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

URGENT

July 26, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-3418

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: HHS Drafting Service RE: S 1757, Health Security Act

DEADLINE: **4:00 P.M. July 26, 1994**

COMMENTS: HHS (Peter Hickman) prepared paper that describes the payment methodology for the PBMs to be included in Sen. Mitchell's proposal.

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~~
Chris Jennings
Jack Lew
Lynn Margherio
Greg Lawler
Len Nichols
Mike Dost
Janet Forsgren

LRM #I-3418

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: HHS Drafting Service RE: S 1757, 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

9/26/94

TO: TO CHRIS JENNINGS

RE: RESPONSE TO YOUR REQUEST

I have attached a paper which describes the payment methodology for the PBMs and the measures we suggest be included in the Mitchell proposal which would reduce the possibility of skimming by the PBMs. On a separate track, we are working with Kathy King on modifications to the Duranberger proposal for paying risk HMOs using a bidding process. The payment to the PBMs would parallel this process.

I spoke with Theresa and confirmed with her that the Mitchell proposal includes the additional (CPI) rebate on single source drugs (same as in HSA). I conveyed this to Scott at CBO.

Peter Hickman

Payment Methodology for PBMs

- Payment to PBMs would be parallel to the bidding process envisioned under the Mitchell bill for risk HMOs. Plans would submit bids both for the Medicare benefit and for the standard mandatory "Medigap" benefit which would fill in the deductible and coinsurance. The bid for the "medigap" benefit could not exceed 95% of the actuarial value of the deductible and coinsurance under the fee-for-service benefit.

Measures to Reduce Possibility of Skimming By PBMs

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

  Rationale - Prohibiting enrollment through the plan, as is allowed in the current risk program, would eliminate opportunities for plans to selectively enroll healthy individuals.

- Marketing Restrictions - Direct marketing (e.g. door to door, telemarketing) to beneficiaries would be prohibited. As with the risk program, all marketing materials would have to be approved in advance by the Secretary.

  Rationale - Similar to enrollment issue.

- Disenrollment Surveys - Plans would be required to pay for surveys of individuals who disenroll from the plan during the open enrollment period. Such surveys would attempt to determine whether individuals with medical conditions that require extensive use of prescription drugs are over-represented among disenrollees and what practices of the plan led to the decision of these individuals to disenroll. Plans would face a termination of their contract and/or civil money penalties and intermediate sanctions if they were found to engage in practices that encouraged the disenrollment of such individuals.

  Rationale - Would discourage plans from engaging in practices that would lead to the disenrollment of individuals with medical conditions that require extensive use of prescription drugs.

- Review of Cost-sharing structure - Both HMOs and pharmacy benefit plans would be prohibited from having differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that the Secretary believes would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription

drugs.

Rationale - Prevents cost-sharing structure from being used to discourage enrollment of individuals with high drug needs.

- State-wide Service Areas - Contracts would require state-wide service areas. Pharmacy benefit plans would be required to provide access to a pharmacy in every community throughout the state.

  Rationale - Plans could not "red-line" low-income areas or other areas determined to be less desirable.

- Review of Prior Authorization Programs - The Secretary would have to approve prior authorization programs to ensure both fair procedures and that such programs are not guise for discouraging enrollment of individuals with medical conditions that require extensive use of prescription drugs.

  Rationale - Prevents prior authorization programs from being used to discourage enrollment of individuals with high drug needs.

- Beneficiary Compliance Program - Pharmacy benefit plans would be required to have programs to work with enrollees to improve compliance with prescribed drug regimens.

  Rationale - Such a program would ensure that beneficiaries with significant drug needs are monitored.

- Beneficiary Cost-Sharing - Beneficiaries would be guaranteed 5% savings on average cost sharing relative to fee-for-service benefit.

  Rationale - This guarantee would attract individuals with high drug costs to the PBMs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: JOANNE To: Judy / CHRIS

Phone: (202) 690- _____ Phone: _____
(202) 690-6870
FAX: (202) 401-7321 Fax: _____

Number of Pages (Including Cover): _____

Comments: ① REVISED COMM. RATING ② DEM LA'S FMAP

June 3, 1994

NOTE TO: Gary Claxton/Larry Levit

FROM: Bridgett Taylor

Senate Finance would like to know what the community rate would be if you created a separate purchasing pool for the individual market (unemployed/self employed) and compared that rate to the rate for each of the following groups:

1) 2 to 100
2) 2 to 500
3) 2 to 1000

They would like to see this in both a mandatory and a voluntary market.

Their deadline, if possible, is Monday, June 6 COB.

Thanks,
BT

cc: Jerry Klepner
Karen Pollitz
Chris Jennings
Judy Whang

Ken Thorp

To: Ken Thorpe
From: Jim Mays, Jeanne Lambrew
Re: **Size Effects in a Two Pool System**

Mandatory System

The following table shows the ratios and single person CBO 1994 premiums for two pools assuming a mandatory: non-workers and individuals in HSA-like premium pools (assumes all workers below the firm size cut-off). For example, the 146% value for size 1,000 means that the average premium in the pool for non-workers would be 46% more expensive than the premiums in the pool composed of all employees in firms less than 1,000 employees in a premium pool. The ratio and workers' pool premiums vary since the size of the pool changes. The premiums are more expensive in the smaller pool since there is a different demographic composition that has on average a higher risk. The HSA single premium is higher than that of the other worker pools since it includes both workers and non-workers.

Maximum Employer Size for Workers Pool	Single Premium: Non-Worker Pool (1994 $)	Single Premium: Worker Pool (1994 $)	Ratio of Non-Workers Pool Premium to Workers Pool Premium
1,000	$2,993	$2,049	1.46
500	$2,993	$2,065	1.45
100	$2,993	$2,128	1.41
HSA: 5,000*	$2,100		

* Health Security Act includes non-workers and workers in regional alliances.

Voluntary System

The question of how these ratios would change in a voluntary system is more complicated. Biased selection would make them higher since the large number of lower cost uninsured would be much less likely to buy in if there is no mandate. How big an effect this would be would depend on the parameters of the voluntary system, especially any subsidies and insurance market regulations.

NOTE: Although the request asks for a pool with non-workers and the self-employed, we do not have information available at this time to include the self-employed with the non-workers.

Response to Senate Finance Democratic LA's FMAP Request

Attached are four tables showing the effects of alternate FMAPs on 1992 expenditures; the specifications are those on the attached memo.

For each table:
The first column of the table shows the 1992 FMAP, using the legislated formula.

The second column displays the new FMAP that was calculated according to the specifications. The total taxable resources used in Alternative I is a 3-year average for 1990-1992 from Treasury. The poverty and income data come from the March 1993 CPS. The states' share of individuals at less than 100% of poverty is a 3-year average for 1990-1992. The states' share of individuals at less than 150% of poverty and the states' share of total income are only for 1992 (due to time constraints, the 3-year averages were not used; this may cause some instability in the results). A multiplier was calculated for each of the FMAP alternatives so that there is budget neutrality and a 50% minimum.

The third column shows the FY 1992 federal Medicaid payments to states. These expenditures were calculated by applying the FMAP to the total FY 1992 expenditures as reported in Medicaid Statistics FY 1992. Note that this may not exactly match with other reported expenditures since the total includes services like family planning that are not matched at FMAP. The HCFA Medicaid actuaries think that this is a good approximation, however, of medical assistance payments.

The fourth column shows what the state would have received in 1992 if the new FMAP were in place. It was calculated by multiplying the total (federal and state share) expenditures by the new FMAP.

The fifth column shows the percent change in expenditures from baseline that results from the use of the new FMAP.

The sixth column displays the federal cost of holding states harmless. It was assumed that the states could choose which FMAP they would like to apply, and that states would choose the higher of the two rates. The column shows the federal costs that result when states choose the new FMAP when it is higher than the old FMAP.

① Δ MULTIPLIER
② <150% - CJ

MEDICAID FORMULA CHANGES

Existing formula

Federal Medical Assistance Percentage (FMAP)

FMAP = 1.00 - 0.45 (State PCI / U.S. PCI)2

Alternative I. (GAO alternative 2)

In alternative I state per capita income is replaced with total taxable funding (TTR). This will better reflect a states ability to generate revenue. The U.S. PCI is replaced by the states share of people in poverty. This is based on the number of people with incomes below 150 percent poverty (and 100 percent of poverty). This will better reflect the number of people in need.

FMAP = 1.00 - .4310 (State Share of TTR / State Share of Poverty)

GAO uses the multiplier of .4078 so that the formula would be budget neutral.

This formula maintains a 50 percent minimum matching rate minimum.

Further, all states who would have a lower matching rate under this new formula will be held harmless.

Information from this model should include aggregate national costs, and state by state analysis. We would like separate runs using income below 100% and 150% of poverty.

COMBINED DIFF. - HOLD LOSSES HARMLESS -
STAY IN OLD FORMULA -

COMPARISON -

* GAO/HRD-93-112FS

Alternative II.

In alternative II personal income data is used (like the current formula). This is compared to the states share of poverty. Like model one this adds into the formula a measure of the number of people in poverty, but does not reflect a states fiscal resources as well as model I.

FMAP = 1.00 - .4327 (State Share of Income / State Share of Poverty)

GAo uses the multiplier of .4327 so that the formula would be budget neutral.

This formula maintains a 50 percent minimum matching rate minimum.

Further, all states who would have a lower matching rate under this new formula will be held harmless.

Information from this model should include aggregate national costs, and state by state analysis. We would like separate runs using income below 100% and 150% of poverty.

Alternative I-a: 1992 FMAP: TTR and <100% Poverty-Based FMAP; 50% minimum; Budget Neutral

	Current FMAP 1992	Alternative FMAP (1) Constrained To 50% Minimum	Federal Grant 1992 (2) Current FMAP	Federal Grant 1992 (2) Alternative FMAP	% Change	Cost of State's Choice of Match (3)
United States			66,363,914,755	66,360,319,589	-0.0%	2,088,670,962
Alabama	0.7293	0.7410	1,096,342,784	1,113,919,470	1.6%	17,576,686
Alaska	0.5000	0.5000	99,050,271	99,050,271	0.0%	0
Arizona	0.6251	0.6361	722,448,045	735,124,244	1.8%	12,676,199
Arkansas	0.7566	0.7546	699,374,146	697,538,620	-0.3%	0
California	0.5000	0.5628	5,825,883,562	6,557,079,377	12.6%	731,195,815
Colorado	0.5479	0.5000	541,371,830	494,042,553	-8.7%	0
Connecticut	0.5000	0.5000	1,119,631,094	1,119,631,094	0.0%	0
Delaware	0.5000	0.5000	109,699,852	109,699,852	0.0%	0
Dis. of Col.	0.5012	0.5000	293,329,473	292,627,168	-0.2%	0
Florida	0.5469	0.6382	2,226,955,011	2,598,695,270	16.7%	371,740,259
Georgia	0.6178	0.6547	1,507,712,772	1,597,865,881	6.0%	90,153,109
Hawaii	0.5257	0.5000	179,782,157	170,993,111	-4.9%	0
Idaho	0.7324	0.6675	194,427,112	177,191,358	-8.9%	0
Illinois	0.5000	0.5513	2,106,107,962	2,322,005,295	10.3%	215,897,333
Indiana	0.6385	0.5884	1,414,964,672	1,303,903,717	-7.8%	0
Iowa	0.6504	0.5000	573,800,730	441,113,723	-23.1%	0
Kansas	0.6504	0.5000	594,615,275	457,115,063	-23.1%	0
Kentucky	0.7282	0.7269	1,320,081,567	1,317,715,262	-0.2%	0
Louisiana	0.7544	0.7559	2,511,033,164	2,516,011,977	0.2%	4,978,814
Maine	0.6240	0.6086	453,584,939	442,360,383	-2.5%	0
Maryland	0.5000	0.5000	973,867,909	973,867,909	0.0%	0
Massachusett	0.5000	0.5000	2,067,091,525	2,067,091,525	0.0%	0
Michigan	0.5541	0.5854	2,115,165,974	2,234,608,821	5.6%	119,442,847
Minnesota	0.5443	0.5021	1,043,770,741	962,829,137	-7.8%	0
Mississippi	0.7999	0.8351	856,258,974	893,894,473	4.4%	37,635,499
Missouri	0.6084	0.6115	1,405,578,418	1,412,705,056	0.5%	7,126,638
Montana	0.7170	0.6948	190,543,290	184,643,250	-3.1%	0
Nebraska	0.6450	0.5000	303,686,321	235,415,753	-22.5%	0
Nevada	0.5000	0.5000	181,573,254	181,573,254	0.0%	0
New Hampshi	0.5000	0.5000	552,111,188	552,111,188	0.0%	0
New Jersey	0.5000	0.5000	2,274,492,045	2,274,492,045	0.0%	0
New Mexico	0.7433	0.7806	386,432,414	405,838,040	5.0%	19,405,627
New York	0.5000	0.5178	9,432,934,779	9,768,737,995	3.6%	335,803,217
North Carolina	0.6652	0.6044	1,618,822,468	1,470,781,959	-9.1%	0
North Dakota	0.7275	0.6116	181,341,634	152,450,046	-15.9%	0
Ohio	0.6063	0.5533	2,885,801,714	2,633,638,190	-8.7%	0
Oklahoma	0.7074	0.7127	730,581,464	736,071,340	0.8%	5,489,876
Oregon	0.6355	0.5331	509,167,819	427,148,946	-16.1%	0
Pennsylvania	0.5684	0.5000	3,506,313,559	3,084,371,533	-12.0%	0
Rhode Island	0.5329	0.5000	413,905,034	388,351,505	-6.2%	0
South Carolin	0.7266	0.7123	1,089,949,792	1,068,433,068	-2.0%	0
South Dakota	0.7259	0.6338	172,050,383	150,219,349	-12.7%	0
Tennessee	0.6841	0.6780	1,607,153,569	1,592,926,205	-0.9%	0
Texas	0.6418	0.6614	3,907,220,071	4,026,769,114	3.1%	119,549,043
Utah	0.7511	0.5266	312,908,374	219,382,340	-29.9%	0
Vermont	0.6137	0.5216	153,722,759	130,653,320	-15.0%	0
Virginia	0.5000	0.5000	789,960,287	789,960,287	0.0%	0
Washington	0.5498	0.5000	1,103,976,170	1,003,979,784	-9.1%	0
West Virginia	0.7768	0.7722	723,053,301	718,767,480	-0.6%	0
Wisconsin	0.6038	0.5000	1,202,202,229	995,530,167	-17.2%	0
Wyoming	0.6910	0.5000	82,080,879	59,392,821	-27.6%	0

NOTES

(1) Based on the ratio of the state share of total taxable resources (3-year average for 1990-1992) from Treasury and state share of persons below 100% of poverty (3-year average for 1990-1992) from the Current Population Survey. The multiplier is .4289.

(2) Data from the Medicaid Statistics FY 1992; Table VA-1. NOTE: Included in these data are expenditures at different match rates and disallowances. As a consequence, the reported state and Federal shares are not consistent with the FMAP. The HCFA baseline used in the Federal budget analysis is most consistent with the total expenditures (state plus Federal shares). Thus, for the purposes of this analysis, the combined state and Federal shares were multiplied by the current FMAP to get 1992 Federal grants.

