - Harold
- Ken Thorpe → under 25
- La Losa

6% 8%

who is uninsured

- Rate setting for fee for service

- 50/50 world - $118 Billion 2000

- Plan B → COBRA / - self insured

- more than ...

- Different workers -
  - workers or non workers
  - skill income levels
  - different family status
  - workers in exempt firms

08/02/94 18:39 202 401 7321 HHS ASPE/HP → JENNINGS 005/006

BACKUP DOCUMENTATION FOR MITCHELL SCENARIOS
ASSUMPTIONS

	1994		1997			
	Premiums HSA	Poverty	CURRENT	CR PREM	ER PREM	Poverty
SINGLE	2,100	7,179	2,526	2,526	2,522	7,845
COUPLE	4,200	9,713	5,052	5,052	5,043	10,614
1 P	4,095	12,247	4,925	4,925	4,917	13,383
2 P	5,565	14,781	6,694	6,694	6,682	16,152

GROWT	1.051	
CPI	1.03	
CR Path	1.100736	1.2028039
ER Path	1.0989	1.2007977

NOTE: Both assume no mandate, no caps

Age Rating

Young Singl	1,692
Old Single	3,359

KIDS SUBSIDIES (CBO)

	1994	1997
1-kid	1048	1,261
2-kids	2620	3,151

TO: Chris Jennings

FROM: David Nexon

DATE: 6/5/94

SUBJECT: Data items we need (all for Chairman's mark), per our earlier conversation

1) Estimates of overall impact of Chairman's mark on business by size of firm, divided between those currently providing and not providing coverage.

2) Estimates including 5,000 plus firms and payroll contribution for small exempt and large firms over 1,000 (earlier estimates did not include 5,000 plus firms and appeared to be for premiums only).

3) Five year and year 2000 figures for the components of Title IX: Employer premium payments, household premium payments, Federal subsidy payments (we have five year, but not year 2000); Federal payments for cash recipients; state payments, including moe and cash recipients. For employers, households, and states, we would like to be able to compare to baseline payments.

4) Is tobacco tax number ($32 billion) a 96-2000 figure or a 95-2000 figure. If the former, what is the 95-2000 figure?

5) Budget impact of various cost-containment scenarios provided to Ken.

6) Difference between average premiums of 1,000 plus firms and all people in community-rated pool. How does what the 1000 plus firms would pay if they were paying community-rated premiums relate to the one per cent assessment?

TO: CHRIS JENNINGS

FROM: ANTHONY TASSI

DATE: 06/06/94

SUBJ: Additional Data Items Needed for Chairman's Mark

After talking it over with David, it turns out we need a couple of additional items:

1) The breakout of the revenue from the 2% assessment and 1% assessment

2) The number of firms and workers for each subsidy payroll cap (ie, how many workers are in firms paying 5.5% and how many firms are there)

3) For the Bingaman Option, the number of firms, workers in the exemption -- and revenue broken down for the 1% and 2% assessment of the exempt firms.

Much thanks -- you can fax the info to me (224-3533) or telephone if you prefer (224-6366; -6064; - 5406 david's line)

Post-It™ brand fax transmittal memo 7671 | # of pages ▸ 1

To CHRIS J.	From ANTHONY/DAVID NEXON
Co.	Co. SEN. KENNEDY
Dept.	Phone #
Fax # 456-7431	Fax #

BRADLEY REQUEST

Under this option, premium caps would not be implemented. The costs of the comprehensive benefit package would be unconstrained in the base year. Moreover, premiums would grow at the same rates as under current law.

(1) What would be the impact on subsidies and revenues if there were no premium caps for either the base premium or the rate of growth? (Note that revenues will also be affected by the change in subsidies resulting from the lifting of the premium caps.)

(2) A premium tax will be imposed to compensate for the lost revenues/increased subsidy costs. At what rate should the premium tax be set in order to make up the difference?

We are not to assume induced changes in premium prices in response to the premium tax or lifting of the premium caps.

Questions:

(1) Are we estimating this option relative to HSA, one of the Mitchell options, or what? (Since this request is coming from a Senate Finance member, I would recommend one of the base-case Mitchell options. Is the 12% individual wage cap with 95% CBO premium the correct Mitchell base case?)

(2) What base is the premium tax applied to? (Presumably, the base will be premiums for the comprehensive benefit package.)

