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tax on high cost health plans

Hard cap on Federal health spending

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Solid fail-safe protection for the Federal budget
Subsidies are targeted very well to low income households
Minimizes job losses
Incentives are improved for insurers and patients

Cons
Won't get universal coverage
Very little private sector cost-containment
Premiums in the community rating pool are likely to be high due to adverse selection; subsidies might not be large enough to cover these higher premiums.
Medicare program savings and no expansion of benefits to the elderly

2. Coverage/Insurance Reforms:

No mandate, but firms of 100+ must offer plans.

2 kinds of groups: age adjusted community rated (limited to firms of < 100 and individuals) and experience rated (for all other groups).

Voluntary purchasing pools for individuals and small businesses with 100 or fewer employees with community rating.

Individuals and small groups could also join FEHB plans but would pay the community rate.

Groups of firms under 100, (MEWAs), are grandfathered into their right to receive experience rating.

Firms with more than 100 workers will be experience rated or self-insured.

Guaranteed renewability and limits on pre-existing condition exclusions.

If 95% not covered by 2002, National Health Commission meets to make (nonbinding) recommendations to Congress on achieving universal coverage.

3. Subsidies:

Once eligible, those below 100% of poverty receive a voucher equal to the average premium price in a geographic area.

Once eligible, those between 100-240% receive a sliding percentage of the average premium price.

Subsidy eligibility phased-in -- from 90% of poverty in 1997 to 240% in 2002, IF financing allows.

No cost-sharing subsidies.

4. Benefit package:

One standard (equal to FEHB's BCBS standard) and one basic (catastrophic)

Under 200% of poverty cannot use subsidies for basic plan

5. High cost plan assessment:

Within each group of plans (community rated and experience rated/self-insured) the highest priced 40% are taxed.

Tax rate is 25 percent of difference between the average premium in that group and the plan's premium.

6. Medicaid:

Preserved as a separate program and beneficiaries are not part of the community rating pool.

State option to enroll limited numbers of Medicaid cash (AFDC & SSI) into private health plans.

Growth in Federal payments is capped.

Disproportionate share payments are phased out by 2000.

7. Medicare:

Program savings smaller than HSA, but most of same proposals.

Includes Durenberger bill proposals that push harder for greater HMO enrollment.

No Medicare drug benefit or new long term care program.

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FEHB remains as is, but those eligible for community rating pool are allowed to join.

Indian Health Service, Veterans' health care, and DoD apparently unaffected.

Outline refers to initiative to improve access in underserved areas through increased resources for community health centers. Specific proposals are unclear, however.

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Deduction limited to average premium in each group.

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Fail-safe mechanism funds subsidies only as other Federal health savings become available

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Tobacco tax (2)	- 70.9	-138.4
High Cost Plan Assessment	- 4.7	- 17.1
Tax Expenditures	+ 6.8	+ 70.2
Other Revenues	+ 2.7	+ 7.1
Net Deficit Effect	-11.5	-14.8

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Baseline Total	339.2	376.6	415.0	456.8	504.7	558.5	617.7	683.9	757.6	840.0
Reform										
Low Income Voucher Program	0	0	30.2	49.5	62.4	75.2	87.0	96.3	103.2	109.9
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Medicare	157.7	172.8	186.3	202.1	214.5	226.8	256.4	281.4	309.6	342.7
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ISSUES AND POSSIBLE SOLUTIONS

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Issues	Possible Solutions
Many remain without coverage, perpetuating uncompensated care and cost-shifting to the privately insured.	Add a triggered employer and/or individual mandate.
Premiums will be high in the community rating pool due to adverse selection.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Can still preserve voluntary nature of purchasing cooperatives.
Some moderate-sized firms will be vulnerable to bad experience rating.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.

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Subsidy schedule produces very high marginal tax rates.	Smooth it out by having the poor pay something.
Pegging the vouchers to the overall average (experience rated pool plus community rated pool) in a geographic area means that very low income individuals will have difficulty affording plans in the community rating area.	Tie the subsidies for each type of pool to the average premium in that type of pool.

3. Benefit Package:

Issues	Possible Solutions
Offering a basic and a standard package will lead to adverse selection and uncompensated care.	Limit access to basic plan to those above specified income levels (250% of poverty, for example).

4. High Cost Plan Assessment

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Assessment is likely to fall on plans with a sicker than average enrollment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.
Little revenue will be raised from the assessment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Also, have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.
Assessment is unlikely to lead to significant cost containment in the private sector.	Have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.

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Issues	Possible Solutions
Limitation of Federal payments while leaving Medicaid program and obligations largely as in current system, places states at risk.	Integration of Medicaid program into larger reform. For example, non-cash assistance recipients could be treated as other low income families.
Disproportionate Share Hospital payments phased out faster than uncompensated care is eliminated, which could have adverse impacts on teaching hospitals.	Tie DSH phase-out to decrease in the number of uninsured.

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Issues	Possible Solutions
Proposal includes Medicare program reductions, but no fee-for-service benefit expansions. Some benefit expansions are available through managed care option.	Phase-in Medicare drug benefit as savings allow.
Unclear if Medicare Choice Act provisions are included in the final proposal. If included, achieving a 7% growth target by the year 2000 could lead to across-the-board reductions. This could lead to increased cost-shifting to the private sector.	Develop specific policies for reduction in spending.

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Issues	Possible Solutions
Tax deductibility for individuals tied to the average priced plan in a geographic area penalizes those in plans with adverse selection.	Tie tax deductibility limits to average of plans in that individual's particular pool.

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Issues	Possible Solutions
Financing will be insufficient to fully fund subsidies on a year by year basis, limiting the expansion of subsidies to more income groups.	Broaden the measure of full financing from a year by year metric to a multi-year (3, for example) metric. Alternatively, other sources of increased revenue could be introduced.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

SPECIAL

May 16, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2723

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: JANET R. FORSGREN (for) B Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: EOP Proposed Report RE: HR 3600, Health Security Act

DEADLINE: NOON May 18, 1994

COMMENTS: The attached speech was given by Rick Kronick at the National Managed Health Care Congress last month. The publication "Institutional Investor" (marketed to the pharmaceutical industry) wants to publish excerpts from the speech.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Greg Lawler
Chris Jennings
Jack Lew
Lynn Margherio
Judy Feder
Judy Whang
Jason Solomon
Meeghan Prunty

LRM #I-2723

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: EOP Proposed Report RE: HR 3600, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

photo here

THE NEW NATIONAL HEALTH CARE AGENDA

by Dr. Richard Kronick

It has often been said that health care in the United States is a paradox of excess and deprivation. We use more resources than any other country in the world to produce medical care, yet it's not clear that we produce better health for our population than our industrial trading partners. → INSERT A

Any serious proposal for health care reform must address the problem of excess and deprivation, and President Clinton's Health Security Act does so in 1,372 pages

of excruciating detail. The HSA is built around five principles: guaranteed private insurance, health benefits guaranteed at work, a guarantee that individuals will have a choice of their doctor and of their health plan, changing the rules of health insurance to end unfair insurance company practices, and preserving and strengthening the Medicare program.

Three areas have generated especially heated debate: the requirement that employers contribute to the cost of health insurance, the structure of health alliances, and premium caps.

The only way to achieve health security for all is to require that everyone who is able to makes some contribution to the financing of care. The three main options are: first, employer contribution requirements; second, individual contribution requirements — so called individual mandates; and third, a broadly based revenue such as a value-added tax.

The decision to rely primarily on an employer mandate was based on a simple consideration. Most people who are insured have that insurance paid for through contributions made by their employers. The HSA continues this practice. Besides being least disruptive, the employer mandate has the advantage that efforts by the largest employers to buy better health care for their employees will lead to improvements in the delivery system. INSERT B

It's clear, however, that employers of very low wage workers cannot afford to pay fully for their health insurance and further that part-time, self- employed and unemployed people with low incomes cannot fully pay for their insurance. The solution proposed by the HSA is a variety of subsidies, the structure of which is now being studied by Congress.

A second key judgment concerns the dreaded "mandatory health alliances." What could we have been thinking of to propose creating such monsters? The answer, quite simply, is that to resolve the problems of excess, it is important to create a market for health plans that works. We wanted to use health-care purchasers efficiently and organize the health care system to deliver high-quality care economically. Further, we wanted to create a market that assured consumers that they could choose their own doctor and that they, not their employer or the government, could choose their health plan. INSERT C

Unfortunately, it is not so simple to make a market work and to guarantee consumer choice. Some of us are going to be more expensive than others to take care of and health plans have strong incentives to avoid serving those of us who are going to be expensive. If a market is going to work, we must prevent health plans from prospering through favorable selection of risks and assure that the plans that prosper are those that do a good job of delivering high-quality care. INSERT D

Alliances have been criticized as monopoly purchasers and a first step toward government takeover of the health care system. This reflects a fundamental misunderstanding. Alliances are not purchasers, so they can't be monopoly purchasers. It is the consumers who are purchasers. In the Health Security Act, alliances are required to offer any plan that meets financial solvency and quality criteria with the potential exception of some very expensive plans. And this requirement prevents them from being a purchaser. Alliances are designed to structure the market for health plans in a fashion similar to the way the SEC structures the stock market.

The third issue is premium caps. I and many others, both within and outside the administration, strongly believe that a restructured market will significantly slow the rate of growth of health care expenditures. The question is, who should bear the risk if these anticipated savings do not materialize? One possible answer is to ask employers, employees and taxpayers who are required to pay for health care to bear the risk if these anticipated savings do not materialize; the other is to ask providers and health plans to do so. The Health Security Act chooses the second alternative. When Medicare and Medicaid were passed, blank checks were written to providers. The judgment in the HSA was that this would not be fair to consumers or taxpayers.