(3) The cost of allowing state that would have a lower match under the alternative FMAP to retain their current FMAP.

This analysis does not include the territories.

Alternative I-b: 1992 FMAP: TTR and <150% Poverty-Based FMAP; 50% minimum; Budget Neutral

	Current FMAP 1992	Alternative FMAP (1) Constrained To 50% Minimum	Federal Grant 1992 (2) Current FMAP	Federal Grant 1992 (2) Alternative FMAP	% Change	Cost of State's Choice of Match (3)
United States			66,363,914,755	66,366,906,050	0.0%	1,831,466,174
Alabama	0.7293	0.7140	1,096,342,784	1,073,337,973	-2.1%	0
Alaska	0.5000	0.5000	99,050,271	99,050,271	0.0%	0
Arizona	0.6251	0.6241	722,448,045	721,278,987	-0.2%	0
Arkansas	0.7566	0.7650	699,374,146	707,145,261	1.1%	7,771,115
California	0.5000	0.5751	5,825,883,562	6,700,519,912	15.0%	874,636,350
Colorado	0.5479	0.5000	541,371,830	494,042,553	-8.7%	0
Connecticut	0.5000	0.5000	1,119,631,094	1,119,631,094	0.0%	0
Delaware	0.5000	0.5000	109,699,852	109,699,852	0.0%	0
Dis. of Col.	0.5012	0.5000	293,329,473	292,627,168	-0.2%	0
Florida	0.5469	0.6585	2,226,955,011	2,681,214,614	20.4%	454,259,603
Georgia	0.6178	0.6527	1,507,712,772	1,592,872,165	5.6%	85,159,393
Hawaii	0.5257	0.5000	179,782,157	170,993,111	-4.9%	0
Idaho	0.7324	0.6911	194,427,112	183,460,884	-5.6%	0
Illinois	0.5000	0.5441	2,106,107,962	2,291,794,361	8.8%	185,686,399
Indiana	0.6385	0.5890	1,414,964,672	1,305,331,921	-7.7%	0
Iowa	0.6504	0.5844	573,800,730	515,533,811	-10.2%	0
Kansas	0.6504	0.5000	594,615,275	457,115,063	-23.1%	0
Kentucky	0.7282	0.7223	1,320,081,567	1,309,448,712	-0.8%	0
Louisiana	0.7544	0.7330	2,511,033,164	2,439,832,353	-2.8%	0
Maine	0.6240	0.6217	453,584,939	451,946,330	-0.4%	0
Maryland	0.5000	0.5000	973,867,909	973,867,909	0.0%	0
Massachusett	0.5000	0.5000	2,067,091,525	2,067,091,525	0.0%	0
Michigan	0.5541	0.5423	2,115,165,974	2,070,064,406	-2.1%	0
Minnesota	0.5443	0.5335	1,043,770,741	1,023,018,849	-2.0%	0
Mississippi	0.7999	0.8191	856,258,974	876,823,232	2.4%	20,564,258
Missouri	0.6084	0.6376	1,405,578,418	1,472,946,589	4.8%	67,368,171
Montana	0.7170	0.7023	190,543,290	186,644,584	-2.0%	0
Nebraska	0.6450	0.5142	303,686,321	242,116,886	-20.3%	0
Nevada	0.5000	0.5351	181,573,254	194,309,600	7.0%	12,736,346
New Hampshi	0.5000	0.5000	552,111,188	552,111,188	0.0%	0
New Jersey	0.5000	0.5000	2,274,492,045	2,274,492,045	0.0%	0
New Mexico	0.7433	0.7499	386,432,414	389,865,051	0.9%	3,432,638
New York	0.5000	0.5000	9,432,934,779	9,432,934,779	0.0%	0
North Carolin	0.6652	0.6229	1,618,822,468	1,515,769,405	-6.4%	0
North Dakota	0.7275	0.5661	181,341,634	141,104,049	-22.2%	0
Ohio	0.6063	0.5599	2,885,801,714	2,665,044,863	-7.6%	0
Oklahoma	0.7074	0.7194	730,581,464	742,952,578	1.7%	12,371,114
Oregon	0.6355	0.5802	509,167,819	464,821,816	-8.7%	0
Pennsylvania	0.5684	0.5089	3,506,313,559	3,139,287,752	-10.5%	0
Rhode Island	0.5329	0.5000	413,905,034	388,351,505	-6.2%	0
South Carolin	0.7266	0.7300	1,089,949,792	1,095,047,249	0.5%	5,097,457
South Dakota	0.7259	0.6751	172,050,383	160,016,747	-7.0%	0
Tennessee	0.6841	0.6946	1,607,153,569	1,631,836,362	1.5%	24,682,794
Texas	0.6418	0.6537	3,907,220,071	3,979,748,495	1.9%	72,528,423
Utah	0.7511	0.5733	312,908,374	238,855,377	-23.7%	0
Vermont	0.6137	0.5318	153,722,759	133,198,005	-13.4%	0
Virginia	0.5000	0.5000	789,960,287	789,960,287	0.0%	0
Washington	0.5498	0.5000	1,103,976,170	1,003,979,784	-9.1%	0
West Virginia	0.7768	0.7824	723,053,301	728,225,415	0.7%	5,172,114
Wisconsin	0.6038	0.5104	1,202,202,229	1,016,150,501	-15.5%	0
Wyoming	0.6910	0.5000	82,080,879	59,392,821	-27.6%	0

NOTES

(1) Based on the ratio of the state share of total taxable resources (3-year average for 1990-1992) from Treasury and state share of persons below 150% of poverty (1992) from the Current Population Survey. The multiplier is .4267.

(2) Data from the Medicaid Statistics FY 1992; Table VA-1. NOTE: Included in these data are expenditures at different match rates and disallowances. As a consequence, the reported state and Federal shares are not consistent with the FMAP. The HCFA baseline used in the Federal budget analysis is most consistent with the total expenditures (state plus Federal shares). Thus, for the purposes of this analysis, the combined state and Federal shares were multiplied by the current FMAP to get 1992 Federal grants.

(3) The cost of allowing state that would have a lower match under the alternative FMAP to retain their current FMAP.

This analysis does not include the territories.

Alternative II-a: 1992 FMAP: Income and <100% Poverty-Based FMAP; 50% minimum; Budget Neutral

	Current FMAP 1992	Alternative FMAP (1) Constrained To 50% Minimum	Federal Grant 1992 (2) Current FMAP	Federal Grant 1992 (2) Alternative FMAP	% Change	Cost of State's Choice of Match (3)
United States			66,363,914,755	66,363,578,594	-0.0%	2,606,335,931
Alabama	0.7293	0.7080	1,096,342,784	1,064,346,691	-2.9%	0
Alaska	0.5000	0.5000	99,050,271	99,050,271	0.0%	0
Arizona	0.6251	0.5886	722,448,045	680,242,397	-5.8%	0
Arkansas	0.7566	0.7238	699,374,146	669,058,203	-4.3%	0
California	0.5000	0.5526	5,825,883,562	6,438,598,352	10.5%	612,714,790
Colorado	0.5479	0.5000	541,371,830	494,042,553	-8.7%	0
Connecticut	0.5000	0.5000	1,119,631,094	1,119,631,094	0.0%	0
Delaware	0.5000	0.5000	109,699,852	109,699,852	0.0%	0
Dis. of Col.	0.5012	0.6879	293,329,473	402,599,901	37.3%	109,270,428
Florida	0.5469	0.6244	2,226,955,011	2,542,674,443	14.2%	315,719,432
Georgia	0.6178	0.6485	1,507,712,772	1,582,536,224	5.0%	74,823,453
Hawaii	0.5257	0.5000	179,782,157	170,993,111	-4.9%	0
Idaho	0.7324	0.6364	194,427,112	168,940,027	-13.1%	0
Illinois	0.5000	0.5342	2,106,107,962	2,249,967,485	6.8%	143,859,523
Indiana	0.6385	0.5813	1,414,964,672	1,288,128,867	-9.0%	0
Iowa	0.6504	0.5000	573,800,730	441,113,723	-23.1%	0
Kansas	0.6504	0.5000	594,615,275	457,115,063	-23.1%	0
Kentucky	0.7282	0.7181	1,320,081,567	1,301,850,881	-1.4%	0
Louisiana	0.7544	0.7660	2,511,033,164	2,549,665,667	1.5%	38,632,503
Maine	0.6240	0.6027	453,584,939	438,091,927	-3.4%	0
Maryland	0.5000	0.5000	973,867,909	973,867,909	0.0%	0
Massachusett	0.5000	0.5000	2,067,091,525	2,067,091,525	0.0%	0
Michigan	0.5541	0.5412	2,115,165,974	2,065,951,060	-2.3%	0
Minnesota	0.5443	0.5177	1,043,770,741	992,698,795	-4.9%	0
Mississippi	0.7999	0.8123	856,258,974	869,513,658	1.5%	13,254,684
Missouri	0.6084	0.6066	1,405,578,418	1,401,319,370	-0.3%	0
Montana	0.7170	0.6543	190,543,290	173,878,997	-8.7%	0
Nebraska	0.6450	0.5000	303,686,321	235,415,753	-22.5%	0
Nevada	0.5000	0.5000	181,573,254	181,573,254	0.0%	0
New Hampshi	0.5000	0.5000	552,111,188	552,111,188	0.0%	0
New Jersey	0.5000	0.5000	2,274,492,045	2,274,492,045	0.0%	0
New Mexico	0.7433	0.7456	386,432,414	387,653,495	0.3%	1,221,081
New York	0.5000	0.5643	9,432,934,779	10,645,356,582	12.9%	1,212,421,804
North Carolin	0.6652	0.6023	1,618,822,468	1,465,850,297	-9.4%	0
North Dakota	0.7275	0.5942	181,341,634	148,110,400	-18.3%	0
Ohio	0.6063	0.5114	2,885,801,714	2,434,033,258	-15.7%	0
Oklahoma	0.7074	0.6794	730,581,464	701,684,643	-4.0%	0
Oregon	0.6355	0.5000	509,167,819	400,604,107	-21.3%	0
Pennsylvania	0.5684	0.5000	3,506,313,559	3,084,371,533	-12.0%	0
Rhode Island	0.5329	0.5000	413,905,034	388,351,505	-6.2%	0
South Carolin	0.7266	0.6735	1,089,949,792	1,010,286,929	-7.3%	0
South Dakota	0.7259	0.6289	172,050,383	149,050,745	-13.4%	0
Tennessee	0.6841	0.6798	1,607,153,569	1,597,126,147	-0.6%	0
Texas	0.6418	0.6557	3,907,220,071	3,991,638,305	2.2%	84,418,233
Utah	0.7511	0.5000	312,908,374	208,300,076	-33.4%	0
Vermont	0.6137	0.5000	153,722,759	125,242,594	-18.5%	0
Virginia	0.5000	0.5000	789,960,287	789,960,287	0.0%	0
Washington	0.5498	0.5000	1,103,976,170	1,003,979,784	-9.1%	0
West Virginia	0.7768	0.7744	723,053,301	720,794,634	-0.3%	0
Wisconsin	0.6038	0.5000	1,202,202,229	995,530,167	-17.2%	0
Wyoming	0.6910	0.5000	82,080,879	59,392,821	-27.6%	0

NOTES

(1) Based on the ratio of the state share of total income (1992) and the state share of persons below 100% of poverty (3-year average for 1990-1992) from the Current Population Survey. The multiplier is .4446.

(2) Data from the Medicaid Statistics FY 1992; Table VA-1. NOTE: Included in these data are expenditures at different match rates and disallowances. As a consequence, the reported state and Federal shares are not consistent with the FMAP. The HCFA baseline used in the Federal budget analysis is most consistent with the total expenditures (state plus Federal shares). Thus, for the purposes of this analysis, the combined state and Federal shares were multiplied by the current FMAP to get 1992 Federal grants.

(3) The cost of allowing state that would have a lower match under the alternative FMAP to retain their current FMAP.

This analysis does not include the territories.

Alternative II-b: 1992 FMAP: Income and <150% Poverty-Based FMAP; 50% minimum; Budget Neutral

	Current FMAP 1992	Alternative FMAP (1) Constrained To 50% Minimum	Federal Grant 1992 (2)		% Change	Cost of State's Choice of Match (3)
			Current FMAP	Alternative FMAP		
United States			66,363,914,755	66,362,289,601	-0.0%	2,501,815,563
Alabama	0.7293	0.6814	1,096,342,784	1,024,317,794	-6.6%	0
Alaska	0.5000	0.5000	99,050,271	99,050,271	0.0%	0
Arizona	0.6251	0.5801	722,448,045	670,386,158	-7.2%	0
Arkansas	0.7566	0.7386	699,374,146	682,756,136	-2.4%	0
California	0.5000	0.5703	5,825,883,562	6,645,159,271	14.1%	819,275,710
Colorado	0.5479	0.5000	541,371,830	494,042,553	-8.7%	0
Connecticut	0.5000	0.5000	1,119,631,094	1,119,631,094	0.0%	0
Delaware	0.5000	0.5000	109,699,852	109,699,852	0.0%	0
Dis. of Col.	0.5012	0.6591	293,329,473	385,767,775	31.5%	92,438,302
Florida	0.5469	0.6497	2,226,955,011	2,645,366,721	18.8%	418,411,710
Georgia	0.6178	0.6505	1,507,712,772	1,587,635,280	5.3%	79,922,509
Hawaii	0.5257	0.5000	179,782,157	170,993,111	-4.9%	0
Idaho	0.7324	0.6662	194,427,112	176,853,717	-9.0%	0
Illinois	0.5000	0.5323	2,106,107,962	2,242,130,234	6.5%	136,022,272
Indiana	0.6385	0.5869	1,414,964,672	1,300,514,610	-8.1%	0
Iowa	0.6504	0.5750	573,800,730	507,301,487	-11.6%	0
Kansas	0.6504	0.5000	594,615,275	457,115,063	-23.1%	0
Kentucky	0.7282	0.7168	1,320,081,567	1,299,449,438	-1.6%	0
Louisiana	0.7544	0.7471	2,511,033,164	2,486,693,699	-1.0%	0
Maine	0.6240	0.6206	453,584,939	451,114,850	-0.5%	0
Maryland	0.5000	0.5000	973,867,909	973,867,909	0.0%	0
Massachusett	0.5000	0.5000	2,067,091,525	2,067,091,525	0.0%	0
Michigan	0.5541	0.5000	2,115,165,974	1,908,650,040	-9.8%	0
Minnesota	0.5443	0.5534	1,043,770,741	1,061,232,034	1.7%	17,461,293
Mississippi	0.7999	0.7966	856,258,974	852,685,568	-0.4%	0
Missouri	0.6084	0.6373	1,405,578,418	1,472,331,194	4.7%	66,752,776
Montana	0.7170	0.6668	190,543,290	177,203,297	-7.0%	0
Nebraska	0.6450	0.5045	303,686,321	237,535,884	-21.8%	0
Nevada	0.5000	0.5682	181,573,254	206,342,523	13.6%	24,769,270
New Hampshi	0.5000	0.5000	552,111,188	552,111,188	0.0%	0
New Jersey	0.5000	0.5000	2,274,492,045	2,274,492,045	0.0%	0
New Mexico	0.7433	0.7134	386,432,414	370,912,632	-4.0%	0
New York	0.5000	0.5391	9,432,934,779	10,171,237,157	7.8%	738,302,378
North Carolin	0.6652	0.6254	1,618,822,468	1,521,954,112	-6.0%	0
North Dakota	0.7275	0.5520	181,341,634	137,589,395	-24.1%	0
Ohio	0.6063	0.5243	2,885,801,714	2,495,426,451	-13.5%	0
Oklahoma	0.7074	0.6906	730,581,464	713,179,670	-2.4%	0
Oregon	0.6355	0.5044	509,167,819	404,149,766	-20.6%	0
Pennsylvania	0.5684	0.5000	3,506,313,559	3,084,371,533	-12.0%	0
Rhode Island	0.5329	0.5000	413,905,034	388,351,505	-6.2%	0
South Carolin	0.7266	0.6972	1,089,949,792	1,045,909,512	-4.0%	0
South Dakota	0.7259	0.6746	172,050,383	159,900,901	-7.1%	0
Tennessee	0.6841	0.6999	1,607,153,569	1,644,239,421	2.3%	37,085,853
Texas	0.6418	0.6520	3,907,220,071	3,969,117,023	1.6%	61,896,951
Utah	0.7511	0.5000	312,908,374	208,300,076	-33.4%	0
Vermont	0.6137	0.5000	153,722,759	125,242,594	-18.5%	0
Virginia	0.5000	0.5000	789,960,287	789,960,287	0.0%	0
Washington	0.5498	0.5000	1,103,976,170	1,003,979,784	-9.1%	0
West Virginia	0.7768	0.7870	723,053,301	732,529,841	1.3%	9,476,540
Wisconsin	0.6038	0.5000	1,202,202,229	995,530,167	-17.2%	0
Wyoming	0.6910	0.5126	82,080,879	60,885,455	-25.8%	0