(3) Are we trying to compensate for the deficit gap on a year-by-year basis or the total through 2000/2004? If done on an annual basis, each year will require a different rate.

(4) Will subsidies cover this premium tax? Will the employer mandate cover this premium tax? (If yes, this exercise will require multiple iterations.)

(5) Even if employers are not "required" to pick-up the premium tax, imposition of the premium tax will affect employer costs (since many will). As a consequence, an estimate of a premium tax will have an offsetting impact on income and payroll taxes (the "income offset"). Should the premium tax be set at the rate necessary to close the deficit gap, pre- or post- the income offset? (Recommendation: First show the premium tax rate at the level necessary to close the deficit gap pre-premium tax. Also, show the amount of the income offset due to the premium tax. Next, show the premium tax rate at the level necessary to close the deficit gap if the premium tax also is self-financing (i.e., pays for most of the income offset as well).

(6) Is the premium tax deductible? (Recommendation: yes)

Other Issues:

(1) Priority relative to the request for estimates of Kennedy mark.

(2) OMB will need to provide subsidy gap to Treasury, while Treasury estimates revenue gap over the period. Note that the revenue gap will show the combined effect of the unconstrained premiums on (a) the effects of the mandate; (b) cafeteria plans; (c) corporate assessment (should be slight); and (d) the 1 percent premium assessment. Then, Treasury will produce the rate(s) at which the new premium tax would be set.

(e) self-employed health insurance deduction

conference committee, provides for an interstate banking system with national standards and underlying state flexibility to recognize the diversity of communities across the nation.

Further, when it comes to health reform, states have significant experience, success and track records. They, in fact, have achieved more in the way of reform than Congress has. The Summer 1993 issue of Health Affairs documents successes at the state level in health reform from Florida, Hawaii, Maryland, Minnesota, Oregon and Washington. Significantly, these states have adopted reforms that differ in terms of scope, anticipated outcomes and process.

These variations reflect the diverse needs, ideology and stage of health care evolution in each state. So should national reform. Moving health reform to the states and closer to the people should be a central principle of a national health plan. Only then will we have real accountability and responsiveness to the needs of citizens, business and providers. Only then are we likely to have a reform which will actually deliver its promise of sustained accessibility to a high quality, affordable health care system for all Americans.

How Would This Be Accomplished?

First, the federal government should establish federal standards in those areas where uniformity is required and agreed upon. Standards that the federal government should set include:

1) Universal coverage standard;

2) Cost containment;

3) The composition of a standard benefits package;

4) Insurance reform on issues such as community rating, portability and guaranteed issuance; and,

5) A state-based public authority to assure implementation and to be accountable for these goals.

Certainly these are goals upon which the Congress, the President, the states and the American people can come to some agreement.

However, the federal government should separate the ends and goals of health reform from the means of health reform. The federal government should establish agreed-upon performance objectives to attain the five goals. However, for both political and policy reasons, the federal government should not impose uniform means by which states would achieve the performance objectives.

Rather, the federal government should set forth performance standards that are achievable, provide adequate and equitable financial assistance to states for implementation and hold states accountable for the results.

A fundamental question in determining the federal role in health care implementation should be -- does the particular proposal under consideration require uniformity in process or procedure to achieve national goals? There are a set of limited circumstances which meet

this test. These would include: Medicare, special populations such as immigrants, which impose disproportionate impacts on state and local communities, and national tax policy that creates various health care incentives. The need for national uniformity could also include the special treatment for interstate corporations similar to that received under ERISA.

However, for the vast number of issues, the answer is clearly "no". National uniformity is not required to achieve the goal of universal coverage. For example, to achieve universal coverage and cost containment, states could implement a system resembling Hawaii's, the Clinton administration's plan, managed competition without mandatory alliances, a single payer system, all-payer regulation or a combination of these proposals.

Financing a System Built on Federalism

To attain the nationally established goals, the federal government should make funding available to states in the form of a block grant based on factors such as poverty, state income, other demographics and health care costs. The federal government should utilize funding to provide rewards to states that move more quickly toward the goals of national reform, guarantee funding so long as states continued move toward those goals and possibly impose sanctions on states failing to meet the goals.

States could choose how to finance their share by virtually whatever means they wish.

Beyond that, the federal government should only provide direction and get out of the way of state reform. In fact, the states should be allowed to supplement the federal standard benefits if they so choose, but with their own, non-federal funds.

