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001. memo	Charles J. Lynn to Hilllary Clinton/Jeff Eller Re: Health Care University (8 pages)	6/28/93	P5

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June 1993 HSA [4]

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TO: Reviewers in HHS and on White House staff
FR: Atul Gawande
RE: Modifications to the benefit specifications
DT: 9:19am June 23, 1993

Modifications to the benefits package

We have attached a new benefits section of the draft proposal rewritten according to our previous discussions. In addition, we have corrected for inconsistencies and errors and added excluded sections.

Summary of changes in the benefit specifications

1. Certain benefits have been rewritten to maintain a consistent, relatively broad level of detail. Specifically:

   - Individual reproductive services such as vasectomy and tubal ligation are removed since other categories of services do not cite individual treatments.

   - Allergy testing and injections are removed, since they are implicitly included in professional services.

   - Non-investigational, medically necessary or appropriate organ transplants are removed, since they are implicitly included in hospital and professional services as defined.

   - Reimbursement for training patients in self-management is implicitly included the definition of professional services.

2. Key definitions are added for:

   - "Medically necessary or appropriate" (see attached for specific language -- note that abortion is covered implicitly within the definition).

   - Coverage of investigational therapies. The policy we put forward is that routine costs, i.e., costs that would otherwise be incurred, are covered for investigational treatments that are given as part of an research trial approved by the Secretary or under her guidelines.

3. The following changes in benefit categories are made:

   - There is confusion about the "Big Five's" recommendations for mental health and substance abuse coverage. We were requested to redraft these benefits to phase in later (e.g., 2000). However, we were unclear on the starting point and ending point for the

benefits. Because of this confusion, only the ending point is in the write up at this time.

- ▸ Starting point: If we aim to reduce the cost of Ira's written benefit by 25%, the benefit would include the 30/90 day inpatient limit on hospital and a 2 day hospital deductible (i.e., no coverage for 2 days), the 120 day limit on hospital alternatives, 50% coinsurance for any psychotherapy visit, and no coverage for case management or psychiatric rehabilitation.

  - If further reductions are necessary, preferences are to reduce inpatient limit to 30/75, reduce 120 day limit on hospital alternatives, and avoid outpatient visit limits.

- ▸ Ending point: In the year 2000, benefits increase to a 30/90 day inpatient limit on hospital stays with no day deductibles, 120 day limit on hospital alternatives, coverage of case management and limited psychiatric rehabilitation, and variable cost-sharing and no limits on outpatient visits with psychotherapy beyond 12 visits at 50% coinsurance.

- Adult dental benefits are phased-in in the year 2000.

- Hearing aids, which were not in the benefits proposed by the working group or analyzed for cost, are excluded.

4. Benefits are defined more precisely, correcting for errors in description. Specifically:

   - Rehabilitation therapies are not unlimited in duration. At the end of each 60 days of treatment, the need for continued therapy would be re-evaluated. Additional periods of therapy would be covered only if function is improving.

   - Directions for a definition of home health care services are included. The services covered would be similar to the current Medicare program with limitations that they substitute for hospitalization and that, at the end of each 60 days of home health care, the need for continued services should be re-evaluated.

   - An excluded key to the table of preventive benefits is restored. (See Table I attached.) When excluded, it led to some striking errors. For example, pap smear and

pelvic exam are shown as covered every three years without qualification for children ages 6-19. With the key, it is qualified as being for females who have reached childbearing age and are at risk for cervical cancer.

- An excluded definition of limitations on eligibility for mental health and substance abuse services is added.

5. Plan requirements in establishing their cost-sharing schedules are defined.

6. The draft section offering States a waiver from mental health benefit limits if they integrate public and private mental health systems has been revised in two ways:

   - States must demonstrate that there is capability to manage care in integrated systems and that the integration will not raise premium costs, i.e., additional costs are paid for through state public dollars.

   - The draft proposal had included the "carrot" of Federal matching funds to encourage integration. Given that public acute care costs are being absorbed into the premium without any capture of state dollars, it is not clear why the Federal government should have to provide additional "matching funds" for integration purposes. Instead as a "carrot" to encourage integration greater flexibility in the use of the block grant funds is proposed.

GUARANTEED BENEFITS PACKAGE
Substantive changes marked by *

SERVICES COVERED

- Each health plan must provide coverage for the following categories of services as medically necessary or appropriate with additional limitations and cost-sharing only as specified in this Act or by the National Board:

  - Hospital services
  - Services of physicians and other health professionals
  - Clinical preventive services
  - Reproductive health services
  - Mental health services
  - Substance abuse services
  - Hospice
  - Home health care
  - Extended care facility services
  - Emergency services
  - Ambulance services
  - Outpatient laboratory and diagnostic services
  - Outpatient prescription drugs and biologicals
  - Outpatient rehabilitation services
  - Durable medical equipment, prosthetic and orthotic devices
  - Vision and hearing care including eyeglasses for children
  - Preventive and restorative dental services for children
  - Health education classes

- Specification and definition of service categories

  - Hospital services

    - Covered services
      - Inpatient hospital, including bed and board, routine care, therapeutics, laboratory, diagnostic and radiology services and professional services specified by the National Board when furnished to inpatients.
      - Outpatient hospital services
      - 24-hour a day emergency room services

    - Psychiatric hospital services or services for the treatment of a mental disorder are treated separately below.