When I started teaching at University of California, San Diego five years ago, one of the lectures I inherited was called "Universal Health Insurance: Its Time is Coming". I am looking forward to the near future when I will give a new lecture titled "How Universal Health Insurance Was Enacted in 1994."

Dr. Kronick is a senior policy advisor to the Clinton White House. He is on leave from the Department of Family and Preventive Medicine at the University of California, San Diego. A longer version of this article was the keynote address at the National Managed Health Care Congress in Washington, D.C. in April.

INSERT A

At the same time, close to 40 million people at any point in time have no insurance coverage at all, and tens of millions more are just one pink slip away from losing their insurance.

INSERT B

Besides being least disruptive, requiring employer contributions will encourage the efforts made by the very largest employers to figure out how to more intelligently purchase health care.

INSERT C

We wanted to create a financing system that gives hospitals and doctors the incentives and opportunities to figure out how to use health care resources to deliver high quality, efficient care.

INSERT D

In any given year, 10% of the population accounts for 70% of health care expenditures, and health plans have strong incentives to avoid serving those of us who are going to be expensive.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

PHONE: (202) 690-7450 **FAX: (202) 690-8425**

TO: **FROM:**

NAME: Chris J. **NAME:** Roger McClung

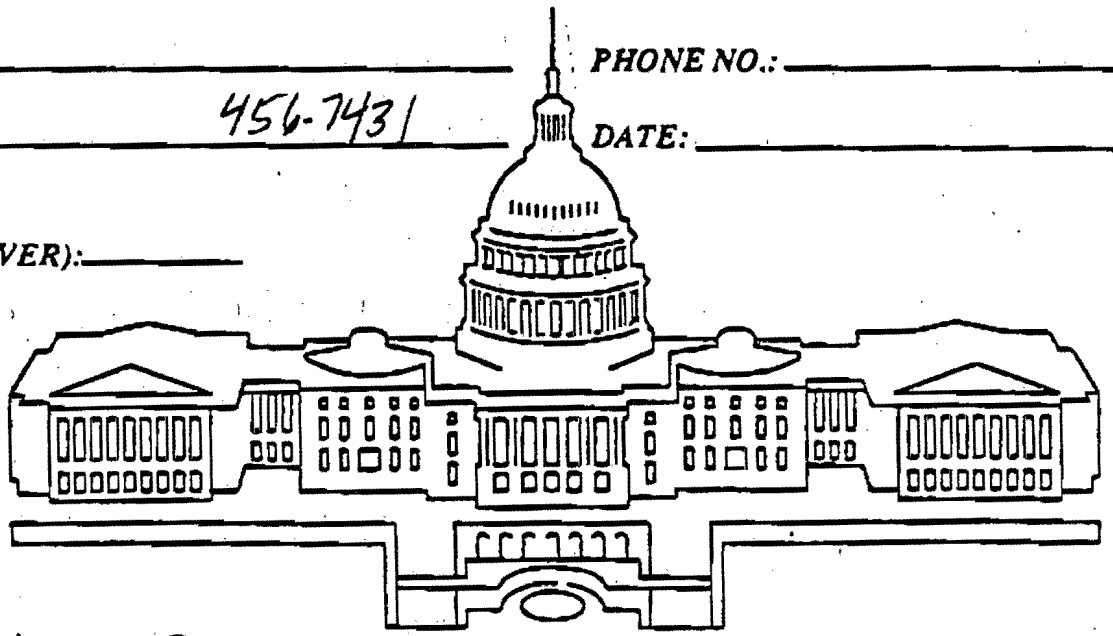
OFFICE: **OFFICE:**

ROOM NO.: **ROOM NO.:**

PHONE NO.: **PHONE NO.:**

FAX NO.: 456-7431 **DATE:**

TOTAL PAGES (INCLUDING COVER):



REMARKS:

Chris —
This is output from Kennedy mark-ups

(1) 2 minor Gregg amendment #1 & 3 accepted as clarification w/out vote

(2) Bingaman compromise alternative to Kassebaum amend. that would have set up benefits board + ~~deleted~~ deleted benefits §.

Roger

SENATOR JUDD GREGG
AMENDMENT
PROTECTION OF CONSUMER CHOICE OF PROVIDER

(1)

AMENDMENT: ~~Strike Section 1003 and replace (1)~~ with:

Add new §(5) to 1003

"Nothing in this Act shall be construed as prohibiting the following:

"(1) An individual from obtaining (at his or her own cost) health care from any health care provider of his or her choice."

Background: This guarantees that Americans can be treated by any physician of their choice. It makes clear that the Act can not prohibit an American from being treated by a particular provider. Of course, if the provider is not part of the individual's health plan, the individual might be personally responsible for paying for care.

(2) Rejected 3:13

AMENDMENT: Add a new subsection (5) to Section 1003, as follows:

"Nothing in this Act shall be construed as prohibiting the following:

"(5) An individual from maintaining his or her existing health insurance policy without any change."

Background: This makes clear that the Act can not force anyone to change his or here existing health care plan if they do not want to.

(3) Add to § 1507(f)(2)

AMENDMENT: ~~Replace Section 1507(f)(2) with:~~

"Nothing in this Act shall be interpreted to: (1) require or force an individual to receive health care solely through his or her health plan; or (2) prohibit any individual from privately contracting with any provider and paying for the treatment or service on a cash basis or any other basis as agreed to between the individual and provider."

Background: This allows individuals to contract for health care as they choose.

O:\BAI\BAI94.658 S.L.C. 5/19 3pm

Accepted 17:0

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide a mechanism for cost containment in the nation's health care system.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. BINGAMAN

Viz:

In section 1101(a), strike "The comprehensive' and insert "Subject to the provisions of section 1603, the comprehensive".

In section 1603(a), insert the following new paragraphs and redesignate the remaining paragraph accordingly:

(2) FISCAL ANALYSIS BY NATIONAL HEALTH BOARD.—

(A) IN GENERAL.—Not later than 6 months prior to the effective date of this Act, the National Health Board, in cooperation with the Congressional Budget Office, shall undertake and a conclude a fiscal analysis of—

(i) the cost of the comprehensive benefits package under section 1101;

(ii) the ability of the health care system's cost containment mechanisms, as defined in this Act, to control health care spending and Federal health expenditures based on current economic projections; and

(iii) the impact of new health care financial obligations under this Act on the Federal budget deficit, in current economic terms, and the source of any projected spending increases, including those described in clauses (i) and (ii), provider reimbursement rates, and administrative expenses.

(B) SUBMISSION OR REPORT.—The Board shall prepare and submit a preliminary analysis under this paragraph not later than January 1,

1997, and submit a final report not later than July 1, 1997, and July 1 of each year thereafter.

(C) REQUIREMENT OF REPORT.—In a report submitted under this paragraph, the Board shall specify the source and amount of any Federal budget deficit increases in order that Congress may more adequately assess other sources of funding or spending reductions that may be appropriate to maintain the benefit package without adjustments.

(D) REPORT.—Based on the fiscal analysis contained in a report under this paragraph, if the Board concludes that the Federal government's obligation to contribute to the health care system (through the provision of subsidies to employers and families) will result in previously unprojected increases in the Federal budget deficit, the Board shall report and make corrective recommendations to the President and the Congress.

(3) REPORT AND RECOMMENDATIONS.—

(A) IN GENERAL.—If determined to be necessary by the Board, in consultation with the Congressional Budget Office, to prevent sig-

nificant Federal deficit increases attributable to the provisions of this Act (or subsequent amendments to this Act), the Board shall include in the reports under paragraph (2)(B), adjustments in specific aspects of the comprehensive benefits package (such as scope of benefits, co-payments, deductibles, and phase-in's for additional benefits) or other appropriate programmatic savings to achieve savings consistent with the findings in a report under paragraph (2).

(B) NO BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains no adjustments in the benefit package, the benefit package described in section 1101 shall become effective, except that the President may take action under section 9100(e)(4) as the President determines appropriate.

(C) BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains adjustments in the benefit package or other appropriate program adjustments, the adjustments shall apply unless a joint resolution disapproving the adjustments is passed by Congress within 45 legislative days of the date of

the submission of the report. The provisions of section 2908 of the Defense Base Closure and Realignment Act of 1990 shall apply to Congressional consideration of a joint resolution considered under this paragraph.

(D) AUTHORITY OF PRESIDENT.—The requirements of this section shall not be limited in any way by section 9100(e)(4) or any other provision of this Act.

(4) SCOPE OF RECOMMENDATIONS.—The Board may make adjustments in the services covered under the benefit package, including any periodicity tables; copayment, deductible, and out-of-pocket requirements; phase-in schedules for additional health benefits; and other appropriate programmatic adjustments. The Board may not require co-payments for preventive health services, but may re-classify services described in section 1101 as preventive services.

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

CR pool 500, Exemption 25, Hard Trigger in 2000, no premium caps

	1995-1999	1995-2004
Subsidies	300	1,077
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(546)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	92
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(97)
Net Other Revenues	(39)	(169)
Net Deficit Effect	10	(116)

50 Billion

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

CR pool 500, Exemption 25, Hard Trigger in 2000, WITH premium cap

	1995-1999	1995-2004
Subsidies	300	1,077
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(546)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	92
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(65)
Net Other Revenues	(39)	(185)
Net Deficit Effect	10	(100)

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

CR pool 500, NO MANDATE, no premium caps

	1995-1999	1995-2004
Subsidies	300	885
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(518)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	91
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(88)
Net Other Revenues	(39)	(151)
Net Deficit Effect	10	(254)

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + _____ DATE: _____

TO: Chris Jennings

Fax: _____

Phone: _____

FROM: Debbie Chang

Fax: (202) 690 - 8168

Phone: _____

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

7/20/94 C

Medicare Savings Proposals

Part A

- Reduce the Annual Hospital Update: Reduce the update for inpatient hospital services by 0.5 percentage points from FY through FY 2000 (FY 1997 is already reduced by 0.5 percentage points so no further reduction would be made for that year).