State Role in Implementation

In a decentralized or federalist system, states would have the responsibility to establish and implement programs to achieve national standards. Among other things, states should have flexibility in the following areas:

1) Organization -- states should be granted the flexibility to establish the health delivery system that best meets the geographic considerations and needs of its population;

2) Financing -- states should be responsible for any cost beyond that established as the basis for federal block grant funding, and therefore, will have a strong incentive to initiate effective cost containment systems, whether by use of market-forces, a regulated payment system or otherwise; and,

3) Regulatory approach -- states have historically and should continue to be primarily involved in the training and licensure of health care providers and have been responsible for the civil justice system, and thus, medical malpractice reform.

Moreover, states such as Hawaii, Washington, Florida, Minnesota and Oregon could maintain and build from the successful and popular

health reforms that they already have in place.

Walking the Road

What is needed is to convert the various unitary plans from explicit health reform road maps to statements of destination.

Due to the late hour of this debate, Congress should look at the objectives of the various plans and pick the proposal that best meets mutually agreed upon goals. The underlying organizational, financing and regulatory details would only be a template for states that would be applicable in the absence of a state's enactment of its own reform structure or in the wake of a failed state plan. In short, the federal template would only serve as a "safety net" for states.

States could opt-out of any federal system as long as they could demonstrate that they could meet the federally established standards that we agree upon.

This strategy is not original. In the President's "Health Security Act", states were given the option of adopting a single payer option in lieu of the purchase of private insurance through mandatory cooperatives. If states declined to use the single payer option, they would be included in the national system. My proposal suggests a similar foundation of a national system but with a broader range of options to states. Provided states meet the test of achieving universal coverage with guaranteed and affordable comprehensive benefits, they could choose from a variety of financing, organization and regulatory arrangements.

Conclusion

In the last election, Americans made it clear that health care reform is of primary importance to the nation. Health care reform is necessary not only for the 38.5 million uninsured in our nation, but also for the health of the economy.

Congress is trying to respond, but at this point, it appears that there will be one of two results: we will either fail to enact health care reform due to partisan bickering; or, we will pass a compromise that will not work, sap momentum for true reform (including stifling reform efforts at state and local levels) and further diminish the public's confidence in the federal government.

We need a path to sustained success. The well trod road of federalism is that way.

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HCFA Alternative to Revised Option C 7/21
(in billions)

Add	
Correct MVPS Upward Bias 1/	$19,360
Delete	
Set Cumulative Growth Targets	$13,125
High Cost Medical Staffs	5,771
Total	$18,896
Net Change	+$464

1/ Correct the upward bias in factor four of the MVPS by treating savings and expansion proposals consistently.

If Medicare is expanded, or if fees are raised (such as for an MVPS adjustment), the full amount of the increase is passed through in the MVPS. However, savings proposals are not treated in the same way. When savings proposals are enacted, for budget purposes, scoring assumes a volume response. Those savings estimates (net of the volume offset) are incorporated into factor 4 of the MVPS. Because scored savings are lower due to the assumed volume response, use of scored savings raises the MVPS. This proposal would eliminate building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings. Effective with MVPS beginning with FY 1995.

HCFA ALTERNATIVE TO Revised Option C

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
ADD orrect MVPS Upward Bias	0	0	20	210	910	1880	2770	3600	4490	5480	19360
Delete Cumulative MVPS	0	0	-75	1725	2325	1500	1625	1850	1975	2200	13,125
tight [illegible] Medicaid staff	0	0	0	524	804	763	820	937	971	952	5771

HCFA Alternative to Revised Option D

7/21

(in billions)

Add	
Correct MVPS Upward Bias 1/	$19,360
DSH (20% to 33%) 2/	6,483
HI Interaction	-194
Total	$25,649
Delete	
Set Cumulative Growth Targets	$13,125
High Cost Medical Staffs	5,771
Lab Coinsurance (Independents)	7,136
Total	$26,032
Net Change	-$ 383

1/ Correct the upward bias in factor four of the MVPS by treating savings and expansion proposals consistently.

If Medicare is expanded, or if fees are raised (such as for an MVPS adjustment), the full amount of the increase is passed through in the MVPS. However, savings proposals are not treated in the same way. When savings proposals are enacted, for budget purposes, scoring assumes a volume response. Those savings estimates (net of the volume offset) are incorporated into factor 4 of the MVPS. Because scored savings are lower due to the assumed volume response, use of scored savings raises the MVPS. This proposal would eliminate building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings. Effective with MVPS beginning with FY 1995.