    - Definitions
      - An institution meeting the requirements of §1861(e) and (f) of the SSA.

  - Mental health and substance abuse inpatient and residential treatment

- Covered services are inpatient hospital as above, crisis residential, therapeutic family or group homes, residential treatment centers -- children, community residential treatment -- adults, community residential treatment and recovery -- substance abuse, residential detoxification services.

- Limitations

  - 30 days per episode, 90 maximum annual for all settings in this category. The annual maximum of 90 can be used as a reserve to extend a 30 day episode after special authorization for medical necessity.

  - Inpatient hospital substance abuse is only for medical detoxification as required for the management of neuropsychiatric or medical complications associated with withdrawal from alcohol or drugs.

  - Inpatient hospital care for mental and substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

- Definitions

  - A hospital is an institution meeting the requirements of §1861(e) and (f) of the SSA.

  - A residential treatment facility are those which meet criteria for licensure for certification established by the State.

  - Eligibility:*

    * Persons are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder, which meets diagnostic criteria specified within DSM-III-R, and that resulted in or poses a significant risk for functional impairment in family, work, school, or community activities.

    * These disorders include any mental disorder listed in DSM-III-R or their ICD-9-CM equivalents, or subsequent

revisions, with the exception of DSM-III-R "V" codes (conditions not attributable to a mental disorder) unless they co-occur with another diagnosable disorder.

* Persons receiving treatment who without such treatment would have met functional impairment criteria are considered to have a disorder.

* Family members of an eligible enrollee may receive medically necessary or appropriately related services (so-called collateral treatment).

- Services of physician and other health professionals.

  - Covered services
    - Includes inpatient and outpatient medical and surgical professional services, including consultations, delivered by a health professional in home, office, or other ambulatory care settings, and in institutional settings.

  - Professional mental health services are treated separately below.

  - Definitions
    - Health professional is someone who is licensed or otherwise authorized by the State to deliver health services in the State in which the individual delivers services.
    - Covered services are those that a helath professional is legally authorized to perform in that State. No State may, through licensure requirements or other restrictions, limit the practice of any class of health professionals except as justified byt he skill or training of such professional.
    - Nothing in this benefit plan requires any plan to reimburse any particular provider or any type or category of provider. But the plan is expected to provide a sufficient mix of providers and specialties and appropriate locations to provide adequate access to professional services.*

- Ambulatory mental health and substance abuse treatment services

  - Covered services include screening and assessment,

clinical management, case management, crisis services, somatic treatments, substance abuse counseling, substance abuse relapse prevention, outpatient therapy.

- Limitations
  - Cost sharing varies by type of service, with outpatient therapy beyond 12 visits subject to a higher cost sharing rate (see table). There is no cost-sharing for case management.
  - To be eligible for substance abuse and relapse counseling, the service must be provided by licensed / certified substance abuse providers.
  - Eligibility criteria as specified for inpatient mental health and substance abuse treatment services except that all persons are eligible for screening and assessment and 24-hour crisis services (i.e., limiting eligibility criteria above do not apply to this category of services).

- Clinical preventive services
  - Covered services are those specified in Table I (based on recommendations of the US Preventive Services Task Force) or as specified by the National Board in regulations.
  - Limitations
    - Must be provided as consistent with the periodicity schedule specified in Table I or as specified by the National Board in regulations.

- Reproductive health services
  - Covers pregnancy-related care and family planning services

- Hospice
  - Specifications are as under the Medicare benefit.
  - Covered services
    - Nursing care provided by or under the supervision of a registered nurse.
    - Medical social services under the direction of a physician.
    - Physicians' services.
    - Counseling services for the purposes of

training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for him or her to adjust to the individual's death.
    - Short-term inpatient care, but respite care is provided only on an occasional basis and may not be provided for more than 5 days.
    - Medical supplies and the use of medical appliances for the relief of pain and symptom control related to the individual's terminal illness.
    - Home health aide and homemaker services.
    - Physical therapy, occupational therapy and speech-language pathology services.

- Limitations
    - Only terminally ill individuals are eligible.
    - Only covers hospice care as an alternative to continued hospitalization.

- Definitions
    - An individual is considered terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the terminal illness runs its normal course.

▶ Home health care

- Covered services
    - Same services as under the current Medicare program with the addition of outpatient prescription drugs and biologicals.