- Reduce the Indirect Medical Education Adjustment: Beginning with FY 1996, Medicare would discontinue making its IME payments to hospitals and begin to contribute its IME dollars to the academic health center all-payer pool. Medicare's contribution to the academic health center pool would be the amount resulting from reducing the IME adjustment factor from 7.7 percent to 5.2 percent in FY 1996. Beginning with FY 1997 the Medicare contribution in the prior year would be increased by the change in the Consumer Price Index.

- Reduce Payments for Hospital Capital: For PPS hospitals, reduce the base capital rate by 7.31 percent; reduce hospital-specific capital rates by 10.41 percent; and reduce the update to the capital rates by 4.9 percent per year between FY 1996 and FY 2003. Pay 85 percent of capital costs for hospitals and hospital units excluded from PPS for fiscal years 1996 through 2003.

- Revise the Disproportionate Share Hospital Adjustment: Reduce the current Medicare disproportionate share adjustment for PPS hospitals when the State in which they are located comes onto the new system by 20 percent.

- Graduate Medical Education (Cash Lag): Beginning with FY 1996, Medicare will cease to make GME payments to hospitals directly and instead will make a contribution into a national pool. Medicare will contribute $1.5 billion in FY 1996 and $1.6 billion in FY 1997 and FY 1998. Beginning with FY 1999, the Medicare contribution in the prior year would be increased by the change in the Consumer Price Index.

- Extend OBRA93 SNF Update Freeze: Eliminate catch-up that would result after SNF two year temporary freeze expires (i.e., cost reporting periods beginning on or after 10/1/95) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy.

- Long-Term Care Hospital Moratorium: Prohibit new long-term care hospitals from being excluded from PPS, effective upon enactment.

2C

Page 2:

- Extend HI Tax to All State/Local Employees: Extend the health insurance (HI) tax to State and local workers hired before 4/1/86, and currently exempt from the HI tax, effective 10/1/95.

Part B

- Use Real GDP in MVPS for Physician Services: Beginning with FY 1995, replace the current historical five-year volume/intensity factor and performance standard factor used in calculating the Medicare Volume Performance Standard (MVPS) with the five historical growth in real gross domestic product (GDP) per capita for the surgery and other categories and real GDP per capita plus 1.5 percentage points for primary care. Eliminate the current 5 percentage point floor on maximum reductions in updates due to physicians' performance relative to the MVPS.

- Set Cumulative Targets for Physician Services: Establish cumulative MVPS rates of increase for each of the three separate categories of service: primary care, surgery and all other services. Cumulative targets would be based on the prior year's MVPS rate of increase for a fixed year (FY 1994). This is in contrast to the current way the MVPS operates where the MVPS for a year is based on the prior year's actual rate of increase in expenditures, without regard to the prior year's target rate of increase. The statutory formula to determine the specific MVPS amount would be used.

- Eliminate Formula Driven Overpayment: Eliminate formula driven overpayments (FDO) from calculation of blended payment amounts for radiology, diagnostic tests and ambulatory surgery services, effective 7/1/94.

- Competitively Bid for Other Part B Items and Services: The Secretary would be required to contract competitively for Medicare services and supplies in a geographic area effective beginning on 1/1/95. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient of the item or service. The items for competitive procurement are MRIs, CT scans, oxygen and oxygen equipment and enteral and parenteral nutrients and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for these selected services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

3C

- Competitively Bid for Laboratory Services: The Secretary would be required to establish the same kind of competitive acquisition system for Medicare lab services as for other selected Part B items and services, beginning on 1/1/95. If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for all lab services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

- Set Income Related Premiums: Beneficiaries with adjusted gross income of $105,000 or more for a single person or $130,000 for married taxpayers filing joint returns would pay a Part B premium equal to 75 percent of Part B costs, effective 1/1/96. There would be a phase-in of the income related premium for singles between $90,000 and $105,000 and married taxpayers filing joint returns between $115,000 and $130,000 if only one spouse was covered by Medicare Part B. (It would be between $115,000 and $145,000 if both spouses were covered by Medicare Part B).

- Incentives for Physicians for Primary Care: Create incentives for primary care by: (a) establishing a resource-based method to pay for the physician overhead component of the physician fee schedule, increasing primary care practice expense RVUs by 10 percent and decreasing RVUs for all non-primary care services as an offset; (b) increasing the work component of RVUs by 10 percent and reducing relative values for all non primary care services as an offset; (c) reducing rates for office consultations to equal office visits and using savings to increase fees for all office visits; (d) reducing the work component of services with "outlier intensity" values and applying the savings to increase the work component of the relative value for primary care services; and (e) increasing the bonus payment for primary care services in rural and urban Health Professional Shortage Areas (HPSAs) to 20 percent and eliminating the 10 percent bonus payment for non-primary are services in urban HPSAs.

- Prohibition of Balance Billing: Effective 1/1/96, no extra-billing would be permitted in Medicare (i.e., payment may only be made on an assignment-related basis).

- Extend Part B Premium at 25% of Costs: Extend the Part B premium at 25 percent of program costs for 1999 and thereafter.

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Parts A & B

- Establish a Home Health Copayment: Establish a copayment for home health visits at 20 percent of the average cost per visit, effective 7/1/95, for all visits except those occurring within a 30 day period following an inpatient hospital discharge.

- Extend OBRA93 Medicare Secondary Payer: Extend permanently the provisions (which OBRA-93 extended through FY 1998): (a) regarding a data match between HCFA, IRS and SSA to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare; (b) making Medicare the secondary payor for disabled employees with employer-based health insurance; and (c) requiring non-Medicare insurers to be the primary payor for ESRD patients for 18 months before Medicare becomes the primary payor.

- HMO Payment Improvements: Beginning in 1995, establish separate national maximum and minimum standards for the Part A and Part B portions of the AAPCC rates. The standards would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC.

  Counties whose Part A AAPCC is above 170 percent of 95 percent of the Part A USPCC would be limited to that amount unless the Part B portion of their rate was below 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same except the standard would be set at 150 percent of 95 percent of the Part B USPCC.

  The minimum standard would not be phased in. Counties whose Part A AAPCC is below 80 percent of 95 percent of the Part A USPCC would be increased to that amount unless the Part B portion of their rate was above 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same.

- Reduce Routine Cost Limits for HHAs: Eliminate catch-up that would result after HH two year temporary freeze expires (i.e., for cost reporting periods beginning on or after 7/1/96) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy. Reduce cost limits on home health services to 100 percent of the median for cost reporting periods beginning on or after 7/1/97.

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- Expand Centers of Excellence: Expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would encouraged to do so by Medicare providing a rebate to the beneficiary equal to 10 percent of the government's savings from the center.

7/20/94 — D

Medicare Savings Proposals

Part A

- Reduce the Annual Hospital Update: Reduce the update for inpatient hospital services by an additional 0.5 percentage points in FY 1997 (for a total of 1.0 percentage points) and by 1.0 percentage points in FY 1998 through FY 2000.

- Reduce Payments for Hospital Capital: For PPS hospitals, reduce the base capital rate by 7.31 percent; reduce hospital-specific capital rates by 10.41 percent; and reduce the update to the capital rates by 4.9 percent per year between FY 1996 and FY 2003. Pay 85 percent of capital costs for hospitals and hospital units excluded from PPS for fiscal years 1996 through 2003.

- Revise the Disproportionate Share Hospital Adjustment: Reduce the current Medicare disproportionate share adjustment for PPS hospitals when the State in which they are located comes onto the new system by 20 percent.

- Graduate Medical Education (Cash Lag): Beginning with FY 1996, Medicare will cease to make GME payments to hospitals directly and instead will make a contribution into a national pool. Medicare will contribute $1.5 billion in FY 1996 and $1.6 billion in FY 1997 and FY 1998. Beginning with FY 1999, the Medicare contribution in the prior year would be increased by the change in the Consumer Price Index.

- Extend OBRA93 SNF Update Freeze: Eliminate catch-up that would result after SNF two year temporary freeze expires (i.e., cost reporting periods beginning on or after 10/1/95) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy.

- Long-Term Care Hospital Moratorium: Prohibit new long-term care hospitals from being excluded from PPS, effective upon enactment.

- Extend HI Tax to All State/Local Employees: Extend the health insurance (HI) tax to State and local workers hired before 4/1/86, and currently exempt from the HI tax, effective 10/1/95.

Part B

- Use Real GDP in MVPS for Physician Services: Beginning with FY 1995, replace the current historical five-year volume/intensity factor and performance standard factor used in calculating the Medicare Volume Performance Standard (MVPS) with the five historical growth in real gross domestic product

(GDP) per capita for the surgery and other categories and real GDP per capita plus 1.5 percentage points for primary care. Eliminate the current 5 percentage point floor on maximum reductions in updates due to physicians' performance relative to the MVPS.

- Set Cumulative Targets for Physician Services: Establish cumulative MVPS rates of increase for each of the three separate categories of service: primary care, surgery and all other services. Cumulative targets would be based on the prior year's MVPS rate of increase for a fixed year (FY 1994). This is in contrast to the current way the MVPS operates where the MVPS for a year is based on the prior year's actual rate of increase in expenditures, without regard to the prior year's target rate of increase. The statutory formula to determine the specific MVPS amount would be used.

- Eliminate Formula Driven Overpayment: Eliminate formula driven overpayments (FDO) from calculation of blended payment amounts for radiology, diagnostic tests and ambulatory surgery services, effective 7/1/94.