2/ Increases reduction in DSH from 20 percent in base package to 33 percent.

HCFA Alternative to Revised Option D

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
ADD Correct MVPS Upward Bias	0	0	20	210	910	1880	2770	3600	4490	5480	19360
DSH @ 3% (=13%)	0	74	246	669	730	795	867	946	1038	1125	6,483
II Interaction											-194
Delete Cumulative Growth Targets											13,125
High Cost Med Staffs											5,771
Coinsurance (Outpatients)											7,136

Additional FY 95-04 Medicare Savings 7/21 (C)
(in billions)

Hospital Update MB-2 1/	$23.8
DSH (25%) 2/	2.4
HI Interaction	-0.8
Total	$25.4

1/ Reduces hospital market basket by MB-2.0 for FY 2001 through FY 2004.

2/ Raises the reduction in DSH payments from 20 percent in base package to 25 percent. The $2.4 billion figure represnts the 5 percentage point difference.

Additional Mcare $25 bil (C)

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
MB-2 01-04	—	—	—	—	—	—	1896	4340	7128	10,408	23,372
DSH 25% Δ=5%	—	28	93	252	274	299	326	356	388	423	2438 26,210 -800 25,410

Additional Medicare Savings Proposals (C) 7/21/94

- Lower Threshold from 100 to 20 Disabled Employees for MSP: Effective 1/1/98, lower the threshold from 100 to 20 employees for disabled persons for application of the Medicare secondary payor provisions.

- Extend ESRD Secondary Payor to 24 Months: Increase requirement for non-Medicare insurers to be the primary payor for ESRD patients from 18 to 24 months before Medicare becomes the primary payor, effective 1/1/96.

- Reduce 1995 Physician Update: Reduce the Medicare fee schedule conversion factor by 3 percent in 1995, except for primary care services.

- Correct MVPS Upward Bias: Correct the upward bias in factor four of the MVPS by treating savings and expansion proposals consistently.

  If Medicare is expanded, or if fees are raised (such as for an MVPS adjustment), the full amount of the increase is passed through in the MVPS. However, savings proposals are not treated in the same way. When savings proposals are enacted, for budget purposes, scoring assumes a volume response. Those savings estimates (net of the volume offset) are incorporated into factor 4 of the MVPS. Because scored savings are lower due to the assumed volume response, use of scored savings raises the MVPS.

  While appropriate for budget purposes, building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings is not keeping with the spirit or intent of the MVPS and leads to an upward bias. It is inconsistent to have a system which provides for reducing the update to recoup for when a prior target was exceeded, but to increase the next year's target because of a volume offset to this reduced update.

  This proposal would eliminate building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings. Effective for MVPS beginning with FY 1995.

7/21/94

Additional $25 bil Medicare Savings Proposals (C)

- Reduce the Annual Hospital Update: Reduce the update for inpatient hospital services by 2.0 percentage points from FY through FY 2001 through FY 2004.

- Revise the Disproportionate Share Hospital Adjustment: Increase the reduction in DSH payments from 20 percent in the base package to 25 percent.

NOTE TO CHRIS JENNINGS 6/17/94

RE: CAPITATED DRUG BENEFIT OPTION DEMO

Attached is my draft of a capitated drug benefit option demo. I talked with Bruce yesterday morning. He was OK with the idea and the attached write-up reflects his comments.

Where do we go from here? Ellen would like to sit down with Kopetski's staff this afternoon and would like to find out what we want ASAP.

Peter Hickman

PAUL D. WELLSTONE
MINNESOTA

United States Senate

WASHINGTON, DC 20510-2303

456 5560
456 2604

FROM THE OFFICE OF SENATOR PAUL DAVID WELLSTONE

FAX COVER SHEET

TO: PRESIDENT CLINTON
via: CHRIS JENNINGS
STEVE RICCHETTI

FROM: ELLEN SHAFFER

DATE: 6/17

MESSAGE:

COVER SHEET + 2 PAGES = 3 TOTAL PAGES

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United States Senate
WASHINGTON, DC 20510-2303

June 15, 1994

President Bill Clinton
The White House
Washington, D.C. 20500

Dear Mr. President: Bill

We have always agreed that universal coverage must be the cornerstone of health care reform. That stand cannot waver as we continue our progress in Congress to enact comprehensive health care reform legislation.