NOTES

(1) Based on the ratio of the state share of total income (1992) and state share of persons below 150% of poverty (1992) from the Current Population Survey. The multiplier is .4371.

(2) Data from the Medicaid Statistics FY 1992; Table VA-1. NOTE: Included in these data are expenditures at different match rates and disallowances. As a consequence, the reported state and Federal shares are not consistent with the FMAP. The HCFA baseline used in the Federal budget analysis is most consistent with the total expenditures (state plus Federal shares). Thus, for the purposes of this analysis, the combined state and Federal shares were multiplied by the current FMAP to get 1992 Federal grants.

(3) The cost of allowing state that would have a lower match under the alternative FMAP to retain their current FMAP.

This analysis does not include the territories.

FAX MESSAGE COVER SHEET

CENTER ON BUDGET AND POLICY PRIORITIES
777 North Capitol Street, NE, Suite 705
Washington, DC 20002

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FYI.

2ND ATTEMPT

FYI

CENTER ON BUDGET AND POLICY PRIORITIES

June 13, 1994

URGENT

TO: Jon Weintraub
Labor Management Subcommittee

FR: Ellen Nissenbaum, Legislative Director

RE: Goodling amendment to delete or modify important WIC provision in the Chairman's health care mark

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may

Rep. Goodling intends to offer two amendments to delete or substantially alter the WIC provision contained in the Chairman's health care reform mark. This provision, included in the President's original proposal, would guarantee full funding of the WIC program by 1996 and through 2000. It establishes a special mandatory fund for WIC in addition to regular appropriations. Since the cost of the WIC fund must be offset with pay-go savings within health care reform itself, this provision does not increase the deficit. In fact, recent studies of cost savings resulting from WIC indicate that this provision will help reduce and even avert costly health expenditures in the future.

Rep. Goodling is expected first to attempt to delete the entire provision. If, as expected, this amendment fails, Goodling will offer a second amendment in a nature of a substitute -- one that poses a more serious threat. The substitute and would gut the WIC provision included in the Chairman's mark by eliminating the guaranteed funding for WIC. *In fact, as explained in the attached analysis, the effect of this substitute would be worse than having no provision at all.*

I've also attached a brief piece describes how the WIC provision in the Chairman's mark would work, and why it is integral to health care reform. Given the larger and more visibly controversial aspects of various reform proposals, the WIC provision in the President's bill and the Chairman's mark has been somewhat overlooked. Yet it is a critical provision to ensure the health of poor pregnant women, infants and young children in this country.

We would urge strong opposition to both of the Goodling amendments to the WIC provision. If you have questions, please feel free to call me at the Center at 408-1080. I hope this information is useful.

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Robert Greenstein, Executive Director

CENTER ON BUDGET AND POLICY PRIORITIES

GOODLING AMENDMENT WOULD GUT WIC PROVISION OF HEALTH CARE BILL

During the mark-up of the health care reform bill, Rep. Goodling is likely to offer an amendment to modify the bill's WIC provision. While the amendment may appear mild, it is not. Although this may not be the goal Rep. Goodling seeks to achieve, the effect of the amendment would be to gut the WIC provision of the bill. In fact, it would damage the WIC program and be *worse than having no provision at all.*

The WIC Provision of the Bill

In 1991, a panel of CEOs of major U.S. corporations with no financial interest in WIC testified before the House Budget Committee that WIC should be fully funded by 1996. To meet the national education goal that by the year 2000 all children should start school ready to learn, the CEOs said, it is essential to fully fund WIC by 1996. They called WIC the "health care equivalent of a Triple-A rated investment."

The Administration has proposed significant funding increases for WIC to meet this goal. But with the discretionary caps becoming exceedingly tight, it is becoming increasingly doubtful that WIC will be fully funded on time.

Failure to fund WIC fully would weaken health care reform. It would result in some women and children not receiving the critical preventive services WIC provides and, consequently, in more health care costs down the road. It would weaken health care cost containment efforts.

Accordingly, the Administration has included a provision in the Health Security Act to ensure that WIC reaches full funding on schedule. The provision states that so long as specified levels are appropriated for WIC each year, the remaining amounts needed for full funding are to be released from a special fund that would be established in the Treasury. The costs of the special fund would be financed with pay-as-you-go savings included in the health care bill. As a result, WIC would attain full funding status and would do so in a manner that maintains fiscal discipline. This provision would not increase the deficit; it would be fully paid for. And it would have one other advantage — it would get WIC to full funding without crunching other key initiatives under the discretionary caps.

The provision has a second — and closely related — component. It states that if, in a given year, the appropriations bill fails to provide the amount needed to trigger the release of WIC money from the special fund, the special fund money

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would instead be released to increase federal support for the school lunch program. This feature of the provision was added for purely technical reasons — CBO said it was necessary to include this provision in order for the special fund expenditures to be counted on the "pay-as-you-go" side of the budget. The expectation, however, is that this feature of the WIC provision would *never be used.* The amounts that the appropriations committees would have to provide to trigger the release of money *for* WIC from the special fund should not be difficult for the appropriations committees to attain. As a result, the special fund money will go to WIC, as intended. It is extremely unlikely that a dime of it would ever go to the school lunch program.

The Goodling Amendment

Rep. Goodling will apparently offer two WIC amendments. First, he will seek to strike the WIC provision from the health care bill. If, as seems likely, that fails, he will offer a substitute.

The substitute would do two things. First, it would delete the part of the WIC provision that releases funds to the school lunch program if the regular WIC appropriation is not high enough to trigger the release of the special fund money for WIC. Second, if the appropriations bill *does* meet the WIC target, the Goodling amendment would provide that the exact amount released for WIC from the special fund would depend on information that USDA collected from states about how much the states estimated they could expend during the coming fiscal year.

The substitute may appear harmless at first blush. In fact, it would injure the WIC program and be worse than having no WIC provision in the bill at all.

- The changes in the substitute would cause all expenditures from the special fund to be counted as discretionary expenditures and be subject to the discretionary cap.

- As a result, the appropriations committees would be faced with a dilemma. If the discretionary caps were sufficiently tight that the committees were unable to provide full funding for WIC within them, the committees would have only one alternative — they would have to fund WIC at levels *below* the amounts that would trigger the release of money from the special fund. Otherwise, all the special fund money would count against their allocation and against the caps.

- The appropriations committees thus would be subjected to strong incentives to fund WIC at significantly *lower* levels than the committees would be likely to provide without any WIC provision in the health care bill at all.

An example may illustrate this point. The Appropriations Committee has just appropriated $3.470 billion for WIC in FY 1995, a $260 million increase over the current year. The FY 1994 level, in turn, represented a $350 million increase. Under the WIC provision of the health care bill, an appropriation level of $3.660 billion in FY 1996 will trigger the release of additional money from the special fund. If the Goodling amendment passes, however, and the Appropriations Committee does not have room for the full amount needed to reach full funding in FY 1996, the Committee's only alternative would be to fund WIC next year at less than $3.660 billion. The result would be the smallest WIC increase in at least five years.

Finally, Rep. Goodling also may argue that his amendment would make sure that more WIC money isn't allocated to states than the states can use. *His amendment is, however, entirely unnecessary to ensure that excess expenditures do not occur.* Any WIC money that can't be used won't result in a federal expenditure. If states can't use all of the money, the result will simply be somewhat lower WIC expenditures — and a slightly lower federal deficit — than if all the money available from the special fund were used. We already appropriate more funds each year for the school lunch program, other child nutrition programs, and many other appropriated entitlement program than is actually used. This is done to make sure enough funding is available if it should be needed. But practice does not result in any additional federal expenditures. If more is provided than is needed, the remainder is simply left unspent.

June 16, 1994

CENTER ON BUDGET
AND POLICY PRIORITIES

HOW WIC FITS INTO HEALTH CARE REFORM

Bringing the WIC program to full funding and integrating WIC more fully into the delivery of health care is an integral part of health care reform. Providing sufficient resources for WIC to reach all of those who are eligible for it would significantly strengthen our preventive health apparatus and avert costly expenditures and poor health down the road.

WIC is one of the most effective preventive health programs known. A GAO study issued last year and based on an examination of all research conducted on WIC found that the WIC program produces large savings in health care costs. The GAO estimated that the $300 million in federal expenditures in 1990 for WIC benefits for pregnant women will avert more than $1 billion in health-related costs over the following 18 years, including savings in Medicaid and in costs borne by hospitals, state and local governments, and private payers.

The GAO found, for example, that WIC reduces the incidence of low birthweight — a leading cause of infant mortality, child disabilities, and other health problems — by 25 percent and cuts the incidence of very low birthweight by 44 percent. "Reducing very low birth weights is particularly important," the GAO noted, "because these infants are more likely to die or become disabled and to need costly care." A subsequent study conducted by Mathematica found further evidence strongly linking WIC to reductions in infant mortality.

WIC also has other beneficial health effects. Researchers at the Centers for Disease Control have found strong associations between the WIC program and reductions in child anemia and have reported that low-income children not enrolled in WIC have a higher prevalence of anemia than those who are enrolled. Studies have also found that WIC improves the diets of preschool children and serves as a gateway to health care. Children in WIC are better immunized and more likely to have a regular source of medical care than comparable children not in the program.

The research findings on WIC are so compelling that in 1991, a panel of CEOs of leading American corporations — including AT&T, BellSouth, Honeywell, and Prudential — testified before Congress and called for full funding of WIC in five years, a goal President Clinton and many Members of Congress from both parties have endorsed. *In their joint testimony, the CEO's described WIC as "the health-care equivalent of a triple-A rated investment."*

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Robert Greenstein, Executive Director

What the Provision Would Do

Accordingly, the Administration has concluded that full funding of WIC is integral to health care reform and has included a provision in the Health Security Act to help ensure this critical goal is attained.

This provision of the Health Security Act would establish a special fund on the mandatory side of the budget, which would be available in addition to regular appropriations for WIC, to help ensure the WIC program reaches full funding status by the end of fiscal year 1996 and remains at full funding levels thereafter. (Although appropriations for WIC have increased each year, tight discretionary caps make it unlikely that full funding will be achieved through discretionary appropriations alone.) The Administration's budget requests a WIC appropriation of $3.564 billion in fiscal year 1995. The Health Security Act provides that if — in years after fiscal year 1995 — discretionary appropriations equal the $3.564 billion level, adjusted for inflation, then additional resources will be made available from the special fund to provide the remaining amounts needed to attain full funding.[1]

The provision stipulates that the amounts deposited in the special fund — and released for use in WIC if sufficient discretionary appropriations are provided — equal approximately $250 million for fiscal year 1996 and $400 million for each of the succeeding four years. The total cost of this provision thus is $1.9 billion over the five years from FY 1996 through FY 2000. This cost would be financed with Pay-As-You-Go savings generated by other provisions of the health care reform bill. It would not count against the discretionary spending caps. Accordingly, providing these funds will not increase the deficit, weaken budget discipline, or squeeze out other worthy programs on the discretionary side of the budget. In fact, given the GAO study on WIC's cost-effectiveness, this provision will help contain health care costs in the future.

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[1] If discretionary appropriations at least equal to the requested FY 1995 level, plus inflation, are not provided in years after FY 1995, the money in the special fund would be used to raise federal support for free school lunches, thereby enhancing the nutritional quality of the lunches. It is anticipated, however, that the designated level of appropriations would be provided for WIC and the money in the special fund would be used to enable WIC to reach and remain at the full funding level. The school lunch component of the provision is included because it is necessary to ensure that the costs of this provision are counted on the mandatory rather than the discretionary side of the budget.

Chris
Pre-Medicare
info

REVISED
June 29, 1994

To: David Abernethy and Ann LaBelle

From: Paul Cullinan

Option: Limit Premiums for Persons age 55-64 with income below $30,000 (singles) and $40,000 (couples) to 7% of income in 1998, 6% in 1999,5% in 2000, and 4% later

Preliminary Estimate of Federal Budgetary Effects
(by fiscal year, in billions of dollars)

1998	1999	2000	2001	2002	2003	2004
2.0	3.1	3.8	4.5	5.1	5.6	6.2

Premium Effect: Upon further review, we have determined that the CBO estimates for the Chairman's Mark had already incorporated the assumption that employers would choose to enroll their early retirees into Part C because of the benefits from Part C's community rating feature. Therefore, this amendment would have no additional effect on the Part C premium.

PRE-MEDICARE HEALTH SECURITY COALITION

For Immediate Release
July 29, 1994

Contact: Eric Shulman
(202) 452-9470
Lisa Merman
(202) 452-9531

Coalition Labels GAO Report on Retiree Health "Highly Misleading" and "Inaccurate"

Cites CBO and OMB Cost Estimates of $3 billion per year for Pre-Medicare Provision of President's Health Plan

Washington, DC -- Calling a new Government Accounting Office (GAO) "fact sheet" on retiree health coverage for people in the 55 64 age group highly misleading and inaccurate, Letitia Chambers, executive director of the Pre-Medicare Health Security Coalition said today, "Both the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) have agreed that the cost of the President's plan to cover retirees in this age group is about $3 billion per year. We feel this is a necessary price to pay for providing health care to millions of Americans aged 55-64."