- Competitively Bid for Other Part B Items and Services: The Secretary would be required to contract competitively for Medicare services and supplies in a geographic area effective beginning on 1/1/95. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient of the item or service. The items for competitive procurement are MRIs, CT scans, oxygen and oxygen equipment and enteral and parenteral nutrients and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for these selected services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

- Competitively Bid for Laboratory Services: The Secretary would be required to establish the same kind of competitive acquisition system for Medicare lab services as for other selected Part B items and services, beginning on 1/1/95. If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for all lab services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

- Income Related Part B Premium: Beneficiaries with adjusted gross income of $105,000 or more for a single person or $130,000 for married taxpayers filing joint returns would pay a Part B premium equal to 75 percent of Part B costs, effective 1/1/96. There would be a phase-in of the income related premium for singles between $90,000 and $105,000 and married taxpayers filing joint returns between $115,000 and $130,000 if only one spouse was covered by Medicare Part B. (It would be between $115,000 and $145,000 if both spouses were covered by Medicare Part B).

- Incentives for Physicians for Primary Care: Create incentives for primary care by: (a) establishing a resource-based method to pay for the physician overhead component of the physician fee schedule, increasing primary care practice expense RVUs by 10 percent and decreasing RVUs for all non-primary care services as an offset; (b) increasing the work component of RVUs by 10 percent and reducing relative values for all non-primary care services as an offset; (c) reducing rates for office consultations to equal office visits and using savings to increase fees for all office visits; (d) reducing the work component of services with "outlier intensity" values and applying the savings to increase the work component of the relative value for primary care services; and (e) increasing the bonus payment for primary care services in rural and urban Health Professional Shortage Areas (HPSAs) to 20 percent and eliminating the 10 percent bonus payment for non-primary are services in urban HPSAs.

- Prohibition of Balance Billing: Effective 1/1/96, no extra-billing would be permitted in Medicare (i.e., payment may only be made on an assignment-related basis).

- Laboratory Coinsurance: Re-establish 20 percent coinsurance on laboratory services furnished in physician offices and hospital OPDs (but not independent labs), effective 1/1/95.

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

- Extend Part B Premium at 25% of Costs: Extend the Part B premium at 25 percent of program costs for 1999 and thereafter.

Parts A & B

- Establish a Home Health Copayment: Establish a copayment for home health visits at 10 percent of the average cost per visit, effective 7/1/95 for all visits.

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- o Extend OBRA93 Medicare Secondary Payer: Extend permanently the provisions (which OBRA-93 extended through FY 1998): (a) regarding a data match between HCFA, IRS and SSA to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare; (b) making Medicare the secondary payor for disabled employees with employer-based health insurance; and (c) requiring non-Medicare insurers to be the primary payor for ESRD patients for 18 months before Medicare becomes the primary payor.

- o HMO Payment Improvements: Beginning in 1995, establish separate national maximum and minimum standards for the Part A and Part B portions of the AAPCC rates. The standards would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC.

  Counties whose Part A AAPCC is above 170 percent of 95 percent of the Part A USPCC would be limited to that amount unless the Part B portion of their rate was below 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same except the standard would be set at 150 percent of 95 percent of the Part B USPCC.

  The minimum standard would not be phased in. Counties whose Part A AAPCC is below 80 percent of 95 percent of the Part A USPCC would be increased to that amount unless the Part B portion of their rate was above 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same.

- o Reduce Routine Cost Limits for HHAs: Eliminate catch-up that would result after HH two year temporary freeze expires (i.e., for cost reporting periods beginning on or after 7/1/96) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy. Reduce cost limits on home health services to 100 percent of the median for cost reporting periods beginning on or after 7/1/97.

- o Expand Centers of Excellence: Expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would encouraged to do so by Medicare providing a rebate to the beneficiary equal to 10 percent of the government's savings from the center.

Preliminary Estimates of Reduction in Uninsured By Program Type, 1997 (Millions of Persons)

Program	Lower Estimate	Higher Estimate
Low-Income Voucher	10	12
Welfare to Work Program	1.5	2
Pregnant Women and Kids Under 240%	4	4.5 (6 using EBRI estimates)
Transitional Job-Loss Program	1.5	2.5
Worker Incentive Programs	2.5	4.5
Other Coverage Effects of Individuals	1.0	2.0
Total Covered	20-21	27.5-29 (or 31 with EBRI)

Preliminary Estimates of Reduction in Uninsured By Program Type, 1997 (Millions of Persons)

Program	Lower Estimate	Higher Estimate
Low-Income Voucher	10	12
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Worker Incentive Programs	2.5	4.5
Other Coverage Effects of Individuals	1.0	2.0
Total Covered	20-21	27.5-29 (or 31 with EBRI)

	Model 1
Government Subsidies:	
1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies:	
5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies:	
10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit * (5 Years)	(394)
Net Effect on Deficit * (10 Years)	(70,596)
Net Effect on Deficit *** adjusted by 50% (5 Years)	(197)
Net Effect on Deficit *** adjusted by 50% (10 Years)	(35,298)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

	Model 2
Government Subsidies:	
1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies:	
5 Years ($m)	331,567
employer	129,668
household	201,899
Government Subsidies:	
10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit *	
(5 Years)	(31,533)
Net Effect on Deficit *	
(10 Years)	(153,081)
Net Effect on Deficit	
adjusted by 50% (5 Years)***	(15,767)
Net Effect on Deficit *	
adjusted by 50% (10 Years)***	(76,541)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

	Model 3
Government Subsidies:	
1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies:	
5 Years ($m)	373,982
employer	130,912
household	243,069
Government Subsidies:	
10 Years ($m)	1,009,331
employer	419,118
household	590,213
Select Revenue Estimates: *	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates: *	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit * (5 Years)	(2,398)
Net Effect on Deficit * (10 Years)	(43,149)
Net Effect on Deficit, Adjusted by 50% (5 Years) ***	(1,199)
Net Effect on Deficit, Adjusted by 50% (10 Years) ***	(21,574)

Model 3: An 80% employer mandate on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is implemented.

Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

Firms not covering their workers pay a payroll assessment of 1% if firm has 1-10 workers and 2% if 11-20 workers.

Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

**** 1 Year subsidy estimates assume a fully phased-in carve-out year.

FACSIMILE TRANSMISSION REQUEST

ADDRESSEE: (Name, Organization, Address)	FROM: (Name, Organization, Address)
Chris Jennings Phone:	Barbara Cooper Phone: 690-7063

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The Medicare Choice Act of 1994 (S. 1996) entirely replaces section 1876 of the Social Security Act. Section 1876 contains the statutory provisions that currently govern Medicare contracts with risk and cost-based health maintenance organizations (HMOs) and competitive medical plans (CMPs). The proposed bill is intended to expand the types of choices available to Medicare beneficiaries, reduce the cost to beneficiaries and to Medicare, and level the playing field between managed care plans and Medicare fee-for-service.

I. Summary of the Major Provisions of S. 1996

Competitive Bidding. S. 1996 accomplishes the above goals by establishing a competitive bidding process for Medicare. Medicare market areas are determined, consisting of geographic areas in which Medicare-contracting health plans will compete among themselves and will "compete" against fee-for-service Medicare. Health plan options available to beneficiaries will include employer-sponsored health plans, available only to employees and former employees, that choose to contract under the provisions of S. 1996.

Enrollment. There will be a coordinated open enrollment period during which Medicare beneficiaries will choose a Medicare-contracting plan or fee-for-service Medicare (with or without Medigap coverage--a choice that is also to be made during the coordinated open enrollment period). Enrollment is for a period of one year, during which time plan premiums and coverage cannot be changed. Beneficiaries will make decisions based on unbiased comparative information prepared by the Secretary. The default enrollment is fee-for-service Medicare.

Payments to Health Plans. Health plans are to submit "bids" or premium requirements to the Secretary in August of each year, beginning in 1995. By October 1 of each year, the Secretary will announce the "per capita rate," or government contribution towards premiums, for each market area. The bill specifies the method of determining the per capita rate, or Government contribution. The contribution is based on the lowest health plan bid, subject to certain adjustments based on other plan bids, and subject to certain maximum amounts. To the extent that the per capita rate is less than the health plan bid, the Medicare beneficiary pays the difference to his or her selected health plan in the form of a premium. If the government contribution exceeds the health plan bid, a beneficiary choosing such a health plan is entitled to a rebate from the health plan, or the amount can be applied toward the cost of supplemental benefits purchased from the health plan. Health plans will also collect the Medicare Part B premium that would have otherwise been paid to the Government (for beneficiaries not in fee-for-service Medicare). (Subsequent written information from Senator Durenberger's staff indicates

that in determining the Government contribution, the average is to be used, and that the fee-for-service "premium" would be included in determining that average.)

Payments to health plans are to be risk-adjusted.

Cost to Beneficiaries of Fee-for-Service Medicare. The per capita rate, or Government contribution, for an area, also determines how much beneficiaries choosing fee-for-service Medicare will have to pay in the way of a Part B premium. There is also a provision imposing a penalty for choosing a Medigap supplement that causes Medicare fee-for-service expenditures to rise. (Subsequent written information from Senator Durenberger's staff indicates that there would be no change to the current rules in areas where fee-for-service was the only option.)

Health Plan Standards. The standards for health plans are liberalized with the purpose, according to Senator Durenberger's staff, of allowing preferred provider organizations and other types of managed care organizations to enter into Medicare contracts.

The Secretary is authorized to enter into risk-sharing arrangements in market areas.

Rural Bonus. For beneficiaries residing in "underserved rural areas" within a market area, there is a 10% bonus on per capita payments to contracting health plans enrolling such beneficiaries, available through the year 2000. The bonus payment is to be used to improve access to care for such areas, and is not available to the beneficiary for a reduction in his or her premium.

Benefit Standardization. Benefit standardization among health plans is achieved by requiring that plans offer either the Medicare benefit package with the Medicare fee-for-service coinsurance and deductible structure, or the Medicare benefit package with actuarially equivalent cost-sharing requirements "consistent with common practices among health maintenance organizations and other managed care health plans."