- Limitations
    - Only covers services for an indvidual requiring home-based care as an alternative to continued institutionalization (i.e., inpatient treatment in a hospital, skilled nursing or rehabilitation facility)
    - At the end of each 60 days of treatment, the need for continued therapy shall be re-evaluated. Additional periods of therapy are covered only if at risk of hospitalization or institutionalization.*

▶ Nonresidential mental health and substance abuse treatment services

- Covered services include partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services,

therapeutic respite services, behavioral aide services.

- Limitations
  - 120 days/year for all services listed in this category
  - Services in this category are provided for the purpose of averting the need for, or as an alternative to, treatment in residential or inpatient settings, or to facilitate the earlier return of individuals receiving inpatient or residential care, or to restore the functioning of individuals with serious mental or substance abuse disorders, or assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community.
  - Therapeutic respite services are delivered for the purpose of providing a planned or unplanned break (several hours, overnight, or several days as determined to be clinically necessary and appropriate) for an individual with mental disorders and his/her caregivers in order to reduce stress and prevent disruption of primary caregiving.
  - Eligibility criteria as specified for inpatient mental health and substance abuse treatment services.

- Extended care facility services
  - Covered services:
    - Inpatient services in a skilled nursing or rehabilitation facility.
  - Limitations
    - Only covers services required by an indvidual requiring facility-based care after an acute illness or injury as an alternative to continued hospitalization.
    - Coverage is limited to a maximum of 100 days per calendar year.

- Ambulance services
  - Covers ground transportation by ambulance, including air transportation by an aircraft equipped for transporting an injured or sick

individual.

- Limitations
  - Ambulance is covered only where the use of an ambulance is indicated by the individual's condition. Air transport is covered only when other means of transportation is contra-indicated by the individual's condition.

▶ Outpatient laboratory and diagnostic services

- Covers prescribed laboratory and radiology services, including diagnostic services provided to individuals who are not inpatients of a hospital, hospice or extended care facility.

▶ Outpatient prescription drugs and biologicals.

- Covers drugs, biological products, and insulin when furnished on an outpatient basis.

- Limitations
  - Must be prescribed for use in an outpatient setting.
  - No frequency or quantity limitations other than reasonable rules for amount to be dispensed and number of refills.
  - Health plans are permitted to establish formularies, drug utilization review, generic substitution, mail order programs.*

▶ Outpatient rehabilitation services

- Covered services are:
  - outpatient occupational therapy;
  - outpatient physical therapy;
  - outpatient speech-pathology services for the purpose of attaining or restoring speech.

- Limitations
  - Coverage only for therapies used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury.
  - At the end of each 60 days of treatment, the need for continued therapy shall be re-evaluated. Additional periods of therapy are covered only if function is improving.*

▶ Durable medical equipment, prosthetic and orthotic devices

- Covered services and items

- Durable medical equipment;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ;
- Leg, arm, back and neck braces;
- Artificial legs, arms and eyes (including replacements if required due to a change in physical condition);
- Training for use of above items.

- Limitations
  - Coverage only for items that improve functional abilities or prevent further deterioration in function.*
  - Coverage does not include a custom device.*

- Vision and hearing care including basic eyeglasses for children

  - Covered services
    - Routine eye exams, including procedures performed to determine the refractive state of the eyes.
    - Diagnosis and treatments for defects in vision, including eyeglasses and contact lenses.
    - Routine ear exams.

  - Limitations
    - Eyeglasses and contact lenses limited to children under the age of 18.
    - Routine eye exams limited to one per 2 years for persons 18 years of age or more.

- Preventive and restorative dental services for children.

  - Covered services
    - Treatment for dental disease and injury, including relief of pain and infection, restoration of teeth, and maintenance of dental health.
    - Orthodontia where necessary to avoid reconstructive surgery.

  - Limitations
    - Except for emergency dental services, limited to children under age 18.
    - Coverage for persons 18 years and older is implemented in the year 2000.*

- Health education classes

- Plans are permitted to cover health care courses or training for patients that reduce behavioral risk factors and promote healthy daily activities. Such courses may include smoking cessation, nutritional counseling, stress management courses, skin cancer prevention, and physical training classes. Cost sharing would be determined by the plan.

- Mental health and substance abuse services are covered elsewhere.

- Exclusions from coverage --
  - Specific services: private duty nursing, cosmetic orthodontia and other cosmetic surgery, hearing aids,* adult eyeglasses and contact lenses, in vitro fertility services, sex change surgery and related services, private room accomodations, custodial care, and personal comfort services and supplies.

  - Investigational treatments, except as indicated below.

  - Services that are not medically necessary or appropriate (see section below).