"This is far lower than the GAO estimate of $180 billion over ten years and an excellent example of why we should rely on those agencies of Congress and the Executive Branch -- CBO and OMB -- that were set up for the express purpose of making budget estimates.

Chambers cited several problems with the GAO fact sheet. "First, it appears to ignore the fact that more than half of these retirees or their spouses work in other jobs. Under the President's plan, those 'new' employers would be required to pay for health insurance, not the government. This alone could reduce the GAO cost estimate by up to 50 percent."

"Second, the study fails to recognize that the President's plan (as well as others) has low income subsidies for working and non-working people. Such subsidies have no linkage to the pre-Medicare provision and will be part of any health care reform plan. Yet the GAO report appears to include these subsidy costs as costs of the pre-Medicare provision."

"Third, the study fails to recognize that some employer plans are more generous than the President's proposed federal minimum benefit package. These additional benefits would not be taken over by the federal government yet GAO appears to assume the government will pay 80% of these costs as well."

"Finally, the study ignores the likelihood that health care reform will slow the growth in health care costs -- a major objective of all the health reform proposals -- and assumes that neither the companies nor the federal government will make changes to reduce costs. As a result, the study finds that health care estimated to cost $9.9 billion in 1993 (employer share - $7.9 billion) will cost a staggering $38.8 billion by 2007."

"The fact is that universal health insurance cannot be achieved without addressing the needs of this vulnerable population group. We cannot allow non-working Americans to slip through the cracks of health care reform," Chambers concluded.

-more-

Key Facts about the Pre-Medicare Population

- Of the 5.3 million non-working Americans aged 55-64, most – about 60 percent – receive no health benefits from former employers;
- Most people in the group are of modest means – 75% have incomes below $25,000 per year and half have incomes below $20,000 per year;
- Most have difficulty finding affordable health insurance as a result of declining health or pre-existing conditions -- an estimated 2.7 million people aged 55-64 have no health insurance coverage;
- Minorities and women are particularly vulnerable. African-American males, for example, are almost twice as likely as whites to be disabled or unable to work and only half as likely as whites to have health insurance coverage from former employers;
- Many in this group would not be able to afford Medicare Part C coverage without financial assistance. Part C coverage for couples will cost about $4,400 plus out-of-pocket expenses of about $2,400 which represents 30 percent of income for a non-working couple with an annual income of $23,000.

The Pre-Medicare Health Security Coalition is a broad-based coalition of retiree, consumer, labor and industry groups that support affordable health coverage for non-working persons aged 55-64.

###

RIEGLE PROPOSAL

Amendment

Purpose: To make health care coverage affordable to non-workers between the age of 55 and 64 who are not yet eligible for Medicare.

This group is uniquely vulnerable. They have trouble finding affordable care, limited financial resources and limited work options. This group has higher health care needs and greater out-of-pocket cost than the general population.

Proposal

This proposal would place a cap on insurance premiums as a percent of income for non-workers between the age of 55 and 64. By the year 2000, no one in this group with individual income under $25,000 or couples with income under $35,000 will have to spend more than 4 percent of income on health insurance premiums.

Subsidies

This amendment caps total premium cost for non-workers between the age of 55 and 64 as a percent of income on a phased down schedule from 7% to 4% over 6 years. In the third year of the program, 1998, a cap of 7% would go into effect. In 1999, a 6% cap would go into effect, in 2000 a 5% cap would go into effect and in 2001 a 4% cap would go into effect. This cap would be maintained at 4% thereafter.

The premium cap would be phased out for individuals with adjusted gross incomes between $25,000 and $35,000 and for couples with incomes between $35,000 and $45,000. These income levels would be indexed annually from the date of enactment.

Costs

No cost in the first year. The cost over five years, from 1995 through 2000 is $8.9 billion. The cost over ten years, 1995 through 2004 is $30.3 billion.

These estimates are based on CBO projections of similar proposal in the Ways and Means Committee bill. Lower subsidies and age adjustments to the community rate in the Chairman's mark would increase the cost above these projections. However, a less generous benefits package compared to Ways and Means and a quicker phase out of subsidies in our proposal would lower these projections. (Ways and means ends benefits at $30,000 for singles and $40,000 for couples.)

Premium Cap and Cost Estimates 1995-2000

Year	Income Cap	Cost
1995	none	0
1996	none	0
1997	none	0
1998	7%	($2.0)
1999	6%	($3.1)
2000	5%	($3.8)
2001	4%	($4.5)
2002	4%	($5.1)
2003	4%	($5.6)
2004	4%	($6.2)
10 year total*		($30.3)

* Numbers in billions

Arguments in support of this provision

- o This is a uniquely vulnerable population with great health needs, trouble getting affordable care, limited financial resources, limited work options.
- o The term "Early retirees" is a misnomer because the primary cause of early retirement is health problems of the individual or a family member. Many other "early retirees" are simply unemployed and unable to find work. Three-fourths of such unemployment results from job loss or layoffs.
- o This age group and non-workers in particular have higher than average health care costs.
  - According to EBRI people between the age of 55 and 64 use an average of 37% more services than people between 45 and 54 and over 50% more services than people between 35 and 44.
  - Non-working people age 55 to 64 have health expenditures 65% higher than the working near elderly.
  - Further their out-of-pocket expenses average $1200-1500 annually - far higher than younger populations.

- Most in this group have low or moderate incomes
  - 34 percent less than 150 percent of poverty
  - 55 percent less than 250 percent of poverty

- In an employer based system, these people do not have an employer. These people will be responsible for the employer share (minus any low income subsidy). As such they will be paying a considerable higher percentage of income for health care than the working population.

- Under a system of community rating with adjustments for age, this group will have higher premium costs and this protection becomes even more important.

- U.S. competitiveness is hurt by retiree health costs; competitors don't have these burdens. Mature industries are particularly hurt.

- Companies continue to cut retiree health benefits by either raising retirees costs or dropping benefit altogether.

- So, if we don't address this issue people will continue to lose benefits.

Response to Opposition

- "Its a bailout for big industry."
  - Only 40 percent of all non-works have health care benefits from former employers. Many of these benefits are limited in scope.
  - Less than 3 percent of the targeted population is from the auto industry
  - People who gain the most are the low and moderate income pre-Medicare population
  - Good policy should not be disregarded because some of the benefit goes to companies who have historically helped meet the health needs of former workers.
  - This will also make these companies more competitive with companies who do not have to bear retiree health costs.
- "Many more people will retire because of this provision. More companies will force people in this age group out."
  - Health insurance is only one factor in making a decision to retire. Income from pensions and savings are much more significant as is the general satisfaction and the other rewards of work.
  - This issue has been blown out of proportion. The administration proposal which had more generous benefits was estimated to induce between 350,000 and 600,000 early retirees, but most of this resulted from the certainty of coverage at community rates - not the special early retiree subsidy.

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COMPANY/LOCATION: WHITE HOUSE

FAX #: 456-6218

FROM: ALLEN MOORE

 # OF PAGES (including this cover): 8

SPECIAL INSTRUCTIONS/MESSAGE: As requested. Note: the Levin amendment provides subsidies up to 30,000 for individuals and 40,000 for couples. The Riegle amendment phases them out --. 25,000 - 35,000 for individuals 35,000 - 45,000 for couples.

Original [ ] will [ ] will not follow by:
1) Mail - 2) Messenger - 3) Federal Express

Optional Language Re Universal Coverage Triggers

The Commission must report to Congress biennially. The Report must include, but is not limited to, analysis of: topics:

structure and performance measures of every market area (HCCAs within states), including the structure of the delivery system, number, organizational form and enrollment in all certified health plans; state implementation of responsibilities, including establishment of coverage areas, status of small group insurance reforms, development of purchasing cooperatives and other buyer reforms; status of transition of Medicaid toward managed care and integration into purchasing pools; evaluation of adequacy of subsidies for low income individuals; status of Medicare recipients, including transition of Medicare into risk contracts; progress toward coverage among employed including status and level of voluntary employer contributions and participation rates in pools and among large employers.

Each report must include the percentage of individuals who are enrolled in accountable health plans, including Medicare, Medicaid, low income, and employed individuals.

Each biennial report (1997, 1999) must also include informal recommendations, specific to each market area, on how the area might increase coverage among the residents.

In the event that 95% of all Americans are not enrolled in an accountable health plan, or remain in a publicly funded program (Medicare, Medicaid, VA, CHAMPUS), the 2001 Commission report must also include:

formal and specific recommendations to Congress on how market areas that have failed to reach 95% coverage can achieve that status. Those formal recommendations MUST address all relevant parties, including states, employers, employees, unemployed and low income individuals, beneficiaries of public programs etc.

Congress must consider, within 6 months, all the recommendations of the Commission. Congress must enact the Commission recommendations or an alternative which will ensure coverage at the levels required under this act.

If Congress fails to act within the specified period, the following provision will automatically take effect:

All individuals in the non-complying coverage area will be automatically enrolled in the low cost plan in the region (or randomly enrolled). HHS will develop a process by which this provision can be enforced. HHS enforcement may include requirements on employers to deduct the premiums from individual wages, IRS enforcement proceedings, or any other enforcement mechanisms that will achieve the desired level of coverage in the area.

Clinton allow MEWAs to continue

Employer Group Purchasers

Jeffords-Durenberger-Kassebaum divides employers into three classes, based on employer size.

1. Small Employer Group Purchasers: 100 full-time employees or less. May purchase a qualified health plan at the adjusted community rate, modified for age, through either independent insurance agents or through private, non-profit, purchasing groups.

2. Dual Choice Employers: Between 101-250 full-time employees. May elect to be treated as either a "large employer" or "small employer." Election remains in effect for three years.

3. Large Employer Group Purchasers: More than 250 full-time employees. May offer either a state-certified health plan for which the employer negotiates the rate (experience-rated), an employer-sponsored health plan (risk-bearing plan) or both types of plans as a group health plan. Large employers may group together to negotiate health plan prices.

Employer Requirements

All employers must offer their employees (including part-time and seasonal workers) a choice of at least three health plans-- one of which is a point of service option plan. Employers may meet this obligation, in part, by offering qualified association plans. Employers also must provide their employees with information regarding how to obtain health plans. If the employee requests, the employer must enroll them in their choice of health plan and deduct the amount of the premium from wages, minus any employer contribution.

Large employer purchasing group health plans must meet same insurance reform requirements as other health plans, including no pre-existing condition, open enrollment, guaranteed issue, guaranteed renewal, portability, etc. However, more appropriate solvency requirements for risk-bearing plans will be developed by the Department of Labor.

Association Health Plans

The Jeffords-Durenberger-Kassebaum amendment grandfathers existing association health plans that have been in existence for three years prior to the date of enactment. These include trade and professional associations, religious organizations, public entity associations, and Chambers of Commerce. Association health plans must meet solvency requirements developed by HHS and take all comers in their designated association. Otherwise, all qualified health plan insurance reform requirements apply.

Individuals

Individuals not employed by an employer purchaser may purchase a qualified health plan directly from an agent or from a private purchasing group. Or, if they are members of an association which offers an association health plan, they may purchase directly from that association.

COBRA

Unlike the Chafee/Clinton bills, COBRA is not abolished. This accomplishes two main objectives: (1) avoids confusion and disruption for consumers by allowing individuals to continue coverage under their current plan for up to two years after they leave employment; and (2) helps stabilize premium rates in the community-rated pool.

BENEFITS PACKAGE

The Board would be authorized to: develop recommendations to clarify covered benefits and cost-sharing; develop interim coverage decisions in limited circumstances; consult with expert groups for appropriate schedules for covered services; propose modifications to the benefits package that would not go into effect unless enacted by Congress under base-closing procedures.

Congressional priorities: within the constraints of the actuarial limits, Congress directs the Commission to adhere to the following priorities.

a) parity for mental health, with emphasis on designating a set of managed mental health services for maximum flexibility and efficiency

b) consideration for needs of children and vulnerable populations, including rural and underserved persons.

c) Preventive Care

The standard benefit package can not exceed the actuarial value equivalent of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

The board shall establish multiple cost sharing schedules that vary depending on the delivery system by which health care is delivered to individuals enrolled in a qualified health plan. In addition the Board will provide for a "catastrophic" option designed to prevent adverse risk selection when combined with the risk adjustments called for in the bill. This option will contain higher cost sharing and/or fewer benefits.

Def of Med Necessity

Covered Services

A qualified health plan shall provide for coverage of the items and services described below only for treatment and diagnostic procedures are medically necessary for appropriate as defined in S. 1770 as amended by Durenberger:

- Inpatient and outpatient care.
- Emergency, including appropriate transport services.

- Clinical preventive services, including services for high risk populations, immunizations, tests, or clinician visits.
- Mental illness and substance abuse.
- Family planning and services for pregnant women.
- Hospice care.
- Home health care.
- Outpatient laboratory, radiology and diagnostic.
- Outpatient prescription drugs and biologicals.
- Outpatient rehabilitation services.
- Vision care, hearing aids and dental care for individuals under 22 years of age.
- Investigational treatments.

FLORIDA

DEPARTMENT OF INSURANCE (DOI) STANDARD PLAN
ESTIMATED COST PER MEMBER PER MONTH (PMPM)
HMO Option

SERVICE	DOI STANDARD PLAN	
	COVERAGE / COPAYMENT AMOUNT	DOI PMPM ESTIMATE
HOSPITAL INPATIENT SERVICES		
Hospital Charges Other Than Those Listed Below	$100 Copayment / Day (Days 1-5)	
Alternate Childbirth Delivery Arrangements		
24-Hour Hospital Admission and Discharge	$100 Copayment / Day (Days 1-5)	
Freestanding Birth Center		
	TOTAL	$28.65
HOSPITAL EMERGENCY ROOM SERVICES (copayment waived if admitted)		
Emergency Room (emergencies only)	$100.00 Per Visit	
Emergency Room (non-emergencies)	Not Covered	
Ambulance (emergencies)	$50.00 Per Visit	
Ambulance (non-emergencies)	Not Covered	
	TOTAL	$2.61
OUTPATIENT and HEALTH CARE PROVIDER SERVICES		
Hospital Services		
Outpatient Surgery	$50 Copayment	
Outpatient Therapy	$20.00 Copayment Per Visit	
Outpatient DX, Lab, X-Ray	Covered in Full	
Freestanding Outpatient Care Centers		
Outpatient Surgery	$50 Copayment	
Outpatient Therapy	$20.00 Copayment Per Visit	
Outpatient DX, Lab, X-Ray	Covered in Full	

Total is on page 5.