Any additional benefits are available only as supplemental coverage under standardized plans authorized by the Secretary under Medigap statutory authority, and available either through health plans or supplemental insurers. Supplemental coverage must be purchased from the health plan in which the individual is enrolled, except that individuals opting for fee-for-service may purchase supplemental coverage from any sponsor of supplemental coverage.

S. 1996 also requires that at least one of the standardized supplemental plans consist of (a) drug coverage with (b) other coverage that "would resemble coverage typically offered by health maintenance organizations to employer groups, including an annual out-of-pocket maximum beneficiary liability (covering coinsurance, copayments, and

deductibles)." (Subsequent written information from Senator Durenberger's staff states that there are two required standardized supplemental plans, one covering drugs and the other a catastrophic expenses plan, as opposed to the language of S. 1996, which requires that there be one plan covering drugs and catastrophic expenses.)

Fee-for-Service Cost Containment. S. 1996 also contains fee-for-service cost containment provisions. Spending targets are determined for fee-for-service by market area, with population-adjusted year-to-year growth limited, on a phase-in basis, to the consumer price index plus 2.5%. Excess spending is "recouped" by lowering provider payments to recover 50% of the excess, and by increasing premiums for beneficiaries choosing fee-for-service to recover the remaining 50%.

II. General Comments

Positive Aspects of S. 1996. S. 1996 contains many provisions that will improve the Medicare managed care program, some of which are also found in the Health Security Act:

- Standardization of benefits,
- Uniform open enrollment periods including both health plans and Medigap insurers, as well as employer plans,
- Year-long lock-in, and
- Unbiased information dissemination and unbiased enrollment procedures, with expanded information on quality and cost.

These reforms can address many of the problems of the current managed care program--in particular, favorable selection into HMOs and varying levels of knowledge among beneficiaries about managed care.

The proposed bill also expands choices for Medicare beneficiaries in terms of the types of health plans available, and the bill provides incentives for health plans to enroll Medicare beneficiaries in underserved areas, and in lower-payment areas.

The bill includes administrative simplification provisions that are beneficial to the program.

Areas of Concern. There are some provisions of the bill and features of the competitive bidding model that should be more closely examined.

Competitive Bidding and Risk Adjusters. More specific comments are provided below regarding the details of competitive bidding. As a general comment, competitive bidding would seem to work well only in areas where there are multiple health plans, and competitive bidding can only work well if there is a reliable risk adjuster for determining plan payments.

The risk adjuster is especially important under the S. 1996 scenario that involves penalties for beneficiaries choosing a fee-for-service option. S. 1996 does not specifically mention a health status or other risk adjusters (such as risk adjusters for vulnerable populations), and the competitive bidding model proposed in S. 1996 as currently written could be implemented with essentially the current adjusted average per capita cost (AAPCC) methodology.

It would be inappropriate to institute any system in which individual Medicare beneficiaries suffer financial penalties that might not exist if there were more refined risk adjusters. There is no guarantee that the unbiased enrollment process and financial advantages of choosing managed care (which currently exist in Florida and Los Angeles) envisioned in S. 1996 will change the current situation in which HMOs are enrolling a healthier than average population.

(Subsequent written material from Senator Durenberger's staff indicates that their proposal is to "explicitly allow the Secretary to adjust for heart disease, cancer or stroke" (the categories suggested by Mathematica Policy Research, Inc.).)

Basis for Determining Government Contribution. As the bill is now written, beneficiary contribution levels are based on the lowest bid in an area, with a modest add-on related to the average bid (explained below). Subsequent written information from Senator Durenberger's staff indicates that the average is to be used, that the fee-for-service "premium" would be included in determining that average, and that there would be no change to the current rules in areas where fee-for-service was the only option. It would be preferable to use a weighted average bid to determine contribution levels--although determining the weighted average is a problem because it is not known in advance how many beneficiaries will be enrolled in each plan and in fee-for-service.

Cash Rebates. The possibility of cash rebates to Medicare beneficiaries is troublesome. A cash rebate is an inducement to choose a particular plan and may interfere with the ability of a beneficiary to make an informed decision in choosing a health plan based on criteria that the beneficiary should be considering: price, quality, convenience, and willingness to give up freedom of choice of providers.

On the question of price, rather than having a rebate, the same result of program savings and making lower-priced plans more attractive is achieved by the Government's paying low-bid health plans at the level of their bid and having the product offered at a zero premium. All zero-premium plans would be equal, if there were multiple zero-premium plans in an area, which in a sense results in beneficiaries having a greater range of choices among plans because the rebate plan is no longer more attractive than plans that bid at a level that resulted in a zero premium.

It is also misleading to have cash rebates if a plan is also permitted to have deductibles and coinsurance at Medicare levels or at the same actuarial level (as S. 1996 allows); the only Medicare beneficiaries who benefit from cash rebates in such a case are those who use no medical services or are low utilizers of services-- resulting in possible favorable selection.

Beneficiary Penalties. There are a variety of beneficiary penalties, or what can be viewed as penalties, that are difficult to justify:

- The Part B premium varies by area, in relation to fee-for-service costs in a given area; this is a major departure from the current practice of having a uniform national premium. Failure to meet fee-for-service targets, whether there may be valid reasons or not, results in a surcharge to the beneficiary for 50% of the excess. Both of these provisions discriminate against Medicare beneficiaries residing in certain areas, and the penalty beneficiaries suffer results from something that is not, realistically speaking, within their control (area medicare expenditure levels and the rate of growth in expenditures). We also do not have sufficient knowledge about the cause of regional variation in health care costs to impose this sort of penalty on beneficiaries.

- The surcharge on Medigap policies that cause increases in program expenditures is difficult, if not impossible, to administer. How is it determined that a particular policy results in higher program costs? Is this to be determined on a person-specific basis? On a policy-by-policy basis? How do we control for health status? If, for example, it is found that a policy offering drugs lead to higher program costs, is it not likely that such a policy is attractive to sicker individuals? Perhaps of greater concern is that this provision penalizes Medicare beneficiaries for purchasing insurance.

Health Plan Standards. Because S. 1996 is intended to be part of a larger bill which establishes health plan standards, it is unclear whether standards are

sufficient to ensure that Medicare beneficiaries are guaranteed the highest possible quality of care through stable, viable contracting organizations. (This is discussed in more detail below.)

We are also concerned that the anti-discrimination provision of S. 1996 is not as broad as it should be (as broad, for example, as the anti-discrimination provisions of the Health Security Act).

I. Specific Provisions of S. 1996 and Comments

S. 1996 contains the following sections, which become the new subsections of section 1876 of the Social Security Act:

New 1876(a): Market Areas

Medicare market areas are established that will include all Medicare beneficiaries. Metropolitan statistical areas cannot be subdivided in forming such market areas. Designation of the market areas should be done in such a way as to "maximize" the number of beneficiaries who have access to a contracting health plan."

Comments

The designation of Medicare market areas is an important issue. Under the competitive bidding scenario of S. 1996, the market area in which a Medicare beneficiary resides will determine the level of contribution by the Federal Government towards the individual's choice of health plan (or the Part B premium level for fee-for-service). The requirement that metropolitan statistical areas cannot be subdivided, two problems arise: managed care plans will have to extend their provider networks, or be willing to pay for services on a fee-for-service basis in outlying areas of certain MSAs; and use of a wider area (the county) than is currently used for Medicare HMO payments can lead to gaming of the payment system as health plans attempt to encourage enrollment of individuals living within the relatively lower-cost areas of larger metropolitan areas.

In terms of non-metropolitan areas, if, for example, the Secretary were to deem that the appropriate market area is the geographic unit comprised of all rural areas of the State, then this imposes a hardship on managed care plans who must meet the requirement of being available throughout the Medicare market area.

(The Health Security Act addresses this issue by allowing health plans to cover less than an alliance area, though the alliance could require the coverage of certain

geographic areas as a condition of alliance participation. The Health Security Act recognizes that some plans--e.g., staff-model managed care plans-- cannot cover an entire large geographic area. The only similar provision of S. 1996 is a provision that a plan must cover the market area "unless the Secretary determines it appropriate for such plan to target unique community needs within the medicare market area.")

New 1876(b): **Medicare Health Plans**. (1) Contracts and (2) Certification Requirements. Any health plan wishing to do business with the Federal Government may enter into a contract as long as

- Medicare covered services are provided when medically necessary, for a uniform premium for one year;
- The plan does not discriminate against beneficiaries based on health status and other factors related to health care utilization;
- The plan demonstrates that it can provide services throughout the market area, unless the plan is permitted to "target unique community needs";
- The plan demonstrates financial solvency;
- There is an ongoing quality assurance system (same language as current 1876);
- There is compliance with Medicare advance directive requirements (same language as current 1876);
- There are limitations on provider risk-sharing arrangements (same language as current 1876);
- The plan collects and provides to the Secretary standard information on performance and quality of the plan, to be disseminated as part of the comparative marketing material;
- The plan is able to provide non-Medicare-covered benefits; and
- The plan offers standardized supplemental packages as required under S. 1996.

New 1876(b): **Medicare Health Plans** (cont.) (3) Cost-Sharing and (4) Capacity Limits. Health plans must either use the same coinsurance and deductible structure of fee-for-service Medicare, or provide "actuarially equivalent" benefits with "cost sharing requirements that are actuarially equivalent to the cost-sharing requirements [of

Medicare] and consistent with common practices among [HMOs] and other managed care plans."

A point-of-service option for out-of-network services may be made available to Medicare enrollees (who will then be required to pay higher out-of-pocket expenses for out-of-network services), if the plan has a network through which all covered services can be obtained without the higher cost-sharing, and beneficiaries are informed of such option.