Just as the Senate Committee on Labor and Human Resources reinforced that commitment last week, troubling signals have appeared from the press and some Members indicating that universal coverage is not a realistic goal.

As you well know, the building blocks of meaningful reform are inextricably linked. Universal coverage is not only a humane goal, one which most industrialized countries have attained. Because it would end wasteful and inflationary cost-shifting, it is also key to making health care affordable.

Affordable, universal coverage is impossible without meaningful, employer-based financing. We have been debating this issue long enough to be clear on this point. Suggestions that we waste more years and more lives tinkering around the edges of almost covering everyone, trying to make health care almost affordable, are a diversion from the fair and workable framework you have presented. Unworkable proposals that would put the burden on individuals to pay most of the costs of their care, or project employer contributions into some distant future, cannot achieve the health care reform that Americans are counting on us to deliver.

The legislative process involves compromise. There will certainly be major compromises on matters of importance as different views shape the final health care legislation. But there must be a firm foundation on which those compromises are built. Universal coverage, affordable for all and fairly financed, must remain the basis of that foundation.

717 HART SENATE OFFICE BUILDING
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TEL: Jun 17,94 12:46 No.015 P.02

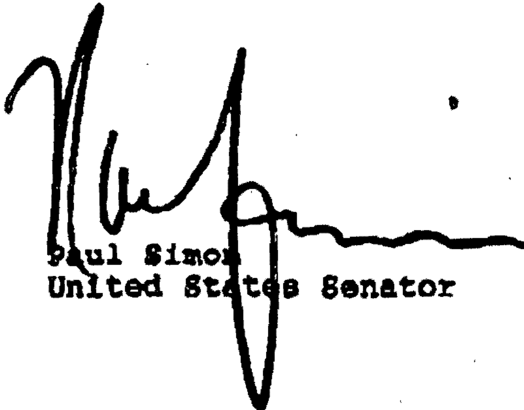
Those of us on the Labor Committee have already accepted difficult compromises and will have difficulty sacrificing further.

We look forward to assisting your efforts toward the goal of true universal coverage for health care in any way that we can.

Sincerely,

Paul David Wellstone
United States Senator

Howard Metzenbaum
United States Senator



Paul Simon
United States Senator

Carol Moseley-Braun
United States Senator

THE WHITE HOUSE

WASHINGTON

June 16, 1994

MEMORANDUM FOR TRAVELING STAFF AND MILITARY PERSONNEL

FROM: STEPHEN F.W. CAVANAH, M.D. SC
WHITE HOUSE PHYSICIAN

SUBJECT: Travel Advisory for the July 5-12 European Presidential Trip to Riga/Warsaw/Naples/Bonn/Berlin

There are no specific "required" immunizations for entry into these countries. However, the following immunization is recommended for those traveling to Riga (Latvia) or to Naples (Italy):

1. Gamma globulin (good for up to 3 months). This provides protection against hepatitis A.

The following standard immunizations are recommended for all travelers:

1. Up-to-date diphtheria-tetanus (within 10 years);
2. Polio vaccination (once in adulthood if not previously adequately immunized).

The White House Medical Unit in Room 107/OEOB is available for routine immunizations for Presidential trips. The hours for immunizations are 9:00 a.m. to 11:00 a.m. and 1:00 p.m. to 3:30 p.m.

Food and water precautions are suggested for Riga and Naples. Common sense dictates the avoidance of raw/rare meat, fish, or shellfish. The American Embassy in Italy reports that Hepatitis A is a significant risk in Naples; therefore, we recommend extreme caution with seafood.

Personal items should include extra glasses, sunglasses, adequate contact lens support, medications, sanitary products, and sunscreen. Those going to Naples should be advised that they may be in hotels without air conditioning and should plan accordingly, i.e., drink plenty of fluids.

Point of contact is Dr. Stephen F.W. Cavanah in Room 107, phone number 757-2476.

6/16/94

NOTE TO CHRIS JENNINGS

RE: CAPITATED DRUG BENEFIT OPTION DEMO

Attached is my draft of a capitated drug benefit option demo. I talked with Bruce this morning. He was OK with the idea and the attached write-up reflects his comments.