PMPM = Per member Per month

SERVICE	DOI STANDARD PLAN	
	COVERAGE / COPAYMENT AMOUNT	DOI PMPM ESTIMATE
Primary Care Physician Services	$10 Copayment Per Visit	
Office Visits	Covered in Full	
Inpatient Visits	Covered in Full	
Miscellaneous Office Services	Covered in Full	
Injections	Covered in Full	
Lab, X-Ray	Covered in Full	
Specialty Care Physician Services		
Office Visits	$20.00 Copayment Per Visit	
Inpatient Visits	$20.00 Copayment Per Visit	
Consultations	$20.00 Copayment	
Emergency Room Visits	$20.00 Copayment Per Visit	
Miscellaneous Office Services	Covered in Full	
Injections	Covered in Full	
Lab, X-Ray	Covered in Full	
Radiology and Pathology	Covered in Full	
Surgery as Inpatient	Covered in Full	
Same Day Surgery	Covered in Full	
Surgical Care in Provider's Office	Covered in Full	
Assistant	Covered in Full	
Anesthesia	Covered in Full	
Non-Surgical Spine and Back Disorder Treatment	$10.00 Copayment Per Visit	
Transplant	Covered in Full	
	TOTAL	$42.84

SERVICE	DOI STANDARD PLAN	
	COVERAGE / COPAYMENT AMOUNT	DOI PMPM ESTIMATE
EDUCATIONAL AND PREVENTIVE SERVICES		
General Health Education		
Office Visit Education		
Preventive Services	Preventive Medical and Reproductive Care is Subject to a $150 Calendar Year Maximum Benefit	
Health Assessment Exam	$25.00 Copayment Per Exam	
Pediatric and Adult Immunizations	Covered In Full	
Pap Smears/Mammograms, etc.	Covered In Full	
Family Planning Services	Covered In Full	
Oral Contraceptives	$8 / Prescription or Refill	
Contraceptive Devices	$50 Copayment	
Implantable Contraceptive Devices	$50 Copayment	
Routine Eye and Ear Exams	Covered as Part of the $150 Benefit Allowance	
Eyeglasses (children through 18)	Not Covered	
Hearing Aids (children through 18)	Not Covered	
Dental Services (children through 18) - Preventive Services	Not Covered	
Dietary Instruction	Not Covered	
	TOTAL	$12.71

SERVICE	DOI STANDARD PLAN	
	COVERAGE / COPAYMENT AMOUNT	DOI PMPM ESTIMATE
MENTAL HEALTH SERVICES Inpatient	$100.00 Copayment (days 1-5), Balance Covered in Full	
Residential Treatment	Not Covered	
Outpatient Treatment Services	$10.00 Copayment Per Visit (20 visits per calendar year)	
SUBSTANCE ABUSE SERVICES Inpatient	Not Covered	
Residential Treatment	Not Covered	
Outpatient Treatment Services (40 visits)	Not Covered	
	TOTAL	$2.90*
OTHER SERVICES Durable Medical Equipment	Covered in Full	0.86
Orthotics and Prosthetics	Covered in Full	0.24
Skilled Nursing Services	Covered in Full	0.14
Home Health Care Services	Covered in Full	0.81
Hospice	Covered in Full	
Prescription Drugs	$7 for Generic; Brand Prescriptions are not Covered	$11.63
TOTAL		$13.68

* Includes the component price for all covered mental health services
** Includes the component price for all covered mental health and substance services

SERVICE	DOI STANDARD PLAN	
	COVERAGE / COPAYMENT AMOUNT	DOI PMPM ESTIMATE
HOSPITAL INPATIENT SERVICES		28.65
HOSPITAL EMERGENCY ROOM SERVICES		2.61
OUTPATIENT and HEALTH CARE PROVIDER SERVICES		42.84*
EDUCATIONAL AND PREVENTIVE SERVICES		12.71
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		2.90
OTHER SERVICES		13.68
TOTAL		$103.39

	DOI STANDARD PLAN
Total 1/1/93 PMPM	$103.39
Trend to 1/1/94	$107.94
Projected Geographic Adjustment to Reflect Anticipated Statewide Experience (0.975)	
Projected Morbidity Adjustment to reflect Anticipated Enrollee Population (1.100)	
Sub-total for Tampa region (AA estimate only)	
Total PMPM Adjusted for Administration/Premium Tax/Surplus - Assuming 15%	
CHPA Administration Fee	
Total for Tampa region (AA estimate only)	
TOTAL (Statewide)	$107.94

* Includes Provider Services

MEDICARE

A. Maintain Medicare as a separate program.

Medicare is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

Medicare remains a separate program and continues to be federally administered. Beneficiaries enrolled in part B continue to pay a monthly premium. The statutorily defined Medicare benefits continue to be the Medicare benefit package in both fee-for-service and managed care.

B. Individuals could maintain coverage through private health plans when they become eligible for Medicare.

Individuals have the option to remain in an accountable health plan (AHP) when they become eligible for Medicare. If they remain, they continue to receive the standard benefit package with the full range of options available to the non-Medicare population.

Plans may offer a separate rate for the Medicare-eligible population. The Board is required to prescribe methods for risk adjustment.

For individuals choosing an AHP, Medicare will pay the federal contribution calculated for Medicare risk contracts. Individuals are responsible for paying the difference between the premium charged and the federal contribution.

During the annual enrollment period, Medicare-eligibles may choose a new plan through their employer/purchasing cooperative or they may return to the traditional Medicare program.

C. Medicare Select would become a permanent option in all States.

Medicare Select is a demonstration program limited to 15 states (including North Dakota, Missouri and Minnesota) established in OBRA 1990 to allow managed care organizations to deliver supplemental benefit packages to Medicare beneficiaries. An individual buying a Medicare Select policy is buying one of the 10 standard Medigap plans. The only difference is that Medicare Select policies deliver care through preferred providers. The program is scheduled to expire in 1995.

Medicare Select would be a permanent option in all States. Medicare Select policies will be offered during Medicare's coordinated open enrollment period. Plans may not discriminate based on pre-existing conditions.

D. Medicare risk contracts would be improved.

MEDICARE SYSTEM REFORM:

Medicare Health Plans: Medicare health plans must be Accountable Health Plans willing to provide all Medicare benefits under a risk contract for a uniform monthly premium for a year. Employers may sponsor Medicare health plans for former or current employees. This increases the choice of plans to beneficiaries -- may be PPOs, indemnity plans, traditional HMOs, or other insurance arrangements.

Standard Benefit Packages: Medicare health plans will offer a standard benefit package comprised of the current Medicare benefits defined in statute or an alternative package, defined by the Secretary, covering identical services but with cost-sharing consistent with typical managed care practice.

Standardize the supplements that risk contractors may offer in addition to Medicare benefits. Medicare health plans must offer two supplements: one which would cover catastrophic costs and other items traditionally covered in employer-sponsored plans, and one covering outpatient prescription drugs. The standardized medigap plans would be made comparable to the standardized risk contract supplements.

[option: The current standardized medigap plans would be changed to prohibit Medigap from filling in more than one-half of the 20% part B coinsurance. Beneficiaries currently holding Medigap plans covering the entire 20% coinsurance would be exempt from this change as long as they renew their current insurance.]

Medicare Market Areas: Move from counties as the geographic area for uniform capitated rates to MSAs plus adjacent rural areas to be defined by the Secretary. The federal contribution for a Medicare health plan will be the same throughout the Medicare market area.

Enrollment Process: Medicare beneficiaries will have a coordinated annual open enrollment period to choose from all plans (including Medigap insurers) offering products to Medicare beneficiaries. Plans may not discriminate based on health status and must take all comers. An appeal process is provided to allow beneficiaries to disenroll between annual enrollment periods. Medicare beneficiaries will have the opportunity to disenroll if their primary care physician leaves the plan's network.

Beneficiaries not selecting coverage through the enrollment process will be automatically enrolled in Medicare fee-for-service, unless they selected a health plan in the prior year.

Uniform Information: The Secretary of HHS will provide to all Medicare beneficiaries in a market area uniform materials for enrolling in health plans. The Secretary will also provide uniform informational materials including quality information, plan features, restrictions and price. Also, the Secretary will review and approve all marketing materials to be distributed by plans.

PAYMENTS TO MEDICARE HEALTH PLANS:

AAPCC Calculation: Requires that the AAPCC be a direct calculation in each market area, adjusted to reflect anomalies like the use of military/veterans/other facilities.

Federal Contribution to Health Plans:

option 1: (pure price competition)

The federal contribution is calculated as the average of fee-for-service per capita cost in the market area and the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits.

option 2: (FFS cost is not included in the calculation)

The federal contribution will be the lower of: 95% of AAPCC (adjusted fee for service costs), or the average of the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits.

The Secretary will determine the amount of savings achieved from enrollment in Medicare health plans with federal contributions below 95% of AAPCC and will have the authority to increase this 95% of AAPCC ceiling in low cost areas.

Risk Adjustment: Strengthen the risk adjustment by explicitly allowing the Secretary to adjust for heart disease, cancer, or stroke. Also, give the Secretary authority to impose penalties on plans that knowingly discriminate against beneficiaries based on health status.

Beneficiary Premiums/Rebates: Beneficiaries pay the difference between the federal contribution and the total premium charged by the health plan they select. If the health plan's premium is less than the federal contribution, the beneficiary is entitled to a rebate that they may take in cash or apply to supplementary coverage. The rebate would be treated as non-taxable income.

Beneficiaries eligible for Medicare prior to 1999 may always enroll in Medicare FFS (regardless of local costs) for the regular part B premium only.

If the federal contribution is less than 95% of AAPCC and the beneficiary selects Medicare FFS, the beneficiary pays an additional premium to the Federal Government equal to the difference between the federal contribution and 95% of AAPCC. (This is only applicable in areas where plans, on average, are providing Medicare benefits for less than FFS.)

Assessment of Risk Contracts: Create the Health Plan Payment Assessment Commission to provide on-going, comprehensive analysis, review, and recommendations regarding Medicare payments to health plans.

E. Administrative Simplification.

Gives the Secretary authority to consolidate the functions of fiscal intermediaries and carriers.

Provides for coordination of Medicare and supplemental insurance claims processing.

Permits standardized, paperless process.

F. Improvements in hospital payment methodologies would include:

1. Medicare Dependent Hospitals:

- Maintains Byrd bill provisions that would (1) base payments on a 36 month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990; (2) conform target amounts to extension of additional payments; and (3) clarification of updates. Would extend Medicare-dependent hospital classification through 1998.

- Demonstration project regarding payment to larger Medicare dependent hospitals: The Secretary would establish a demonstration project to determine the effect that the use of a modified payment system by larger Medicare dependent hospitals would have on (1) the cost of care under Medicare Part A, (2) access of Medicare beneficiaries in rural areas to quality health care and (3) the development of integrated health delivery systems in rural areas. During the period of the demonstration project, payments to participating hospitals would be equal to the sum of the amount determined on the basis of the average hourly wage index computed for the nearest urban area in the region in which the project is conducted, as adjusted by the national adjusted operating standardized labor amount for rural areas.

2. EACH/RPCH program improvements and extension to all States:

- Expands the EACH/RPCH program to all states.

- Treatment of hospital inpatient services in a Rural Primary Care Hospital:

  Maintains the Byrd bill provisions that (1) a RPCH cannot have more than 6 beds; (2) the RPCH cannot perform surgery or any service requiring general anesthesia (unless the risk of transferring the patient outweigh the benefits); (3) the Secretary can terminate the RPCH designation if the average length of stay for the previous year exceeded 72 hours. In determining the average length of stay, cases which exceed 72 hours due to inclement weather or other emergency conditions are not included in the calculations; and (4) the GAO must submit a report determining if the revised RPCH criteria have resulted in RPCHs providing patient care beyond their abilities or have limited RPCHs' abilities to provide needed services; (5) eliminates the Byrd provision requirement that the attending doctor must certify that the patient is expected to be discharged within 72 hours.

- Designation of EACH hospitals

  Maintains Byrd bill provisions that (1) urban hospitals can be designated as EACHs and do not need to meet the 35 mile criteria, but do have to meet all the remaining current law criteria. Urban EACHs would still be subject to the Medicare Prospective Payment System; (2) hospitals located in adjoining states and otherwise eligible as EACHs and RPCHs can participate in a state's rural health network and these hospitals or facilities are permitted to receive grants

- Skilled Nursing Facility Services in RPCHs

  Maintains Byrd bill provisions that permit RPCHs to maintain swing beds except t hat the number of swing beds may not exceed the total number of swing beds established at the time the facility applied for its RPCH designation. Beds in a distinct-part SNF do not count towards the total number of swing beds.

- Maintains Byrd bill provision to extend the deadline for the development of prospective payment system for inpatient RPCH services to January 1, 1996.

- Payment for outpatient rural primary care hospital services

  The RPCH may be paid by the two payment methods as specified under current law until the development of an all inclusive PPS for outpatient RPCH services in January 1, 1996. Customary charges are not used when determining these payment rates.

- Clarification of physician staffing requirement for RPCHs

Maintain Byrd bill provision which clarifies that physician staffing criteria only apply to doctors of medicine and osteopathy.

- Maintains Byrd bill technical amendments relating to Part A deductible, coinsurance and spell of illness.

- Authorization of Appropriations of $15 million annually for FY 1990-1998.

- Antitrust protections: The DOJ/FTC would be instructed to issue formal guidelines for EACH/RPCHs.

- No limitation on number of RPCHs in non-EACH states

The Secretary would be permitted to designate an unlimited number of RPCHs in non-EACH states. The RPCHs must establish relationships with a full-service rural hospital that meet the same criteria as EACHs with the exception of the criteria that the EACH have 75 beds.

- Pilot Program for clinically based alternative to the 72-hour rule

HHS would be required to conduct a pilot program that would allow RPCHs to admit patients on a limited DRG basis instead of using the 72-hour average length of stay criteria.

3. Making Medical Assistance Facilities permanent and available to all States:

Codify the MAF requirements into Medicare, allowing Medicare to reimburse on a cost basis those facilities which meet the MAF requirements. The key MAF requirements are (1) the facility is located in a county with fewer than 6 residents per square mile or is located more than a 35 mile drive or 30 minutes from a full-service hospital; (2) provides inpatient care for a period no longer than 96 hours, and provides emergency services to ill or injured persons prior to admission to the facility or prior to their transportation to a full-service hospital; (3) permits a PA or NP to admit and treat patients under the medical direction and supervision of a physician who need not be present in such a facility.

Would develop a grant program for states that operate MAFs. The grant program would be modeled after the EACH/RPCH program.

4. Extension of the Rural Health Transition Grant Program:

Extends the program through FY 1998 with authorized appropriations of $30 million annually, FY 1993 - 1998. Reports from grantees would be required every 12 months. As of October 1, 1994, RPCHs are eligible for rural health transition grants.

MEDICARE REFORM

I. SYSTEM REFORM:

Medicare Health Plans:

Current Law: An eligible organization is a public or private HMO or competitive medical plan which is federally qualified or meets certain requirements.

Proposal: Medicare health plans must be Accountable Health Plans and willing to provide all Medicare benefits under a risk contract for a uniform monthly premium for a year. Employers may sponsor Medicare health plans for former or current employees. This increases the choice of plans to beneficiaries -- may be PPOs, indemnity plans, traditional HMOs, or other insurance arrangements.