Capacity limits are determined by the Secretary through regulations (as in current 1876).

Comments

1. ***Health Plan Standards***

As noted above, because S. 1996 is intended to be part of a larger bill which establishes health plan standards, it is unclear whether standards are sufficient to ensure that Medicare beneficiaries are guaranteed the highest possible quality of care through stable, viable contracting organizations. S. 1996 eliminates the requirement that a contractor be State-licensed and either a Federally-qualified HMO or an entity that meets the current 1876 definition of a competitive medical plan (CMP). According to later information provided by Senator Durenberger's staff, it is intended that S. 1996, as part of a larger health care reform bill, have a certification process for all "accountable health plans," including Medicare plans.

It is important to note that many of the CMP provisions which duplicate Federally-qualified HMO provisions (providing services on a prepaid, capitated basis; protections against insolvency; entering into risk sharing arrangements with providers) are intended to demonstrate that an organization is able to enter into a risk contract for the enrollment of Medicare beneficiaries. That is, the entity must clearly show its ability to bear risk. In fact section 1876(h) authorizes the Secretary to deny a request for a risk contract from an otherwise qualified organization (including a Federally-qualified HMO) if "the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract." The CMP provisions of section 1876 seek to ensure that Medicare contracts are entered into only with organizations able to bear risk for a comprehensive range of benefits. (Note that S. 1996 also does away with the cost contract option for HMOs, making risk the only Medicare option.)

Among the indicators of quality and stability, and beneficiary protections, that S. 1996 does away with, from the current section 1876 language, are the

following (some of which may be included in a larger bill's set of standards for all health plans):

- *Elimination of a clear availability and accessibility requirement which, we assume, would be part of a larger bill's set of standards for all health plans.*

- ***Elimination of the current 1876 grievance and appeal rights** (although Senator Durenberger's staff viewed this as an oversight);*

- *Elimination of the requirement that no more than half of an organization's membership be non-Medicare/Medicaid (the so-called 50/50 requirement), as well as the requirement that an organization have a minimum number of non-Medicare members before beginning operation under a Medicare contract;*

- *Elimination of external review of quality by Medicare's peer review organizations; and*

- *Elimination of the intermediate sanctions and civil monetary penalties of section 1876 for activities such as health screening or underservice, and does not provide the Secretary with authority to terminate a contract for poor performance.*

  > *(Senator Durenberger's staff noted that a termination would arise through decertification of a health plan. S. 1996 does contain provisions for the Secretary to impose financial penalties for health plans that "knowingly violate the prohibition against discrimination against potential enrollees based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services." (Emphasis added.))*

From additional information provided by Senator Durenberger's staff, we know that the intent is to expand the types of delivery networks that are eligible for Medicare contracts--specifically to make preferred provider organizations (PPOs) eligible for Medicare contracts. The current status of PPOs in relation to Medicare risk contractor appears to be unclear to some Capitol Hill staff. Some PPOs are currently eligible for contracts (and at least one PPO, the Hawaii Medical Services Association competitive medical plan, is a section 1876 cost contractor and former risk contract. The current 1876 language states that an eligible organization must provide the full range of services

"primarily" in-plan. HCFA has defined "primarily" as being at least 50% of services; therefore, PPOs that have an at-risk capitated enrollment receiving at least 50% of services currently meet the section 1876 definition of an eligible organization.

2. *Anti-Discrimination*

S. 1996 has a non-discrimination clause only prohibiting discrimination "against beneficiaries based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services," without adding discrimination on the basis of other factors.

Other factors should be added, as in the Health Security Act, which states (at section 1402(c)):

> *No health plan may discriminate, or engage (directly or through contractual arrangements) in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of race, national origin, sex, language, socio-economic status, age, disability, health status, or anticipated need for health services.*

3. *Standardization Not Extended to Copayments and Out-of-Pocket Expenses; Preventive Services Optional*

S. 1996 contains the following language:

> *Each medicare health plan must offer either...(i) medicare benefits, including the cost-sharing requirements otherwise provided in this title; or (ii) actuarially equivalent medicare benefits, as established by the Secretary in regulations, which are medicare benefits, but with cost sharing requirements that are actuarially equivalent to the cost-sharing requirements otherwise provided in this title and consistent with common practices among [HMOs] and other managed care plans.*

Senator Durenberger's staff informed us that this was not necessarily intended to standardize benefits (for example, with all fee-for-service plans having a Medicare-like coinsurance and deductible structure, and all managed care plans having an HMO-like structure with nominal copayments). Under current law, Medicare HMOs may vary use any combination of copayments, coinsurance and premiums to collect revenue from their members, as long as the actuarial value of the amount collected does not exceed the actuarial value

of beneficiaries' out-of-pocket expenses in fee-for-service Medicare. However, such variability does not permit comparability of pricing among plans, which is an essential feature of a competitive bidding model.

Current law permits risk HMOs to add, as mandatory supplemental benefits, items such as preventive services and unlimited hospital stays that are typical of HMOs and which they view as an integral, cost effective element of their benefit package. HCFA's direction in HMO benefit standardization is to continue to permit HMOs to include such services, for which they are permitted to charge members a premium (as non-Medicare-covered services).

New 1876(c): Employer-Sponsored Health Plans, (1) Criteria for Certification, (2) Secondary Payer Coverage

The Secretary is to determine standards for such health plans through regulations. At a minimum, such health plans must provide at least the Medicare benefit package at a premium no higher than the "base beneficiary premium," with the package made available to all current and former employees. In addition, such a health plan must be willing to accept a capitation from Medicare for the actuarial value of the Medicare secondary package for the "working aged" who choose to obtain their Medicare secondary coverage through the plan.

Comments:

- *The spouses of employees and former employees appear to be ineligible for employer health plan coverage.*
- *Employer health plans may choose to participate in Medicare Choice, but they are not obligated to do so (and thereby assume the risk entailed by accepting capitation payments). Hence, to the extent that they do not participate, any program savings for Medicare resulting from non-participating employer health plans that are effective in managing care accrue to the fee-for-service sector in a given market area. (It is assumed that employer plans would accept a capitation and be at risk for Medicare services; however, because some sections of S. 1996 make a distinction between "Medicare health plans" and "employer-sponsored health plans," it is not clear that the latter must meet the requirement of the proposed 1876(b)(2)(A) that the plan accept a capitated payment for a year for the provision of all covered services.)*

- *It is unclear whether HMOs that contract under 1876 as non-employer-sponsored plans may also be employer-sponsored plans. That is, currently, many employers use HMOs as the vehicle for offering employer-sponsored plans. Would that continue? Who would be at risk, the employer or the HMO? Could an HMO have a different bid for the same package--Medicare--for the general public versus employer group enrollees?*

- *If employer plans are non-participating plans, are they subject to any standardization requirements? (It appears that they are not.)*

- *It is envisioned that there would be a separate calculation for the "working aged" capitation rate. Would this be a calculation for a market area, or for each individual employer-sponsored plan, given the degree to which benefits can vary among plans?*

New 1876(d): Managing Medicare Choice, (1) Medicare Health Plan Premiums, (2) Annual Open Enrollment, (3) Information Regarding Medicare Options in a Market Area

A coordinated annual open enrollment period is established. Medicare beneficiaries choose either a contracting plan, fee-for-service Medicare, or, if the beneficiary is eligible, an employer-sponsored health plan. Any supplemental coverage must also be selected during the coordinated open enrollment period. Health plan choices remain in effect for the year. Beneficiaries will be given comparative information on coverage, cost and quality of available health plans. Current section 1876 language requiring the Secretary pre-issuance review of a health plan's marketing material is retained. Individuals with employer primary coverage and Medicare secondary coverage are only eligible for enrollment in an employer-sponsored plan.

Mid-year enrollments are permitted for new eligibles ("individual first becomes entitled to benefits under Part A or enrolled under Part B only"), in the event of the termination of a plan, or for individuals moving to a new geographic area.

The default enrollment is fee-for-service, or, for continuing enrollment from one year to the next, the same health plan as in the preceding year.

Plan "bids" are submitted by August 1 of each year, beginning in 1995, for the following calendar year.

Comments:

It is not clearly stated that the enrollment process will be unbiased, even though that is the intent, according to Senator Durenberger's staff.

For competitive bidding to succeed there must be multiple bidders; however,

- *In some areas fee-for-service will be the only option (and the competitive bidding provisions of this bill that penalize beneficiaries choosing fee-for-service will have an effect in those areas even though there is no other option--although subsequently Durenberger's staff indicated that it is not the case);*

- *Some areas may have only one bidder, and that bidder can easily "game" the bidding process to receive payment at, in many cases, 100% of the area fee-for-service cost, resulting in higher program payments than the current risk contracting program at 95%, and because health plan payments are insulated from any spending targets, such a situation may continue indefinitely (the 100% issue can also be a matter of concern in areas where there are multiple bidders because the bidders can predict with relatively high accuracy the maximum payment level, and may "shadow price" in relation to that maximum, with or without collusion with other plans in an area);*

- *Participation by employer-sponsored plans (or any plans) is not mandatory. It is unclear whether there is a sufficient incentive for employer plans to participate.*

- *The current Medicare risk contracting program has been most successful in high payment areas such as Miami and Los Angeles. The proposed bill may make contracting in such areas unattractive because of the extremely low maximum payment amounts in such areas (low in relation to current payments, and even low--at 1.2--in relation to the Health Security Act payment ceilings of 1.5 for Part B and 1.7 for Part A).*

(On the one-year lock-in issue, subsequent written information provided by Senator Durenberger's staff indicates that there will be an appeals process allowing beneficiaries to disenroll mid-year, and that beneficiaries may disenroll from a health plan if their primary care physician leaves the plan.)