TABLE I -- COVERED CLINICAL PREVENTIVE SERVICES

Age	Immunizations	Tests	Clinician Visits***
0-2	4 DTP, 3 OPV, 3-4 HiB, 1 MMR, 3 HBV	1 Hematocrit, 2 Lead*	7
3-5	1 DTP, 1 OPV, 1 MMR	1 Urinalysis	2
6-19	1 Td	Pap/pelvic** every 3 years after menarche	5
20-39	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years*** +	Every 3 years
40-49	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years*** +	Every 2 years
50-64	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic and Mammogram++ every 2 years	Every 2 years
65 +	1 Td every 10 years Pneumococcal - once Annual influenza	Cholesterol every 5 years Mammogram++ every 2 years	Annually

Key

* = Children at high risk for lead exposure

** = Papanicolaou smears and pelvic exam for females who have reached childbearing age and are at risk of cervical cancer.

*** = Once three annual negative smears have been obtained.

\+ = For females of childbearing age at risk for sexually transmitted disease, an annual Pap smear and screening for chlamydia and gonorrhea.

++ = Females only.

+++ = All visits include immunizations, laboratory tests and other screening tests, including history, blood pressure measurement, risk assessment and targetted health advice/counseling.

DTP = Diphtheria, tetanus, pertussis vaccine
OPV = Oral polio vaccine
HiB = Haemophilus influenzae type B vaccine
HBV = Hepatitis B vaccine
MMR = Measles, mumps, rubella vaccine
Td = Tetanus diphtheria toxoid

In addition targetted tests are as included on p 22 of the briefing book (see attached).

INTEGRATION OF PUBLIC AND PRIVATE MENTAL HEALTH CARE SYSTEMS

The benefit package requires the maintenance of the existing public system for mental health and substance abuse. However, health reform offers the opportunity to develop systems of care where it would be possible to integrate the public and private systems. In order to promote the eventual integration of the public and private systems for treatment of mental and addictive disorders into a single system of care, states are encouraged to use the flexibility allowed under health reform to fold their expenditures for public mental health and substance abuse programs into funding available to regional health alliances and require integrated care for mental and addictive disorders. Federal block grant funding will be available to assist in the development of community based systems of care.

States interested in adopting this direction may obtain a waiver from the limits in the benefit package after showing that the capacity to manage mental health and substance abuse care through integrated systems is feasible in the state and the waiver will not result in additional premium costs. States choosing this approach would be given greater flexibility in their use of block grant funds.

SPECIFICATION AND DEFINITION OF "MEDICALLY NECESSARY OR APPROPRIATE"

- Treatments that are medically necessary or appropriate shall be covered. Treatments that are not medically necessary or appropriate shall be excluded from coverage.[1]
  - A "treatment" is an intervention intended to improve significantly the physical or psychological condition of the enrollee or to prevent or mitigate a health outcome adverse to the enrollee.[2]
    - "Intervention" means a diagnostic, therapeutic or other health-related procedure or service described by the following parameters: (i) the physical or psychological characteristics of the enrollee to whom the intervention is applied; (ii) the technical method of applying the intervention; (iii) the type of provider applying the

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[1]These provisions determine coverage of specific treatments potentially included in the enumerated categories of covered services. They are not intended to expand the scope of covered services beyond those enumerated categories.

[2]The term "treatment" is intended to encompass not only therapy for acute illness or injury but also preventive care, care for disabilities and reproductive care.

intervention; and (iv) the setting in which the intervention is applied.[3]

- "Adverse health outcome" means a physical or psychological condition that constitutes a significant change adverse to the enrollee or a physical or psychological condition that lies outside the normal range.[4]

- The term "medically necessary" has the meaning as defined under 42 USC Section 1395y(a)(1).

  - Note: Grandfathers in well-accepted treatment as covered benefits. For established plans, coverage of a service in the past should be considered good evidence of "standard practice." Over time, it is anticipated that clinical research may reveal certain existing treatments to not be medically necessary or appropriate.

- A treatment is "medically appropriate" if it is effective, beneficial and judicious.

  - "Effective" means that, in the reasonable judgment of the provider at the time the treatment is administered, sufficient evidence exists to conclude that the benefits to the enrollee of the treatment outweigh its risks.[5]

  - "Beneficial" means that, in the subjective judgement of the enrollee at the time the

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[3]"Intervention" includes diagnosis, prevention and other health services. This definition specifies the dimensions along which treatments are to be evaluated for medical appropriateness. For example, "a mammogram in a health woman under 30 with no family history" is clearer than "a mammogram"; "pre-anesthesia evaluation by a physician assistant" is clearer than "pre-anesthesia evaluation." However, this provision should be seen as establishing in federal law any particular level of documentation as a prerequisite for coverage.

[4]A "treatment" should be administered with the <u>intent</u> of affecting the enrollee's health to a significant degree. In addition, the definition of "adverse health outcome" is constructed to allow for plans to cover elective abortions (a significant change adverse to the enrollee) while excluding coverage for cosmetic facial surgery (a slightly large nose would be a normal variation).