Standard Benefit Packages:

Current Law: Risk contracting HMOs must, at minimum deliver Medicare services (defined in statute). Supplements offered by risk contracts and retiree wrap-around coverage are not standardized.

There are 10 standardized Medigap insurance policies which insurers may offer Medicare beneficiaries.

Proposal: Standardize the Medicare benefit package for risk contracts. Risk contractors may offer either the benefit package as provided in statute or an alternative package covering identical services but with cost-sharing consistent with typical managed care practice.

Standardize the supplements that risk contractors may offer in addition to Medicare benefits. Medicare health plans must offer two supplements: one which would cover catastrophic costs and other items traditionally covered in employer-sponsored plans, and one covering outpatient prescription drugs.

The standardized medigap plans would be made

comparable to the standardized risk contract supplements. The current standardized medigap plans would be changed to prohibit medigap from filling in more than one-half of the 20% part B coinsurance. Beneficiaries currently holding medigap plans covering the entire 20% coinsurance would be exempt from this change as long as they renew their current insurance.

Medicare Market Areas:

Current Law: The capitated payments to Medicare HMOs is determined county by county.

Proposal: Move from counties as the geographic area for uniform capitated rates to MSAs plus adjacent rural areas to be defined by the Secretary. The federal contribution for a Medicare health plan will be the same throughout the Medicare market area.

Enrollment Process:

Current Law: A participating plan must have an open enrollment period of at least 30 days duration every year.

Proposal: All plans (including medigap insurers) offering products to Medicare beneficiaries must participate in a coordinated process by which beneficiaries will select their Medicare and supplemental coverage once a year. Plans may not discriminate based on health status. An appeal process would be provided to allow beneficiaries to disenroll between annual enrollment periods. Medicare beneficiaries will have the opportunity to disenroll if their primary care physician leaves the plan's network.

Beneficiaries not selecting coverage through the enrollment process would be automatically enrolled in Medicare FFS, unless they selected a health plan in the prior year.

Uniform Information:

Current Law: Beneficiaries are given general information regarding the Medicare program at the time they enroll in Medicare. There is no effort to compare price, quality or other aspects of

Medicare HMOs with Medicare FFS. Information mostly relies on the insurance industry's marketing efforts.

Proposal: The Secretary would provide to all beneficiaries in a market area uniform materials for enrolling in health plans. The Secretary would also provide uniform informational materials including quality information, plan features, beneficiary restrictions and price. Also, the Secretary would review and approve all marketing materials to be distributed by plans.

II. PAYMENTS TO MEDICARE HEALTH PLANS:

Federal Contribution to Health Plans:

Current law: The Secretary calculates the average fee for service per capita cost nationwide and adjusts it by age, sex, institutional status, Medicaid eligibility and geographic county. The federal contribution is 95% of this amount (the AAPCC).

Proposal:

Opt #1: The federal contribution will be the average of fee for service per capita costs and the average of the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits.

Opt #2: The federal contribution will be the lower of:

-- 95% of AAPCC, or

-- the average of the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits.

Beneficiary Premiums/Rebates:

Current law: Beneficiaries pay the part B premium to the Federal Government and pay any additional premium to the Medicare HMOs directly for Medicare benefits or supplementary coverage. Medicare HMOs may not give beneficiaries rebates on their part B premium, but are required instead to increase benefits.

Proposal: Beneficiaries continue to pay part B premium to the Federal Government.

Beneficiaries continue to pay the difference between the federal contribution and the total premium charged by the health plan they select. If the health plan's premium is less than the federal contribution, the beneficiary is entitled to a rebate that they may take in cash or apply to supplementary coverage. The rebate would be treated as non-taxable income.

If the federal contribution is less than 95% of AAPCC and the beneficiary selects Medicare FFS, the beneficiary pays an additional premium to the Federal Government equal to the difference between the federal contribution and 95% of AAPCC. This requirement is waived for all beneficiaries eligible for Medicare prior to 1999, who can always enroll in Medicare FFS for the regular part B premium only.

Refinements to the AAPCC Calculation:

Current law: The AAPCC is an indirect calculation, and includes aberrations (working aged, use of military/veterans/other facilities).

Proposal: Require that the AAPCC be a direct calculation in each market area, adjusted to reflect anomalies like the use of military/veterans/other facilities.

Risk Adjustment:

Current Law: Risk adjusts for age, gender, institutional status, Medicaid eligibility and geographic county. Although the Secretary has the authority to add a health status adjuster, no adjustment is currently made.

[Mathmatica's December 1993 study cited the lack of a health status risk adjuster as a reason why Medicare paid more for enrollees in managed care than it should have.]

Proposal: Strengthen the risk adjustment by explicitly allowing the Secretary to adjust for heart disease, cancer or stroke. Also, give the Secretary authority to impose penalties on plans that knowingly discriminate against beneficiaries based on health status.

Low Cost Market Areas:

Current Law: There is no allowance under current law for increasing the federal contribution in low cost areas. Consequently, Medicare HMOs have concentrated in high cost areas where the capitated payment is very high relative to more of the country.

Proposal: The Secretary will determine the amount of savings achieved from enrollment in Medicare health plans with federal contributions below 95% of AAPCC. The Secretary will have the authority to increase this 95% of AAPCC ceiling in low cost areas.

Assessment of Medicare Risk Contracting:

Current Law: The Prospective Payment Assessment Commission provides recommendations to the Congress on payment methodologies for hospitals and other services covered under Medicare part A. The Physician Payment Review Commission provides recommendations regarding physician payment and other services covered under part B.

Proposal: Create the Health Plan Payment Assessment Commission to provide on-going, comprehensive analysis, review, and recommendations regarding Medicare payments to health plans.

III. MEDICARE SIMPLIFICATION:

Medicare simplification:

Current Law: Medicare services are paid through fiscal intermediaries and carriers.

Proposal: Gives the Secretary authority to consolidate the functions of fiscal intermediaries and carriers.

Provides for coordination of Medicare and supplemental insurance claims processing.

Permits standardized, paperless process.

IV. MEDICARE COST CONTAINMENT

Cost containment:

Current law: Medicare pays physician services based on a fee schedule. Hospitals are paid on a per episode capitated fee. In addition, Congress has reduced provider payments repeatedly over the years to achieve further savings in the program.

Proposal: Replace the proposed across the board cuts with a local growth target in market areas with Medicare costs of at least 90% of the national average. This limit could include all providers (FFS and health plans).

Also, we would like to propose the following:

Provide for demo projects to test the feasibility of establishing volume performance standards by or within states, specialties, hospital medical staff, or groups of physicians. [This provision was introduced in 1991 by Senators Rockefeller and Durenberger. I understand the Administration has been looking at doing this.]

I. COST CONTAINMENT:

A. AUTOMATIC FAIL SAFE BUDGET PROTECTION

A baseline of federal health expenditures (projected Medicare and Medicaid spending less reforms included in the proposal and including tax spending) is established. If additional savings are achieved, the voucher phase-in is accelerated. If savings are less than anticipated, the following automatic actions will occur to prevent deficit spending -- the voucher phase-in is delayed, the assessment on high cost insurance plans is ~~implemented~~, the expanded tax deduction phase-in is slowed down and out-of-pocket limit is increased for health insurance -- or Congress may act on an alternative recommendation by the Health Commission.

B. PENALTY FOR HIGH COST HEALTH PLANS DESCRIPTION NEEDED

C. INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS

~~Individual and small employer purchasing groups.~~ The membership of these purchasing groups will ~~be~~ limited to employers and employees in businesses of 100 or fewer employees, and to all other individuals ~~not~~ enrolled in a health plan who live or work in ~~the~~ a State designated area. Nothing in this Act requires the establishment of a purchasing group -- nor prohibits the establishment of more than one -- in an area.

Establishment, Organization, Duties

An individual and small employer purchasing group will be required to:

- be chartered under state law and operated as a not-for-profit corporation (insurers are prohibited from forming small employer purchasing groups or having a majority vote);
- be governed by a Board of Directors consisting of members of the group;
- fulfill the following duties:
  - -- enter into agreements with qualified health plans;
  - -- market qualified health plans ~~throughout the entire~~ State ~~designated area~~;
  - -- enter into agreements with small employers and individuals;

-- disseminate standardized information to members regarding price, outcomes, enrollee satisfaction, and other information pertaining to the quality of the plans offered within the group, as well as information regarding other qualified plans operating within the State designated area;

-- offer eligible individuals the opportunity to enroll in a qualified general access plan, and to change plans through an open season process.

D. ACCOUNTABLE HEALTH PLANS

(1) STANDARDS FOR ACCOUNTABLE HEALTH PLANS: The National Association of Insurance Commissioners (NAIC) is directed to develop standards for health plans within six months of enactment. In most cases, states will determine whether or not a plan meets these standards. In the event the NAIC does not meet the deadline, the Secretary of Health and Human Services (HHS) will finalize standards within one year of enactment.

Qualified health plans must:

- guarantee eligibility to all applicants;
- guarantee availability of covered services throughout the state designated area in which the plan is offered;
- guarantee renewal to all enrollees, except in instances of non-payment of premiums, fraud or misrepresentation, or relocation outside the area;
- not discriminate on the basis of health status;
- not deny or limit coverage based upon preexisting conditions;
- offer the benefit packages to all enrollees, and throughout the entire state designated area (supplemental benefits would have to be priced and offered separately);
- provide for ~~arbitration~~ dispute resolution to resolve benefit, service and medical liability disputes;
- meet financial solvency, enrollment and quality assurance criteria;
- meet premium payment and collection criteria;
- comply with rating requirements that limit the variation in premiums charged within a state designated

area to family status and age;

- participate in a risk adjustment program of the State (or the HHS Secretary) to equalize the risk among plans so no plan is penalized for having too many poor health participants;

- comply with administrative standards and reporting requirements;

- meet requirements for designated underserved areas;

- provide, at least once a year, ~~such information as the State or the HHS Secretary (depending upon who is the appropriate certifying authority) deems~~ necessary to evaluate the performance of the plan, and prepare comparative materials for review by consumers.

E. STANDARD BENEFIT PACKAGE

Covered Services: A qualified health plan shall provide for coverage of the items and services described below only for treatment and diagnostic procedures are medically necessary ~~or~~ appropriate as defined in S. 1770 as amended by Durenberger:

- ~~Inpatient and outpatient~~ care.

- Emergency, including appropriate transport services.

- Clinical preventive services, including services for high risk populations, immunizations, tests, or clinician visits.

- Mental illness and substance abuse.

- Family planning and services for pregnant women.

- Hospice care.

- Home health care.

- Outpatient laboratory, radiology and diagnostic.

- Outpatient prescription drugs and biologicals.

- Outpatient rehabilitation services.

- Vision care, hearing aids and dental care for individuals under 22 years of age.

- Investigational treatments.

F. REQUIREMENTS ON LARGE EMPLOYER PLANS

requirements for large employer plans, including multiple employer purchasing groups, multiemployer and self-insured plans. Generally, the insurance market reform standards that apply to the individual and small employer group market also apply to large employer plans. However, the rules vary somewhat, since many large employer plans are self-insured or operate on an interstate basis. Health plans offered under the Federal Employees Health Benefit Program (FEHBP) must meet the standards for large employer plans. Neither large employers, nor their employees may purchase insurance through an individual and small employer purchasing group. However, large employers are free to form purchasing groups of their own, or with other large employers.

Standards for Large Employer Plans

The HHS Secretary shall develop standards for large employer plans to require that they:

- guarantee availability to all eligible employees (with certain exceptions for collectively bargained plans);
- not discriminate on the basis of health status;
- prohibit exclusion of coverage based upon preexisting conditions;
- guarantee to all enrollees coverage for the standard health benefits;
- meet quality assurance criteria;
- provide standardized information to evaluate the performance of the plan.

The Secretary of Labor shall develop standards for large employer plans to require that they:

- meet financial solvency requirements, consistent with Section 414 of ERISA;
- meet premium payment and collection criteria;
- [provide mediation procedures for hearing and resolving malpractice claims;]
- offer both the standard and catastrophic benefit packages;
- provide an alternative plan if more than 50% of the

eligible employees so elect (applies only when the employer makes no contribution to the plan on behalf of its employees);

- provide for equitable enrollment criteria.

Corrective Action/Disqualifications/Termination: If either Secretary, or a plan sponsor, determines that a plan cannot meet these standards, corrective actions must be taken within 90 days. If corrections cannot be made, the two Secretaries shall develop an action plan for concluding the affairs of the plan and for requiring contingent coverage for the effected employees.

G. INSURANCE MARKET REFORMS

Consumer protection and market reforms. These include requiring brokers or insurers who offer coverage in a qualified health plan, outside of a purchasing group, to furnish prospective enrollees with standardized information provided by the State on all qualified health plans within the State designated area; prohibiting insurers offering health plans from charging discriminatory commissions or prices based upon health status; prohibiting insurers offering health plans from conditioning the purchase of a qualified plan on the purchase of other insurance products.

H. AMENDMENTS TO ERISA

This part conforms the Employee Retirement Income Security Act (ERISA) with the standards applicable to large employer plans (including self-insured, fully insured and multi-state plans) under the bill. It eliminates the applicability of ERISA to small employer health plans and large employer health plans that are fully insured. It grandfathers certain existing Multiple Employer Welfare Arrangements (MEWAs), and restricts the creation of new MEWAs to those who can meet specified certification requirements. And, it provides for repeal of COBRA upon full implementation of the HEART Act.

Coverage of Group Health Plans: Current ERISA law is retained with respect to self-insured health plans. However, ERISA does not apply to health coverage provided through an insured health plan. Except in the limited instances where another exception applies, those plans not regulated under ERISA will be regulated under the appropriate State authorities. Plans regulated by ERISA must comply with various sections of current ERISA law regarding claims procedure, civil enforcement and related issues, under the oversight of the Secretary of Labor. They must also meet new reporting and disclosure requirements which may include expedited reporting.

Treatment of Multiple Employer Welfare Arrangements (MEWAs): MEWAs providing health benefits that receive certification by the Secretary of Labor will be treated as large employer plans. MEWAs seeking to commence operations after January 1, 1994, may only do so upon certification by the Secretary of Labor that the arrangement meets specified criteria (e.g., solely provides medical care, is organized by a group with a purpose other than providing health insurance, and is sponsored by an entity described in this Act).

Revision of COBRA Continuation-of-Benefits Requirements: Repeals COBRA continuation-of-benefits requirements upon full implementation of this Act, since market reforms contained in the Act will provide all eligible employees with guaranteed access to continued coverage.

I. ROLE AND STRUCTURE OF NATIONAL HEALTH BOARD

The ~~Board~~ Commission would be authorized to: develop recommendations to clarify covered benefits and cost-sharing; develop interim coverage decisions in limited circumstances; consult with expert groups for appropriate schedules for covered services; propose modifications to the benefits package that would not go into effect unless enacted by Congress under base-closing procedures.