New 1876(d) Managing Medicare Choice (cont.), (4) Risk Adjustments and (5) Payments to Plans

Capitation payments to health plans and employer-sponsored plans are risk-adjusted using the same factors as are currently in use (age, sex, disability, and Medicaid status), and other factors deemed appropriate by the Secretary. The Secretary may enter into risk-sharing arrangements in a market area, "if the Secretary deems it to be appropriate."

There are penalties for discrimination (as discussed above in the section on health plans).

While plans are paid a risk-adjusted rate, plans are also responsible for collection of the entire beneficiary premium, consisting of the amount that in fee-for-service would be the Part B premium plus any additional difference between the plan "bid" for the Medicare package and the Government contribution. Plans are required to provide a rebate to beneficiaries if the plan "bid" is below the Government contribution amount (in which case, the beneficiary also has no Part B premium obligation). The rebate may be in the form of a discount on supplemental coverage elected by the beneficiary.

Comments

- *See the preceding general comments on risk adjustment. Although subsequent written information from Senator Durenberger's staff proposes to have express authority for a health status adjuster suggested by Mathematica, it would be preferable to allow HCFA's current intensive research efforts in this area to continue and to have that research be the basis of developing a risk adjuster--which may in fact be the health status adjuster suggested by Mathematica.*

New 1876(e): Medicare Per Capita Rate (the Government contribution towards premiums)

Contributions Towards Health Plan Premiums

The Government contribution, or Medicare per capita rate, for a market area is the lesser of

(a) a **maximum per capita rate** or
(b) the **"benchmark" premium** for the area less the "base" beneficiary premium for the area.

The figure is announced by October 1 of each year.

The maximum per capita rate is

THE (US) FEE FOR SERVICE PER CAPITA COST IN ALL MARKET AREAS

TIMES

A MARKET AREA ADJUSTMENT FACTOR

MINUS

THE BASE BENEFICIARY PREMIUM FOR THE MARKET AREA.

Formula 1: *Maximum Per Capita Rate*

In the above formula, the (US) FFSPCC includes only fee-for-service expenditures (capitation payments to health plans and employer-sponsored plans are excluded), and FFS costs are determined using solely FFS expenditures (unlike the current US per capita cost that forms the basis of the county adjusted average per capita cost--the USPCC includes payments to Medicare HMOs, which are removed at the county level in determining the AAPCC). Although S. 1996 specifies that market area calculations of local FFSPCC exclude expenditures for Medicare secondary individuals, this is not specified for the determination of the US FFSPCC. In determining the local fee-for-service per capita costs, the "Secretary shall make other adjustments as may be necessary to allow an accurate comparison of FFSPCC for the medicare market area with premiums charged by medicare health plans in such area."

The BASE BENEFICIARY PREMIUM varies by area, and is the Medicare Part B premium (as specified in current law for 1994 and 1995, and 25% of the actuarial rate for beneficiaries age 65 and over thereafter), but the amount is adjusted by the ratio of the area fee-for-service per capita costs to national fee-for-service per capita costs.

S. 1996 also adds provisions, under a new section 1893, discussed below, that imposes premium surcharges for exceeding spending limits in an area and for having coverage under a supplemental policy that causes Medicare expenditures to increase.

The MARKET AREA ADJUSTMENT FACTOR of the above Formula 1 is the ratio of the local to national fee-for-service costs, subject to the following minimum and maximum amounts:

local/US ≤ .8, base is .8	If the local to national ratio is less than .8, .8 is the area adjustment.
local/US >.8 and < .95, base is .85 + (.1 x ((local-.8)/.15))	If the local to national ratio is greater than .8 but less than .95, the area adjustment is .85 plus 10% of the ratio, in relation to .15, of the amount over .8. (For example, if the initial local to national ratio is .9, the ratio becomes .85 plus 10% of .10/.15, which is 10% of .666, or .0666. The revised local to national ratio is .85 + .0666, or .9166. If the initial local to national ration is .949, the adjusted ratio is .85 plus 10% of .149/.15, or approximately .1, resulting in an adjusted ratio of approximately .95.)
If local/US is ≥ .95 and < 1.05, base is not adjusted	If the local to national ratio is at least .95 but less than 1.05, there is no adjustment.
IF local/US is ≥ 1.05 and < 1.2, base is 1.05 + (.1 x ((local-1.05)/.15))	If the local to national ratio is between 1.05 and 1.2, the adjustment is 1.05 plus 10% of the ratio, in relation to .15, of the amount over 1.05. (For example, if the initial ratio is 1.15, the adjusted ratio is 1.05 plus 10% of .10/.15, or .066. The ratio becomes 1.116 rather than 1.15.
If local/US ≥ 1.2, base is 1.2	If the local to national ratio is 1.2 or greater, the adjustment factor is 1.2.

There is a budget neutrality provision requiring that the adjustment factors be changed to ensure that total spending does not exceed what spending would have been had all areas been paid at the (unadjusted) market area fee-for-service per capita costs. The Secretary is also authorized to develop an alternative formula for determining

The Secretary and the Physician Payment Review Commission are to report to Congress every two years on the method of determining the maximum per capita rate.

The Secretary is also given authority to use an alternative formula to determine the maximum per capita rate for a market area under the "pattern" specified in S. 1996.

The benchmark premium is

THE LOWEST HEALTH PLAN PREMIUM "BID" IN A MARKET AREA PLUS A FIXED PERCENTAGE (20% AFTER 1998) OF THE DIFFERENCE BETWEEN THE LOWEST BID AND THE AVERAGE BID

Formula 2: *The Benchmark Premium*

The FIXED PERCENTAGE of the portion of the average bid counted towards the benchmark is 80% in 1996; 60% in 1997; 40% in 1998; 20% thereafter.

Comments

Varying the Part B premium by market area is not a feasible option. (See also the preceding general comments on penalties to beneficiaries.)

As noted above, limiting the market area adjustment factor to a maximum of 1.2 seems very low. If there are to be upper and lower limits, more thought should be given to the factors that contribute to regional variation. Input prices, at least, should be recognized as contributing to regional variation, such that, in many urban areas, a 1.2 limit is unjustifiably low.

New 1876(f): Beneficiary Premiums

Cost to Medicare Beneficiaries in Fee-for-Service

Prior to 1/1/99, the premium for beneficiaries choosing (sic: in some areas, there is no choice, however) fee-for-service, is the BASE BENEFICIARY PREMIUM, as defined above (the Part B premium adjusted by the local variation factor), plus any surcharge arising from S. 1996's cost containment provisions.

Beginning January 1, 1999, Medicare beneficiaries in fee-for-service will pay a Part B premium that varies by area, consisting of the difference between the fee-for-service per capita costs for the market area and the Medicare per capita rate for the area (the per capita rate being the Government contribution towards a health plan as determined

PARTICULAR COMPLEXITIES ASSOCIATED WITH A TRIGGER WITHOUT UNIVERSAL COVERAGE AT THE START

Some proposals for triggered mandates require universal coverage from the start (e.g. an employer requirement above a certain size, with an individual requirement below that size), with the trigger applying only to whether employers below a certain size are required to contribute.

Universal coverage makes it easier to establish a competitive and fair insurance market, because uncompensated care is eliminated and risk selection can be more easily controlled.

A trigger without universal coverage from the start (i.e. with no individual mandate to begin with) makes implementation more complicated in a number of ways, including:

- **AGE RATING.** Until universal coverage is achieved, age adjustments to premiums are necessary to prevent younger/healthier individuals from dropping existing coverage. Age rating is unfair, increases subsidy costs, and is more complicated for employers and families.

- **PRE-EXISTING CONDITION EXCLUSIONS.** Similarly, to guard against people delaying the purchase of insurance until they need health services, pre-existing condition exclusions for the previously uninsured are necessary.

- **UNCOMPENSATED CARE.** Without universal coverage, uncompensated care will continue to distort competition among providers and health plans. Uncompensated are pools are needed to spread the financial burden of serving the remaining uninsured fairly across all health care providers. Accurately measuring uncompensated care can be difficult, and uncompensated care pools require a new (and temporary) administrative structure.

- **MEASUREMENT.** Evaluating whether coverage objectives have been met (particularly if the objectives vary by employer size) is difficult and costly without universal coverage because there would not likely be an enrollment system that includes information about all families.

ALTERNATIVE COMPROMISE PROPOSAL

This proposal builds on the Mitchell/Breaux/Boren-type model, with the following changes:

- It allows for a voluntary insurance market to achieve universal coverage.

- Employers and families who choose to purchase coverage receive subsidies to make coverage affordable (as in the Mitchell/Breaux/Boren-type model).

- For the working population, coverage objectives are established by size of employer, and are evaluated over a five year period.

  - **For firms with 100 or more employees:** After three years, unless 85% of the currently uninsured employees working for these firms are covered, a mandate goes into effect for these firms.

  - **For firms with 25 to 99 employees:** After four years, unless 80% of the currently uninsured employees working for these firms are covered, a mandate goes into effect for firms with 25 or more employees.

  - **For firms with fewer than 25 employees:** After five years, unless 75% of the currently uninsured employees working for these firms are covered, a mandate goes into effect for all firms.

- After five years, to ensure universal coverage, any family not covered through their employer must purchase coverage.

- Insurance market reforms apply upon enactment (e.g., guaranteed issue of coverage and community rating), but special provisions are made so long as the purchase of insurance is voluntary.

  - Insurers are permitted to apply a waiting period for pre-existing conditions when previously uninsured people purchase coverage.

  - Insurers are permitted to adjust community rates by age, but not by health status or other factors.

- To enhance competition and ensure fair application of fall-back premium caps, uncompensated are pools are formed so that the financial burden of serving the remaining uninsured is spread fairly across all health care providers.