[5]This provision would exclude coverage of experimental or investigational treatments.

treatment is administered, the benefits of the treatment outweigh its risks; provided, however, that emergency treatment administered to the enrollee shall be deemed to be beneficial.[6]

- o A treatment is "judicious" unless, in the reasonable judgment of the plan before the treatment is administered, another medically appropriate treatment is available that would be (i) substantially as effective for the enrollee and (ii) significantly less costly to the plan.[7]

COVERAGE OF INVESTIGATIONAL TREATMENTS

- Routine medical costs associated with an investigational treatment that is part of an approved research trial are covered. Specifically, medically necessary or appropriate treatments required to be administered in order to administer an investigational treatment in accordance with an approved research trial in which an enrollee participates shall be covered.[8]

  - ▸ An "investigational treatment" is a treatment the effectiveness of which has not been determined.

  - ▸ An "approved research trial" is a peer-reviewed and approved research program, as defined by the Secretary, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which

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[6]"Beneficial" emphasizes the importance of the enrollee in the decision to administer a treatment. It is intended that emergency treatment be deemed beneficial and that treatments administered to persons subject to legal guardianship under the applicable law of informed consent be judged beneficial by the guardian. However, treatments not judged "beneficial" should not be administered by providers with the expectation of payment.

[7]"Judicious" is intended to allow and encourage plans to develop practice guidelines that will permit the delivery of high-quality care within a budget. "Judiciousness" is intended to be established for specific treatments through scientific guidelines at the plan level, not through retrospective claims denial or through cost-benefit decisions by individual providers.

[8]This provision is intended to require coverage of "routine medical costs" associated with an investigational treatment that is part of an approved clinical trial -- i.e., medical costs associated with the investigational treatment which would be incurred even if the investigational treatment were not administered.

must be demonstrated in order for that treatment to be medically necessary or appropriate.[9]

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[9]Although the Secretary is ultimately responsible for approving a trial, it is intended that coverage be automatically available for trials that are approved by tone of the National Institutes of Health, by the FDA, by Dept of Veterans Affairs, or by a qualified nongovernmental research entity as identified in NIH guidelines.

Benefits policy -- cost sharing

- **Limited deductibles and copayments for consumers.** Consumer out-of-pocket costs for health services in the comprehensive benefit package will be limited, to ensure financial protection, and standardized, to ensure simplicity in choosing among health plans.

  - **Standard cost-sharing.** Health plans are required to use standard consumer cost-sharing requirements. Plans must demonstrate their ability to remain solvent under their chosen cost-sharing schedule in order to remain certified.

    As described on the attached pages, health plans may choose one of three cost-sharing schedules:

    1) **Low cost-sharing:** $10 copayments for outpatient services; no copayments for inpatient services.
       - e.g., managed care plans and health networks

    2) **Higher cost-sharing:** $200 individual/$400 family deductibles; 20% coinsurance; $2000/3000 maximum on out-of-pocket spending.
       - e.g., non-managed fee-for-service plans with unrestricted choice of physician and hospital

    3) **Combination:** Low cost sharing (#1) if enrollees use preferred providers; higher cost-sharing (#2) if they use out-of-network providers.
       - e.g., "preferred provider organizations," "point of service" plans

  - **Health plans may not increase, decrease or otherwise alter the cost-sharing provisions.**

  - **Simplified consumer choice.** Since cost-sharing is standardized, consumers have a simplified choice of three different styles of cost-sharing.

Health network cost sharing

1. General plan design		
	Overall plan deductible	None
	Overall plan coinsurance	$10 copayment per visit
	Annual out-of-pocket limit (No lifetime maximum)	None necessary
2.	Hospital services	
	Inpatient	Full coverage
	Outpatient	$10 copay per visit
3.	Physician services (non-surgical): Office, inhospital and home visits	$10 copay per visit
4.	Preventive care, well-baby care and pre-natal care delivered in outpatient setting (includes the services recommended by the US Preventive Services Task Force)	Full coverage
5.	X-ray and laboratory tests	No copayment
6.	Extended care, home health care and hospice as substitute for hospitalization	Full coverage; 100 d max on SNF/Rehab hosp
7.	Physical, occupational, speech therapy to regain function following illness or injury	$10 copay per visit
8.	Outpatient prescription drugs	$5 copay per script
9.	Mental health services	
	Inpatient	Full coverage; 30 d/episode, 90 d/yr max
	Hospital alternative	Full coverage; 120 d/year max
	Outpatient	$10 per visit (incl. outpatient psych, day hospital, home-based services) except outpatient psych visits > 12per year $20 per visit; no limits.
10.	Dental services	
	Children under 18	$10 per preventive visit; $25 per intervention treatment
	Adults (NONE)	
11.	Vision services	$10 per routine eye exams; $10 for one pair glasses for children per year

Indemnity (fee-for-service) style cost sharing
(*=benefit changes)