Where do we go from here? Ellen would like to sit down with Kopetski's staff soon (This is not a today issue, but it sounded like she wanted to start talking tomorrow).

Please get back to me on comments and process(?)(!). It is HCFA night at the O's so I am ducking out a little early to get my kids. You can leave a long message on my voice mail or mark this up and fax it back (690-8168) or do both.

Peter Hickman

06-16-94 02:13 PM FROM OLP P01

DEMONSTRATION OF CAPITATED DRUG BENEFIT OPTION

SUMMARY - The Secretary would be required to initiate a demonstration under which beneficiaries would be given the option of receiving their drug benefits through a drug benefit management (DBM) plan instead of standard Medicare. This option would structured similar to the current Medicare risk program. The demonstration would start two years after the effective date of the standard drug benefit and would be authorized in 6 states for 5 years.

ENROLLMENT

- During an annual, 30-day open enrollment period, beneficiaries in the demonstration states would have the option of enrolling to receive their drug benefits through a DBM plan with a Medicare contract or HMO/CMP with a risk contract. Beneficiaries who become entitled to Medicare between open enrollment periods would have the option of enrolling in the month preceding entitlement to Medicare. As with the risk program, no health screening would be permitted.

- The Secretary would prepare materials that would provide information that would assist beneficiaries in making a choice among the available drug benefit plans, HMO options and standard Medicare. The cost of preparing these materials would be born by the plans. As with the risk program, all marketing materials would have to be approved in advance by the Secretary. Direct marketing (e.g. door to door, telemarketing) to beneficiaries would be prohibited.

- Beneficiaries wishing to enroll in a plan could do so only through a third party designated by the Secretary. Enrollment in the plan would be for one year, or until the next open enrollment period.

STANDARDS

In order to be eligible to participate in this demonstration, drug benefit management plans would have to have a contract with the Secretary. There would be no limit on the number of contractors in a demonstration state. The Secretary would develop standards similar to those under the risk contracting program and other standards that would address:

- Access to community pharmacies
- Drug utilization review requirements
- Formulary structure (definition of major indications, minimum requirements and procedures for a physician obtaining coverage of a drug not on the formulary)

- o Beneficiary safeguards in regard to use of prior authorization
- o Compliance programs
- o Procedures for out-of-area claims
- o Financial requirements
- o Quality standards and 50% commercial enrollment

These standards would be developed by the Secretary one year prior to the start of the demonstration.

DBM plans would be required to provide access to a pharmacy in every community throughout the state. In addition to this statewide pharmacy network, mail-order pharmacies could be offered by plans as an option to enrollees.

BENEFICIARY COST-SHARING

Similar to the risk contract program, plans would have the option of offering a cost-sharing structure that would be different from that under standard Medicare. They could

- o require a monthly premium in lieu of part or all other cost-sharing.
- o offer a point-of-service option with coinsurance higher than the 20% under standard Medicare.

However, the actuarial value of the plan's premium and cost-sharing could not exceed 95% of the actuarial value of the deductible and coinsurance under standard Medicare.

In addition, plans would be prohibited from having differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that the Secretary believes would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription drugs.

PAYMENT

One year prior to the start of the demonstration, the Secretary would develop a payment methodology based on the costs of the drug benefit under standard Medicare. Payment to plans would be discounted to take into account the savings generated by restrictive formularies and pharmacy networks.

During the first three years of the demonstration, the Secretary could require plans to provide complete utilization data in order to refine the payment methodology. The Secretary would have the authority to audit this data.

SCOPE

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The demonstration would be authorized for six states selected by the Secretary. In selecting the states, the Secretary would include both highly rural and urban states and states with both a high and low managed care penetration.

The demonstration would begin two years after the start of the standard drug benefit and would continue for five years.

EVALUATION

After the third year of the demonstration, the Secretary would conduct an evaluation to determine whether the capitated DBM plan option should be made available to all beneficiaries.

In particular this evaluation would examine:

- The desirability of a drug only option as compared with a drug benefit provided by an HMO/CMP under a risk contract.
- The differences in effectiveness of drug utilization review provided in standard Medicare, plans under the drug benefit option and HMO/CMPs with risk contracts.
- The extent to which plans experienced favorable selection and the impact of this selection on potential savings under the payment methodology.
- Whether differences existed in potential cost-savings of capitated drug benefit management plans in rural vs urban areas.

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