Congressional priorities: within the constraints of the actuarial limits, Congress directs the Commission to adhere to the following priorities.

a) parity for mental health, with emphasis on designating a set of managed mental health services for maximum flexibility and efficiency

b) consideration for needs of children and vulnerable populations, including rural and underserved persons.

c) Premium

The standard benefit package can not exceed the actuarial value equivalent of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program.

The board shall establish multiple cost sharing schedules that vary depending on the delivery system by which health care is delivered to individuals enrolled in a qualified health plan as well as a "catastrophic" (high deductible) option designed to prevent adverse risk selection when combined with the risk adjustments called for in bill.

Establishment, Duties, Operation: The Health Board shall be:

- appointed by the President, in consultation with the congressional leadership;

- charged with development and subsequent modification of detailed benefit packages;

If the Board is advised by the Director of OMB that ~~the~~ baseline spending has been exceeded, ~~it may submit recommended modifications~~ to the Congress to close the gap.

If the Board fails to submit such recommendations, or Congress fails to adopt them, then the following automatic actions will occur to prevent deficit spending:

-- implementation of ~~the~~ assessment on high cost insurance plans;
-- a reduction in eligibility for the voucher program;
-- a reduction in the expansion of the tax deduction
-- an increase in the out-of-pocket limit for health insurance.

J. STATE AND FEDERAL RESPONSIBILITIES IN RELATION TO QUALIFIED HEALTH PLANS

STATE RESPONSIBILITIES: Sets forth state responsibilities, including the designation of areas; certification of plan compliance with insurance market reform standards; development of risk adjustment programs; and, other important duties. As certifying authorities, the states will play a critical role in ensuring fair competition among qualified plans, appropriate consumer protections, and the provision of standardized plan comparison information to consumers.

State Programs: Within one year of the promulgation of insurance reform standards, each state must establish a program to carry out the following responsibilities:

- divide the state into one or more areas, the boundaries of which may be revised periodically, and/or make agreements with other contiguous states to set up interstate areas (no metropolitan statistical area may be incorporated into more than one area; and each area may not consist of less than 250,000 residents;

- provide procedures for the establishment and operation of individual and small employer purchasing groups, including specifying the voting rights of purchasing group members;

- prepare and make available information about prices, outcomes, and enrollee satisfaction for each qualified health plan operating within the state;

- establish a risk adjustment program to ensure a balanced distribution of risk among individual and small employer plans operating within each specified area;

- establish an arbitration process which must be used by plans to resolve disputes concerning payment claims or provision of benefits under a qualified health plan, requests for preauthorization of items or services, or determinations by plans that items or services are not medically necessary or appropriate;

- specify an annual open enrollment period of not less than 30 days.

Waiver of Requirements Each state may submit an application to waive the requirements relating to the treatment of metropolitan statistical areas in drawing the boundaries of specified areas and the corporate structure of a purchasing group. The HHS Secretary will establish criteria and an expedited procedure for the consideration of these waiver applications. Limitations to these waivers are as follows:

- in establishing boundaries for each specified area, a state may not discriminate on the basis of race, religion, national origin, socio-economic status, disability or perceived health status;

- the waiver process may not be used to establish a single-payer system.

K. FEDERAL RESPONSIBILITIES

Sets forth certain authorities for the HHS Secretary as follows:

- act as a state program for health plans offered by an employer with employees in two or more states;

- designate State specified areas, if a State fails to make such designations;

- act as a state program if the state program is not in compliance with the requirements of this Act;

- establish rules, identifying the state (and State specified area) in which individuals reside.

II. UNIVERSAL COVERAGE

provides access to health insurance coverage under a qualified health plan for all U.S. citizens and lawful residents not covered under Medicare; sets forth eligibility and programmatic requirements for low-income assistance vouchers to help pay for health plan premiums, sets a timetable to reach universal coverage by the year 2002, and establishes a baseline for Federal health expenditures.

Voucher Phase-In

- Low-income individuals will receive vouchers to purchase health insurance. By 1997, individuals and families with incomes below 90% of the federal poverty level (who are not eligible for Medicaid) will receive a voucher to purchase health care insurance through qualified health plans in the small employer and individual marketplace. By 2002 the coverage will increase to 240% of poverty. At 100%, the subsidy covers the full premium, up to the "applicable dollar limit"; federal assistance phases out at 240% of poverty.

Expanded Access to Employer Plans

- Employers are required to make available to eligible employees enrollment in a qualified health plan for all eligible employees. Employers must provide information on plans available in the local area. Employers must provide for a payroll deduction when notified of the employee's enrollment in a qualified health plan, if authorized by the employee. Employers are neither required, nor precluded from contributing to the cost of employee health coverage.

UNIVERSAL COVERAGE

The Health Board would report to Congress every 2 years on the demographics of the uninsured, and its findings on why those individuals were uninsured.

In the event 96% of all Americans do not have health insurance by 2002, the Board will develop a package of recommendations to Congress designed to reach universal coverage.

If Congress failed to act on the Health Board package or defeated it without enacting an alternative, an automatic "Free-Rider" penalty would be imposed upon:

- Individuals who do not procure coverage (a special provision will be included allowing childless individuals under 30 to purchase catastrophic coverage

instead of the uniform benefit plan).

ACCESS FOR THE UNDERSERVED

Community-Based Primary Care Grant Program

The HHS Secretary will establish a program to administer grants to the states for the purpose of creating or enhancing community-based primary care entities that provide services to low-income or medically underserved populations. This provision is designed to complement the existing federal Community and Migrant Health Center programs by making flexible funding available to local public health departments, rural hospitals, and other public and private community care entities.

The intent is to better address the needs of those regions of the country with few federal Community and Migrant Health Centers and to assist facilities which may be providing low-cost primary care, but may not possess a wide enough array of services or personnel to qualify as Community Health Centers.

Enhanced Assistance for Community Health Centers and Federally Qualified Health Centers

- Expanded resources will be provided for the current Community and Migrant Health Center programs, and the related Federally Qualified Health Center program;

- this provision is intended to complement the state-based community primary care grant program described above. Both provisions are aimed at addressing the shrinking availability of primary health care services in the country's rural and inner-city communities.

Tax Incentives for Practice in Rural, Frontier, and Urban Underserved Areas

- Physicians practicing in rural, frontier, or underserved urban areas are allowed a tax credit equal to $1,000 a month. Nurse practitioners and physician assistants would also be eligible for a similar credit equal to $500 per month;

- loan repayments under the National Health Service Corps Loan Repayment Program are excluded from taxable income;

- the cost of medical equipment, limited to $32,500 annually, used by a physician in a rural health professional shortage area can be immediately expensed;

- interest, up to $5,000 annually, paid on education loans of a physician, registered nurse, nurse practitioner, or physician's assistant is allowed as an itemized deduction if

the individual agrees to practice in a rural community.

Development of Networks of Care in Rural and Frontier Areas

- The HHS Secretary is authorized to waive certain Medicare and Medicaid requirements for demonstration projects to operate rural health networks. Public and private entities may apply for such waivers. The Secretary may award grants to assist organizations in rural networks planning;

- the Secretary will conduct a study on the benefits of developing a supplemental benefit package and making available premiums that will improve access to health services in rural areas.

Rural and Frontier Emergency Care

A rural emergency medical services program is established to improve emergency medical services (EMS) operating in rural and frontier communities. This program will:

- offer a matching grant program for improving state EMS services. These grants will encourage better training for health professionals and provide necessary technical assistance to public and private entities which provide emergency medical services;

- provide federal grants to states for telecommunications demonstration projects linking rural and urban health care facilities;

- establish an Office of Emergency Medical Services to provide technical assistance to state EMS programs;

- federal grant support will also be provided to the states for the development of air transport systems to enhance access to emergency medical services.

Rural community hospitals meeting eligibility criteria may qualify as Rural Emergency Access Community Hospitals (REACHs). This program will permit existing rural community hospitals participating in the Medicare program to maintain their current status if they meet standards of eligibility as a rural emergency access facility. Current special reimbursement to small rural Medicare--dependent hospitals enacted in Omnibus Budget Reconciliation Act of 1989 will be extended.

PRIMARY CARE PROVIDER EDUCATION

This subtitle features mechanisms to increase the number of primary care physicians.

Medicare GME Demonstration Project

- The Secretary will allow up to seven states to experiment with Medicare direct graduate medical education (DME) payments to increase the number of primary care physicians. Under this program, qualifying states may use different weighting factors, or a community-based health care training consortia, to direct a greater share of its DME funds for primary care medical education. A consortia will be composed of teaching hospitals, medical schools, and ambulatory training sites, with the goal of increasing the number of primary care providers;

- up to seven training consortia nationwide will be eligible to receive Medicare DME waivers directly from the Secretary. Each such consortium will be permitted to determine the most appropriate mechanism to use its DME resources to increase the number of primary care providers, including distributing funding to medical schools.

Community-Based Physician Training

- Medical resident training time in non-hospital-owned community-based settings will begin to be counted in the determination of full-time-equivalent residents for the purpose of making Medicare DME payments with the goal of moving more residency training out of hospitals and into the community;

- for the purpose of Medicare indirect graduate medical education payments (IME), training time in non-hospital-owned ambulatory settings will be counted in the determination of full-time-equivalent residents with the goal of providing equal incentives for hospitals to train primary care residents and sub-specialty residents. In addition, per-institution IME payments are adjusted to assure budget neutrality.

Expansion of National Health Service Corps

- Increases funding for the National Health Service Corps scholarship and the State Loan Repayment programs.

Increased Resources for Primary Care Health Professions Training

Enhances resources for Public Health Service programs which support training of primary care providers as follows:

- increases funding for programs under Title VII of the Public Health Service Act for the training of family physicians, general internists, and general pediatricians;

- creates a new scholarship program and increases Title VII

Public Health Service Act funding for physician assistants;

- increases Title VII Public Health Service Act funding for nurse practitioner training and scholarship programs.

State Programs for Non-Physician Providers

- A demonstration program is created for states and non-profit organizations to experiment with changes in state scope-of-practice laws for nurse practitioners and physician assistants, the retraining of subspecialists to deliver primary care, and other mechanisms to increase the supply of primary care providers.

PROGRAMS RELATING TO PRIMARY AND PREVENTIVE CARE SERVICES

This subtitle enhances state and federal maternal and child health and social services programs and comprehensive school health education programs.

Maternal and Child Health Coordination

A state grant program is established to decrease infant morbidity, reduce low-birth weight infants, and to improve overall maternal and child health. These grants will be used by states to develop and implement coordinated, multi-disciplinary, and comprehensive primary health care and social services, as well as health and nutrition education programs. A state receiving a grant will use such funds to coordinate a broad range of state and federal programs.

School Health Education

Current school health education programs for elementary and secondary school students are improved. States receiving grants under this program will distribute such funds to educational agencies and consortia to establish, operate and improve local programs for comprehensive health education and prevention.

TAX AND ENFORCEMENT PROVISIONS
GENERAL TAX PROVISIONS

This subtitle provides for the tax treatment of employer and employee contributions to health plans and medical savings accounts.

Employer Contributions

- Employer contributions to qualified health plans are excluded from employee income. This exclusion is limited to the weighted average cost of the lowest priced one-half of the qualified plans

offered in the HCCA (this "applicable dollar limit" will vary based on family enrollment status and the age of the principal enrollee);

- contributions to qualified health plans in excess of the limit, or to non-qualified health plans in any amount, are taxable to the employee;

- the employer's deduction for contributions to a qualified health plan is limited to the applicable dollar limit for each employee.

Contributions by Individuals and the Self-Employed

- The health insurance deduction for self-employed persons is extended permanently and increased to cover 100% of the cost of qualified health plans, subject to the applicable dollar limit;

- the medical expense deduction for health insurance premiums for individuals is increased to permit the deduction of 100% of the taxpayer's cost for a qualified health plan, subject to the applicable dollar limit.

PROVISIONS RELATING TO ACCELERATED DEATH BENEFITS

This subtitle clarifies the income tax treatment of accelerated death benefits paid to terminally ill persons. Payments made under a qualified terminal illness rider can be received tax-free as if they were paid after the insured's death.

LONG-TERM CARE PROVISIONS

This subtitle provides tax incentives for long-term care, including a medical expense deduction for long-term care services and tax benefits for the purchase of long-term care insurance. This subtitle also establishes consumer protection provisions applicable to such policies.

Qualified Long-Term Care Treated as Medical Care

- Expenditures for qualified long-term care (QLTC) services are deductible as medical expenses. Such services include diagnostic, preventive, therapeutic, rehabilitative, maintenance and personal care. Provision of such services must be contingent upon certification of impairment in three or more activities of daily living by a licensed health care practitioner.

Treatment of Long-Term Care Insurance or Plans

- Employer provided long-term care coverage which meets certain consumer protection standards promulgated by the NAIC, is excluded from an employee's taxable income. Premiums paid by an individual for qualified long-term care

are deductible as a medical expense;

- qualified long-term care coverage may provide benefits in the form of a per diem as long as such amount does not exceed $100 per day.

Requirements for Issuers of Long-Term Care Insurance

- A penalty of $100 per day per policy shall be imposed on long-term care issuers failing to meet NAIC standards.

Uniform Language and Definitions

- NAIC is directed to promulgate standards for the use of uniform language and definitions in long-term care insurance policies, with permissible variations to take into account differences in state licensing requirements for long-term care providers.

QUALITY ASSURANCE AND SIMPLIFICATION

Under this subtitle, qualified health plans are required to annually report data on the quality of their services, including treatment outcomes and effectiveness to the HHS Secretary, their certifying state, purchasing groups, and to individuals enrolled in the plan. The standards for quality assurance programs and the format for quality data are to be set by regulation.

PART I - STANDARDS AND MEASUREMENTS OF QUALITY

The Secretary will consult with private entities to develop standards with which the quality assurance programs must comply. These standards will require that a qualified health plan annually provide quality data and information to the Secretary, the relevant HCCA and to individuals enrolled in such plan. The standards will protect the confidentiality of individual enrollees. Beginning in 1996, the Secretary will publish an annual report -- to be distributed to each qualified health plan, purchasing group, Governor and State legislature -- on expenditures, volume and prices for procedures. This report will identify:

-- procedures for which there appear to be the greatest need to develop valid protocols for clinical decision-making and review;

-- procedures for which there appear to be the greatest need for strengthening competitive purchasing;

-- states and localities requiring additional cost control measures.

A specialized center of care may submit to the Secretary clinical and other information bearing on the quality of care it provides. Such information shall include sufficient data to take into account outcomes and risk factors associated with treatment through such centers. The Secretary will develop comparative information regarding the performance of such centers with the relative performance of other facilities providing the same services.

The Secretary will study the feasibility of creating an Agency for Clinical Evaluations under which the following will be consolidated:

-- Administrator, Health Care Policy and Research (AHCPR);

-- Director, National Center for Health Statistics;

-- Director, Office of Medical Applications of Research, National Institutes of Health (NIH);

-- Director, Office of Research and Demonstrations, Health Care Financing Administration.