1.	General plan design	
	Overall plan deductible	$200/individual; $400/family
	Overall plan coinsurance	20%
	Annual out-of-pocket limit (No lifetime maximum)	$2000/individual; $3000/family*
2.	Hospital services	
	Inpatient	20% coins
	Outpatient	20% coins
3.	Physician services (non-surgical): Office, inhospital and home visits	20% coins
4.	Preventive care, well-baby care and pre-natal care delivered in outpatient setting (includes the services recommended by the US Preventive Services Task Force)	No deductible or coins
5.	X-ray and laboratory tests	20% coins
6.	Extended care, home health care and hospice as substitute for hospitalization	20% coins; 100 d max on SNF/Rehab hospital
7.	Physical, occupational, speech therapy to regain function following illness or injury	20% coins
8.	Prescription drugs	$250 per year deductible; 20% coins (subject to overall out of pocket limit)
9.	Mental health services	
	Inpatient	20% coins; 30 day/episode, 90 day per year max
	Hospital alternatives	20% coins; 120 day/year max
	Outpatient	20% coins (incl. outpatient psych, day hospital, home-based services) except outpatient psych visits > 12per year @ 50% coins; no limits.
10.	Dental services	
	Children under 18	$50 per year deductible; 20% coins on prevention and 40% coins on interventions / restoration with $1500 per year max on these services; interceptive orthodontia ($2500 lifetime max)
	Adults (NONE) *	
11.	Vision services	20% coins for routine eye exams; 20% coins for glasses for children

Preferred provider style cost sharing

		In-network	Out of network
1. General plan design			
	Overall plan deductible	None	$200/individual; $400/family
	Overall plan coinsurance	$10 per encounter	20% coins
	Annual out-of-pocket limit (no lifetime max)	$2000/individual; $3000/family	
2.	Hospital services		
	Inpatient	Full coverage	20% coins
	Outpatient	$10 per visit	20% coins
3.	Physician services (non-surgical): Office, inhospital and home visits	$10 per visit	20% coins
4.	Preventive care, well-baby care and pre-natal care delivered in outpatient setting (includes the services recommended by the US Preventive Services Task Force)	Full coverage	No deductible or coins
5.	X-ray and laboratory tests	$10 per visit	20% coins
6.	Extended care, home health care and hospice as substitute for hospitalization	Full coverage	20% coins 100 d max on SNF/Rehab hospital
7.	Physical, occupational, speech therapy to regain function following illness or injury	$10 per visit	20% coins
8.	Prescription drugs	$10 per visit	$250 per year deductible; 20% coins
9.	Mental health services		
	Inpatient (30/90 max)	Full coverage	20% coins
	Hospital alternatives (120 d/yr max)	Full coverage	20% coins
	Outpatient (incl 1-12 psych visits)	$10 per visit	20% coins
	>12 outpt psych visits	$20 per visit	50% coins
10.	Dental services		
	Children under 18		$50 per year deductible
	Prevention	$10 per visit	20% coins
	Restoration	$25 per visit	40% coins ($1500 max prevention/restoration)
	Interceptive orthodontia	$10 per visit	20% coins ($2500 life max)
	Adults (NONE)		
11.	Vision services		
	Routine eye exams	$10 per visit	20% coins
	Glasses for children	$10 for one set	20% coins for one set

San Juan Star
Saturday, June 19, 1993 Puerto Rico 30¢

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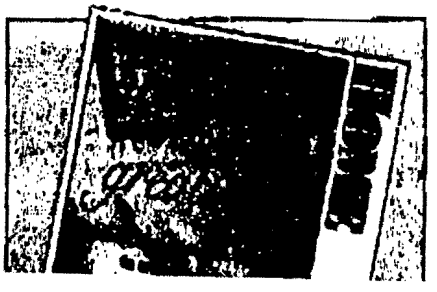
Clinton health reform plan will include Puerto Rico

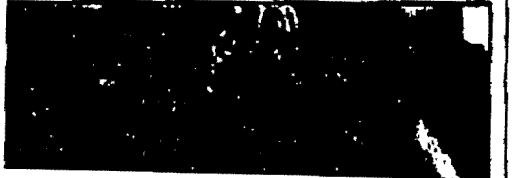
Rosselló gets confirmation from Hillary Clinton. Page 3

Rangel promises further improvement on Senate version of Section 936

936 backers in House and P.R. feel compromise preserved essential elements needed to keep program healthy, but cannot claim "victory" yet. Page 3



Coming home



LOCAL NEWS

Rosselló: P.R. will be included in Clinton's health reform plan

by JORGE LUIS MEDINA
of The STAR Staff

Gov. Rosselló received confirmation Friday from first lady Hillary Rodham Clinton that Puerto Rico will indeed be included in the administration's national health care reform plan.

Rosselló made the announcement from Woodstock, Vt., where he is attending the Democratic Governors' Association meeting.