This approach achieves universal coverage while providing a similar amount of deficit reduction as the Mitchell/Breaux/Boren-type model. However, without premium caps, the deficit would be substantially increased, and employers and families would pay much more.

population, Florida, Pennsylvania, Iowa, Rhode Island and West Virginia have 50% more elderly than Alaska, Utah, Colorado and Georgia.

3) Current levels of insurance coverage. In Nevada, Oklahoma, Louisiana, Texas and Florida, approximately one-quarter of the population under 65 is uninsured. In Hawaii, Connecticut and Minnesota, less than one-tenth is uninsured.
Clearly problems in different states will require different solutions and timeframes.

For example, what would work in rural areas would not work in urban areas. The means of achieving universal coverage and access are undoubtedly different in Florida and Wyoming. Even within rural areas, the health care concerns of those along the rural sections of the U.S.-Mexico border are vastly different from the needs of ranchers in Montana.

Any successful plan must accommodate the broad diversity in this nation. Yale professors Theodore Marmor and Jerry Mashaw stated in a July 7 Los Angeles Times editorial, "Given the diversity of states, their varied experience with health care and intense local preferences, why enact a single brand of national health reform, especially if it's the poorly considered compromise that we seem to be headed toward? By moving compromise in the direction of preserving goals rather than defining means, we can allow states the further thought and experimentation that are needed for effective implementation."

Why Federalism?: Centralized System Unlikely to Work

Presently, there is insufficient field-based experience and consensus to commit the nation to a single health care model. No state, not Hawaii nor California, has had an adequately extensive or sustained experience with a managed care model. There is not an empirical base of evidence suggesting that such a model should be the centerpiece of national health care reform.

Unfortunately, the federal government's failure to provide waivers to Medicaid, Medicare and the Employee Retirement Income Security Act (ERISA) has limited states' creativity for many years. In the mid-1980's, while I was governor, Florida was unsuccessful in its attempt to receive a waiver from the federal government for a Medicaid buy-in program from the Reagan Administration.

Florida Governor Lawton Chiles was in Washington, D.C., just a few weeks ago pushing again for a federal waiver that would provide 1.1 million uninsured Floridians with health insurance. He has been met with foot-dragging and ho-humming from the Health Care Financing Administration. Why?

A New York Times article dated June 12, 1994, may provide an explanation. According to the article, Health Care Financing Administrator Bruce Vladeck warned in a June 1993 memorandum that "The waiver authority could become a way of relaxing statutory or regulatory provisions considered onerous by the states...." He added that waivers "will be used to slow down nationwide reform." After six months effort, the waiver is still not forthcoming.

PRELIMINARY DRAFT
May 16, 1994 (10:51am)

GENERAL DESCRIPTION	**Benefit Package:** · Two benefit packages, a basic package and a standard package, would be defined. The basic package would be [20%] less than the standard package. · Over a 5-year period, if federal saving are achieved, the value of the basic package would be phased-up to the value of the standard package. ▸ Savings would be assessed annually before benefits are expanded. **Firms with more than 20 employees:** · Employers would be required to pay 80% of the average premium for the basic benefit package. · Employers payments would be capped at a specified percentage of each worker's wage. Smaller firms would receive more generous subsidies. · All firms would be eligible for subsidies. **Firms with 20 or fewer employees ("exempt employers"):** · Exempt employers would not be required to provide coverage. · Exempt employers with fewer than 10 workers pay 1% of payroll. · Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers pay 80% of the average premium for the basic package and are eligible for subsidies. · The exemption would be eliminated if 90% of currently uninsured workers are not insured by 1998 and 95% insured by 2000.

* Explanation that sounds as

GENERAL DESCRIPTION (Continued).	**Families:** · Families working for nonexempt employers pay the difference between the 80% of the average premium for the basic package and the premium of the plan they choose. · Families working for exempt employers pay the entire premium. · Families choosing the standard package are responsible for the full difference between the two packages. · Low-income families are capped at a percentage of income for the family share for the basic package. · Families working for exempt employers are capped at percentage of income for the entire premium for the basic package. · Special subsidies for cost-sharing are provided for low-income families during the phase-in period. **Cost Containment:** · Reverse trigger approach. **Subsidies:** · Federal subsidy costs are capped as in HSA **Community Rating:** · The threshold for community rating is reduced to firms with 1000 or fewer employees. · Firms above the threshold would pay a payroll surcharge of 1%.

DETAILED SPECIFICATIONS	
. Structure	· Each health plan would offer two benefit packages, a basic package and a standard package. · Employers would be required to pay a percentage of the basic package. Employers could pay more (toward the standard package or for supplemental benefits). · Families would be required to have at least the basic package. · All families, including families working for exempt employers, could choose either package. Families would pay the difference between the basic and standard package (without subsidies, although employers may contribute).
. Benefit package; phase-in	Two benefit packages, a standard package and a basic package. Basic package phases-up to standard package over five years. Standard package: · HSA benefit package (with 5% reduction). ▸ FFS and HMO packages as in HSA, with 5% reduction as in Energy and Commerce Staff Draft. Basic package: · [20%][1] lower value than standard package. ▸ FFS package with higher (e.g., $1500 - $2000) hospital deducible and higher (e.g., 25%) coinsurance; reduce value of other benefits through higher cost sharing or limits. Preserve preventive care (either with minor copayments or put in the wrap package for children). ▸ HMO package would closely resemble FFS package, with copayments rather than coinsurance. · Federal deficit reduction targets would be incorporated into law. Annual reviews would be conducted to determine if targets met. Benefit expansion would occur only if deficit reduction target is met. ▸ Deficit reduction target would be $50-100 B over ten years.
	Issues: · With two different levels of benefits, adverse selection against the standard benefit package is a danger. Risk adjustment across the packages could increase the cost of the basic package.

[1] Three scenarios should be tested, with the value of the basic package 10%, 15% and 20% less than the standard package.

. Employer Payments	Firms with more than 20 employees: · Employers generally would be required to pay 80% of the average per worker premium for the basic benefit package. ▸ Employer payment for each worker would be capped at the lower of 80% of the average per worker premium or a specified percentage of the worker's wages (Scenario A schedule). ▸ Large firms (over 1000 threshold) would be eligible for subsidies based on the average per worker premium for community- rated employers in the area. Exempt firms: · Exempt employers would not be required to provide coverage. ▸ Exempt employers with fewer than 10 workers pay 1% of payroll. ▸ Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers are treated as above. · The exemption would be eliminated if specified percentages of the population are not covered by specified dates: ▸ 90% of the population must be insured by 1998; ▸ 95% of the population must be insured by 2000. Self-employed people: · OPTION 1. Self-employed people with employees are treated as employees of themselves and are eligible for exemption. Self-employed people without employees pay as under the HSA. · OPTION 2. All self-employed people are eligible for exemption.

. Employer Payments (Continued)	Per worker premiums: The per worker premium calculation would be based on the employer contributions for the basic package; employer contributions above the amount required (including any payment toward the difference between the basic package and the standard package) would be considered to offset family payment responsibility. Firms with fewer than 20 employee that choose to provide coverage are counted in per worker premium calculation.
. Family Payments	Families working for nonexempt firms (including exempt firms that choose to provide coverage): · Families pay 20% of the average premium for the basic package. · Low-income families are capped at a percentage of income for the family share for the basic package. (Scenario A subsidies). Families working for exempt employers: · Families working for exempt employers pay the entire premium (a per worker employer share and a family share) for the basic package. · Families working for exempt employers are capped at a percentage of income for the entire premium. ▸ The cap ranges from 4-6% (Kennedy schedule for exempt workers). Nonworking families: · Nonworkers pay toward the employer share as under Scenario A. Families choosing standard package: · Families choosing the standard package are responsible for the full difference between the basic and standard packages. · No subsidies apply to the difference. Special rules for dual earners: · Families with a worker in an exempt firm and a worker in a nonexempt firm are treated as a family working for a nonexempt firm.

. Subsidies	Federal costs for subsidies are capped as under the HSA. Employers: · Employer payments for an employee for the basic plan are capped at 2.8% to 12% of the employee's wages. (The Scenario A subsidy schedule applies.) · Caps apply to all employers. For experience rated employer, payments are subsidized only up to the level of required employer contributions for the basic plan in the appropriate community rating area. Families: · Family payments for the family share of the basic plan are capped at 3.9% of income. (The Scenario A subsidy schedule applies.) · Families working for exempt employers are capped at 4–6% of income for the entire premium obligation (Kennedy schedule for exempt workers). · Payments for nonworking families for the employer share are based on nonwage income and are capped as under the Scenario A approach. · Special subsidies for cost-sharing are provided for low-income families during the benefit phase-in period. ▸ Low income families enroll in HMOs (if available). For those under poverty, the difference between the standard HMO cost-sharing and the basic HMO cost-sharing is fully subsidized. A portion of the difference would be subsidized (on a sliding scale basis for those between 100% and [150 – 200%] of poverty. Self-employed: · OPTION 1. Self-employed people without employees pay as under Scenario A (e.g., self-employed without employees capped at small employer schedule). · OPTION 2. All self-employed people are treated as exempt workers unless they employ more than 20 workers in their firm.

. Community rating threshold	Firms with 1000 or fewer employees are part of community rated pools. · Large firms cannot elect to be community rated. · Taft-Hartley trusts and rural electric and telephone cooperatives can elect to be experience rated. · State and local governments with more than 1000 employees can elect to be experience rated. · All experience rated employers (including state and local governments) pay a 1% of payroll surcharge.
. Cost containment	· Constrain initial premiums (as under HSA) and growth rates for first three years: ▸ OPTION 1. HSA growth rates through 1998. ▸ OPTION 2. Managed care growth rates through 1998. Mgd Hsa · Constraints are removed after 1998. If growth exceeds projected rates, constraints are applied in following year. [what are we recapturing? what is permitted rate of growth?]