This new agency will be authorized to:

-- set priorities for strengthening the medical research base;

-- support research and evaluation on medical effectiveness through technology assessment, consensus development, outcomes research and the use of practice guidelines;

-- conduct effectiveness trials in collaboration with medical specialty societies, medical educators and qualified health plans;

-- maintain a clearinghouse and other registries on clinical trials and outcomes research data;

-- assure the systematic evaluation of existing and new treatments, and diagnostic technologies in an effort to upgrade the knowledge base for clinical decision making and policy choice;

-- design an interactive, computerized dissemination system of information on outcomes research, practice guidelines and

other information for providers.

PART II - AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR)

Part II gives AHCPR responsibility for evaluating and disseminating information on research priorities and the ability to conduct trials on the effectiveness of medical services. AHCPR must establish a clearinghouse to compile and provide information and research data about the effectiveness trials. A fund investigator will be appointed to initiate research with respect to the relationship between health care treatments and outcomes.

PART III - MEDICAL RESEARCH TRUST FUND

This part establishes a Fund, administered by the HHS Secretary to supplement research activities at NIH and health information communications research by the National Library of Medicine. The Fund is financed by a voluntary check-off on individual tax returns and certain civil penalties imposed under ERISA.

SUBTITLE B -- ADMINISTRATIVE SIMPLIFICATION

This subtitle streamlines administrative processes in the health care system by establishing standards for a health care electronic data interchange (EDI) system to reduce administrative waste in the health care system; provide the information on cost and quality needed to make competition work; create the tools needed to conduct outcomes research to improve the quality of care; and, to make it possible to track down fraud. This subtitle also sets requirements to protect the privacy and confidentiality of health care information, and establishes a National Health Information Commission of private-sector experts.

Adoption of Standards for EDI

- Establishes a federal Health Care Data Panel which recommends to OMB (which subsequently issues regulations that apply to all federal agencies and to the private sector) the adoption of data standards for the electronic exchange of health care information;

- standards shall be based on existing standards, where possible, and include data to monitor access to health care services, and other data sets, as deemed appropriate by the panel.

Timetable for Adoption of Standards

- Standards for EDI are phased-in over time, according to the following timetable: 1) financial and administrative transactions (within 9 months of enactment); 2) initial quality indicator data set (within 12 months); 3) a

comprehensive clinical data set (within 2 years); and 4) standards for electronic patient medical records (within 3 years);

- health insurers and providers are required to comply with the EDI standards or use a health care information clearinghouse to translate data to the standard. There is a grace period for adopting established standards and waivers for small and rural hospitals and others under certain circumstances.

Privacy and Confidentiality

The Act establishes strict privacy and confidentiality standards, enforced by criminal penalties, which require:

- information to be collected only to the extent necessary to carry out the purposes of the Act;
- informed consent for information collected for one purpose to be used for another, unless pooling with other individuals renders the information unidentifiable;
- disposal of information when no longer necessary;
- methods to ensure verifiability, timeliness, accuracy, reliability, utility, completeness, relevance, and comparability of the information must be instituted;
- individuals to be notified (in advance of the collection of such information) as to whether their compliance is mandatory or voluntary, what the record-keeping practices are concerning such information, and how the information will be used;
- that individuals be permitted to inspect and correct their records and be advised on the use of such information.

PATIENTS' RIGHT TO SELF-DETERMINATION REGARDING HEALTH CARE

This title provides for more effective implementation of living wills and advance directives by:

- requiring each qualified health plan, Medicare, and Medicaid to disseminate information on existing state laws regarding patient's living wills and advance directive rights to improve the education, awareness, and exercise of such rights;
- allowing health care providers to honor advanced directives and living wills which constitute a reliable expression of the individual's wishes concerning his or her health care, notwithstanding technical formalities of form, language or

execution specified under state law;

- permitting portability between states so that such directives may be honored, except where they conflict with substantive provisions of state law regarding health care treatment;

- requesting the HHS Secretary to study implementation of the Patient Self-Determination Act of 1990 and make recommendations to Congress.

TREATMENT OF EXISTING FEDERAL PROGRAMS

MEDICAID PROGRAM

OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

- At state option, the Medicaid program will permit AFDC recipients and SSI recipients to receive medical assistance through enrollment in a qualified health plan offered in a local HCCA. The state may not restrict an individual's choice of plan and is not required to pay more than the applicable dollar limit for the HCCA area (as determined under section 2001 of the Act). The state will make all necessary payments of premiums, copayments and deductibles under the selected qualified health plan. The number of individuals electing to enroll in a qualified health plan is limited to a fifteen percent of the eligible population in each of the first three years, and ten percent in each year there after.

PART II -- LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS

- Federal financial participation for acute medical services, including expenditures for payments to qualified health plans, is subject to an annual federal payment cap. The cap is determined by multiplying the per-capita limit times the average number of Medicaid categorical individuals entitled to receive medical assistance in the state plan.

- The per-capita limit for fiscal year 1996 is equal to 118% of the base per capita funding amount. This amount is determined by dividing the total expenditures made for medical assistance furnished in 1994 by the average total number of medicaid categorical individuals for that year. Expenditures for which no federal financial participation was provided and disproportionate share payments are excluded from this calculation.

- In years after 1996, the per-capita limit is equal to the per capital funding amount determined for the previous fiscal year increased by 6 percent for fiscal years 1997

through 2000, and 5 percent for fiscal year 2001 and beyond.

- States are required to continue to make eligible for medical assistance any class or category of individuals that were eligible for assistance in fiscal year 1994.

PART III -- STATE FLEXIBILITY CONTRACT FOR COORDINATED CARE SERVICES

- At state option, the Act establishes a risk contract program within the Medicaid program which allow states to enter into contracts with at-risk primary care case management providers. An at-risk primary care case management provider must be a physician, group of physicians, a federally qualified health center, a rural health clinic or other entity having other arrangements with physicians operating under contract with a state to provide services under a primary care case management program.

- Risk contracting entities must meet federal organizational requirements, guarantee enrollee access and have a written contract with the state agency that includes: an experienced-based payment methodology; premiums that do not discriminate among eligible individuals based on health status; requirements for health care services; and, detailed specification of the responsibilities of the contracting entity and the state for providing for or arranging for health care services.

- Standards are established for internal quality assurance and state options regarding enrollment and disenrollment are specified. State and federal monitoring of quality and access standards are also established.

- In addition, each risk contracting entity providing Medicaid services shall also enter into written provider participation agreements with an essential community provider; or at the election of an essential community provider, each risk contracting entity will enter into an agreement to make payments to the essential community provider for services. Essential community providers include: Migrant Health Centers, Community Health Centers, Homeless program providers, Public Housing Providers, Family Planning Clinics, Indian Health Programs, AIDS providers under the Ryan White Act, Maternal and Child Health Providers, Federally Qualified Health Centers, and Rural Health Clinics.

PART IV -- OTHER PROVISIONS

- The Act phases out Medicaid Hospital Disproportionate share adjustment payments by fiscal year 2000.

SUBTITLE B - MEDICARE

Medicare beneficiaries may choose to remain in the Medicare program or enroll in the same qualified health plans as the non-elderly population. The Medicare risk contracting program is strengthened. The annual rate of growth of Medicare expenditures is reduced from 12% to 7% over the next decade by making adjustments in payments to certain health care providers, and by asking higher income senior citizens to pay a greater share of their part B premiums.

PART I - ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS

- The HHS Secretary is directed to develop and submit to Congress a proposal for the integration of Medicare beneficiaries into qualified health plans. In the interim, Medicare enrollees may opt to enroll in qualified health plans and receive the same benefits as the under 65 population, including prescription drug coverage;

- the federal government would make payments to a qualified health plan, on behalf of the beneficiary, for a portion of the premium up to 100 percent of the average amount Medicare spends per beneficiary in that area. The beneficiary would be responsible for the remainder of the premium. The amount the beneficiary would have to pay would depend on the cost of the qualified health plan selected. Medicare beneficiaries who choose to remain in the existing Medicare program would continue to receive the Medicare benefit package.

PART II - ENHANCEMENT OF MEDICARE RISK CONTRACTS

- The HHS Secretary is directed to develop a new payment methodology for Medicare risk contractors which more accurately reflects the costs of providing care to beneficiaries enrolled in risk contract programs. In the interim, several improvements are made in the methodology for determining the amount of payment to risk contractors;

- these enhancements will increase the number of managed care providers offering enrollment to Medicare beneficiaries, especially in areas of the country where there is currently no option for enrollment in a managed care plan.

PART III - MEDICARE SELECT

Medicare Select, the current demonstration program which allows for the sale of managed care supplemental insurance in fifteen states, will be expanded to the nation as a whole. This provision allows Medicare beneficiaries to purchase lower cost Medigap insurance which provides services through a managed care network, rather than fee-for-service.

PART IV - OTHER PROVISIONS

This legislation slows the annual rate of growth in Medicare expenditures from 12% to 7% over the next decade by making adjustments in payments to health care providers for certain services. Changes include the extension of several Medicare payment policies that are due to expire in 1999. In addition, coinsurance is imposed for laboratory and home health services; hospital disproportionate share adjustment payments are phased-out, and bad debt recognition for hospital services is eliminated.

Finally, the bill increases the Medicare part B premium for individuals whose incomes exceed $90,000 per year and for couples whose incomes exceed $115,000 per year.

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MEDICAL LIABILITY REFORM

This subtitle provides mechanisms to resolve disputes over health care malpractice claims more effectively and efficiently. It puts in place reforms that should lead to a reduction in the practice of defensive medicine, while ensuring that victims of medical malpractice are fairly compensated and quality of care is monitored and maintained.

MEDIATION AND ALTERNATIVE DISPUTE RESOLUTION

- Qualified health plans are required to provide mediation procedures approved by the state in order to facilitate early resolution of potential health care malpractice claims. Any party to a health care malpractice claim is required to participate in mediation if requested by another party to the dispute. All information disclosed in the mediation proceeding is protected from use in any other proceeding unless it is discovered independently.

Mandatory Alternative Dispute Resolution

- All health care malpractice claims must be raised in an alternative dispute resolution procedure adopted by the state and approved by the HHS Secretary, before they can be raised in state or Federal court. The Secretary will develop several models of alternative dispute resolution that the states may adopt, or states may develop their own alternative to be certified by the Secretary;

- upon completion of the alternative dispute resolution, any parties to the dispute may appeal their case to the appropriate state or Federal court. However, if the party seeking the court action receives a worse result than that received in the alternative dispute resolution, that party bears all court costs.

PART II -- LIABILITY REFORM

- Non-economic damages awarded to a plaintiff in a health care malpractice claim or action may not exceed $250,000. The amount of damages awarded to a party must be reduced by the amount of any past or future payment for the same injury. The liability of each defendant for non-economic and punitive damages will be based on the defendant's proportion of responsibility for the claimant's harm. Lawyers may not charge contingency fees greater than 25% of the total award.

Reform of Procedures

- Except for injuries suffered by minors younger than six, the statute of limitations for a health care malpractice claim shall be two years from the date on which the injury and its cause should reasonably have been discovered. The court or other adjudicating body must impose sanctions on individuals who pursue an unreasonable health care malpractice claim or action.

Practice Guidelines

- This section establishes a rebuttable presumption that state-developed, federally-approved practice guidelines constitute an appropriate standard of care. No health care provider may be required to provide, or be held liable for failing to provide, new or experimental treatments until they are found safe and efficacious by the appropriate federal agency.

Drugs and Devices

- No punitive damages will be awarded in a health care malpractice claim or action stemming from a drug or device approved by the Food and Drug Administration, unless relevant information was withheld or misrepresented, or an illegal payment to secure approval was made. Approval by the FDA is an absolute defense to strict liability claims.

SUBTITLE B -- ANTI-FRAUD AND ABUSE CONTROL PROGRAM

This subtitle establishes a stronger, better coordinated federal effort to combat fraud and abuse in our health care system. It also expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices. It would:

- require the HHS Secretary to establish and coordinate a national health care fraud program to combat fraud and abuse in government and private health care programs;

- finance the anti-fraud efforts by setting up an Anti-Fraud

and Abuse Trust Fund. Monies from penalties, fines, and damages assessed for health care fraud are dedicated to the Trust Fund to pay for the anti-fraud efforts;

- increase and extend Medicare and Medicaid civil money and criminal penalties for fraud to all health care programs;

- allow competitors to sue health care providers who defraud the Medicare or Medicaid programs if the government does not bring charges against the fraudulent provider;

- bar providers convicted of health care fraud felonies from participating in the Medicare program;

- require HHS to publish the names of providers and suppliers who have had final adverse actions taken against them for health care fraud.

SUBTITLE C -- TREATMENT OF CERTAIN ACTIVITIES UNDER THE ANTITRUST LAWS

This subtitle will create a more flexible antitrust policy environment for the evolving health care marketplace, and allow the efficient collaboration of providers encouraged by the Act, including the elimination of expensive, duplicative and underutilized equipment and services.

Statutory Safe Harbors

- The "safe harbors" apply to: (1) small provider combinations; (2) activities of medical self-regulatory entities; (3) participation in certain surveys of cost, price, reimbursement, and employee wages and benefits; (4) joint ventures for high technology and costly equipment and services; (5) small hospital mergers, (6) joint purchasing arrangements; and, (7) good faith negotiations;

- the Attorney General, in consultation with the HHS Secretary and FTC Chairman, will solicit suggestions for, and promulgate, additional safe harbors to further health care reform.

Certificates of Review (Waivers) Awarded by the Attorney General

- Providers may petition the Attorney General for certificates of review to obtain an antitrust exemption for relevant activities. If the Attorney General does not reject the application within 90 days, the activity is deemed approved.

Provider Notifications for Reduction of Antitrust Penalties

- Upon notification and publication of proposed ventures, health care providers can limit potential antitrust penalties that may be imposed against the venture to actual damages and avoid "per se" condemnation; applicants for certificates of review for exemption from antitrust laws are automatically treated in this manner;

- certain networks of non-institutional providers obtain these benefits without notification if they meet certain criteria.

New Office at HHS

- The bill creates an Office of Health Care Competition Policy within HHS to assist the Secretary in implementing health care antitrust policy.

SUBTITLE G - DEFINITIONS

Key terms are defined as follows:

- with respect to a health plan, a "delivery system" can be a 1) fee-for-service, 2) preferred provider, 3) staff or group model health maintenance organization (HMO), or 4) such other system as the Secretary may recognize;

- in the case of a health plan operating within one state which has a qualified health plan certification program, the "appropriate certifying authority" is the state commissioner of insurance, or the state authority responsible for regulating insurance; in all other cases, it is the HHS Secretary;

- "dependent" means a spouse or a natural or adopted child who is either under 19 years of age, under 25 years of age and a full-time student or any age, if incapable of self-support because of mental or physical disability;

- an "eligible employee" is one who works at least 30 hours per week for one employer;

- an "eligible individual" is one who is not otherwise eligible for coverage under an employer-based qualified health plan, or one of the equivalent health care programs, or has elected not to enroll in a qualified health plan offered by his or her small employer;

- "equivalent health care programs" include parts A and B of Medicare; Medicaid; the health care program for active military personnel; the veterans health care program; CHAMPUS; the Indian Health Service program; and, any other plan recognized by the Secretary to provide retiree health