Clinton attended the meeting Friday and met with the governors during the afternoon to discuss the administration's health reform plans. It was at that meeting that she spoke with Rosselló.

"This morning I had the opportunity to meet with Ira Magaziner, the president's aide in charge of the national health care reform, in an open forum with the governors attending this meeting," said Rosselló in a prepared statement issued by La Fortaleza.

"In the afternoon, [we] had a private session with Mrs. Clinton. The first lady confirmed to me that Puerto Rico will definitely be included in the national health care reform plan," said the governor.

Rosselló added that Clinton was receptive to his offer that Puerto Rico work with her health care reform task force to iron out the details about the island's participation in the plan.

Further confirmation came from Bob Boorstin, a White House spokesman for the health care plan. Boorstin was asked if Puerto Rico would be fully included in the plan. He replied, "All American citizens and legal residents will have access to the comprehensive health benefits package."

Does that mean full access for Puerto Rico? he was asked.

"Yes," he replied.

News of the island's inclusion overjoyed New Progressive Party leaders like Senate Federal Affairs Committee chairman Sen. Kenneth McClintock, NPP-at large.

"The past 24 hours have been the most productive in terms of our relationship with the U.S. since the day we were granted U.S. citizenship in 1917," said McClintock.

"In less than 24 hours, the efforts of Puerto Rican officials managed to reduce by half the impact of President Clinton's economic package in the Senate and get the island included in the national health care reform plan," he added.

"Gov. Rosselló spent months of effort to the issue of Section 936 while he and Resident Commissioner Carlos Romero Barceló worked together to achieve the inclusion of the island in the health reform plan," said McClintock, who added that the inclusion "will turn the island into the medical center of the Caribbean and help create thousands of jobs in the medical services field."

The announcement ended weeks of speculation that the island would be left out of the plan, following a reported statement by Magaziner.

Magaziner reportedly told members of the health task force that Puerto Rico and the territories could not be fully included in the plan because of the high cost of fully funding Puerto Rico.

The statement sparked an angry reaction from Virgin Islands Delegate Ron de Lugo, who said in a House speech that White House advisors were going to recommend that employers in the insular areas be required to pay, along with employees, for workers' health insurance.

However, those areas would not be fully eligible for the same subsidies that would go to the states to cover for health insurance for the poor and the unemployed because it would reportedly cost too much to fully fund Puerto Rico, said de Lugo.

While the Virgin Islands delegate gave no figures, Romero said at the time that Puerto Rico could expect as much as $1.3 billion a year if it were included in the plan. Currently the island gets some $79 million a year in capped Medicare funds.

■ Health reform plan will allow flexibility, Hillary Rodham Clinton tells governors. 12

INSTITUTO DE ADMINISTRACION Y POLITICA DE SALUD DE PUERTO RICO, INC.

June 22, 1993

Hon. William Jefferson Clinton
President of the United States
The White House
Washington DC 20500

Dear Mr. President:

We have received with great joy the news that Puerto Rico will be included in the National Health Care Reform Plan.

The Institute of Health Administration and Policy represents a coalition of the Health Care Industry of Puerto Rico. Presently we are carrying out a two year research project to coordinate healthcare reform initiatives between Puerto Rico and the United States. This study is funded through a cooperative agreement with the Health Care Financing Administration.

As you well know there has been great uncertainty among the American citizens who live in Puerto Rico that we would not be entitled to participate as equals with our other fellow American citizens that live in the United States. Among those concerns was that budget reasons were considered as grounds to deny equal healthcare services to American citizens because of where they live. You are also well aware that there have never been any doubts when it comes to asking Puerto Ricans to serve in the United States Armed Forces.

Since the Healthcare Reform Task Force was organized it was clearly stated that all Americans will be included. Because this is such an important and crucial issue to all of our people we will be pleased that a policy determination to include all Americans, without exception, be made officially by the Task Force.

In proposing your vision of change for America you have shown great courage by making Healthcare Reform one of your Administration's top priorities. We must now make sure that all Puerto Ricans are made part of that new vision with equal rights with our other fellow American citizens.

We are very certain that the present injustice to Puerto Rico will be made right by the man who promised to make America whole again. Our poor people, our

Medicare and Medicaid beneficiaries, our men in the Armed Forces, our veterans who have served this nation and their families, will be grateful to you, William Jefferson Clinton, for the security and new sense of hope that your commitment to include Puerto Rico in the National Healthcare Reform Plan will represent to them and their families.

Sincerely,

Enrique Baquero
President

CC/ Ira Megaziner
Senior Health Advisor
President's Task Force on Health Care

Hon. Carlos Romero Barceló
Resident Commissioner for Puerto Rico
U. S. Congress

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

JUN 4 1993

TO: IRA MAGAZINER

FROM: DONNA E. SHALALA

SUBJECT: PREMIUM REGULATION

I understand that the regulation of health insurance premiums as the strategy for short-term cost-containment is under serious consideration. We are preparing a more detailed decision memorandum on short-term cost-containment, and will include this alternative among the options, but I have such grave reservations about premium regulation that I wanted to be sure that we do not go too far down this path before we discuss it with the President. My concerns about this approach are outlined below:

Benefits will be reduced or additional persons will be excluded from coverage.

In order to be sure that they remain within a premium cap, insurers are likely to reduce benefits, increase enrollee cost-sharing, and increase cherry-picking and underwriting. Even if we try to impose a maintenance of effort requirement, our burden in monitoring that requirement would be tremendous, particularly since we have virtually no experience in regulating private insurance at the federal level, and most of that experience has been bad. The result will be an extensive bureaucracy placing massive administrative burdens on consumers and insurers, which is still likely to be ineffective. While I am familiar with -- and agree with -- much of the criticism of "command and control" regulation of provider prices, at least we know how to do that, and have an existing, effective administrative infrastructure in place.

Lack of adequate available data with which to measure compliance.

The federal government does not now collect the needed data on insurance premiums and only a minority of States collect even partial data. Although rates of increase could be established and premiums perhaps monitored in the future, we have no data with which to establish a baseline, and several years would be required to collect it.

Insurance reform will distort results.

Reform of the small-group insurance market will be phased in during the early stages of implementing Health Care Reform. As insurance companies begin to eliminate underwriting for pre-existing conditions and move toward community rating, there will be no way

to determine how much of premium growth is due to reform and how much to inflation. With premiums currently varying as much as 300 percent, movement toward the middle under community rating will move some premiums significantly up or down, regardless of the success or failure of efforts to hold down costs.

During this period, we can also expect to see substantial movement of enrollees from one plan to another. Without an accurate health risk adjuster -- which we are unlikely to have in the near future -- we cannot adjust premium growth to accurately reflect changes in the demographics of an insurer's enrollee population.

Inaccurate caps could lead to unnecessary bankruptcies and decreased insurance coverage.

Because of our inability to establish accurate baselines or to accurately account for the impact of insurance reforms and changes in enrollee demographics, we could inadvertently set some caps too low and cause unnecessary insurer failures. As a result, increased numbers of persons could suddenly find themselves without insurance coverage.

Premium caps could omit large segments of the market -- the self-insured.

Self-insured plans represent more than half of total commercial health insurance business. These plans, of course, have no premiums, and while we could use the Internal Revenue System to cap the rate of tax-advantaged growth in employers' health care expenses, this would pose yet another set of administrative burdens and bureaucratic costs.

Insurers lack the tools for controlling costs.

In the short term, prior to full implementation of Health Care Reform, insurers will not have the tools or authority to affect provider prices or behavior. Without market competition or price regulation, insurers will be asked to control premiums but without the ability to control providers. The only methods available to them will be those described above -- benefit cuts, cherry-picking, etc.

Premium caps are untested.

Neither the states, nor the Federal government have very much experience with premium controls in health care. Efforts to control premiums for automobile insurance, a much simpler product, have produced results that have been at best, mixed.

CBO may not credit savings to premium regulation.

For all the reasons listed above, we have been given to believe that CBO would not attribute any system-wide savings to premium regulation.

My staff and I would be happy to discuss these concerns with you in greater detail if you so desire.

cc: Hillary Clinton, The First Lady
Leon Panetta, Director, Office of Management and Budget
Laura Tyson, Chairman, Council of Economic Advisers
Lloyd Bentsen, Secretary, Department of Treasury
Robert Reich, Secretary, Department of Labor

bcc: Bruce Vladeck
Phil Lee
David Ellwood
Ken Apfel
Jerry Klepner
Judy Feder
Ken Thorpe
Barbara Cooper

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REMARKS:

I will be over at OEB for 1:00 pm meeting with Paul Starr, otherwise I'll be here.

On new high cost drugs is the Secretary getting a price negotiating a price or a rebate amount? How would the agreed upon price be implemented.

Peter

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MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Beginning in January, 1996, the Medicare program expands to cover outpatient prescription drugs.

ELIGIBILITY

Any Medicare beneficiary who elects to enroll in the Part B program (as 97 percent of the Medicare population currently do) is automatically enrolled in the new prescription drug benefit. The same financial incentive (penalty) for late enrollment continues to apply for the Part B benefit.

DEDUCTIBLES, COINSURANCE AND CAPS

A $250 annual deductible applies to the new drug benefit. Once the deductible has been met, a 20 percent coinsurance per prescription applies. In addition, a $1,000 annual out-of-pocket cap is in effect for each Medicare beneficiary.

Both the annual deductible and out-of-pocket cap are indexed each year to assure that the same percentage of beneficiaries continue to receive benefits as did with the initial $250 deductible and $1000 cap.

FINANCING

As with other Part B benefits, the Medicare prescription drug benefit is funded by both general revenues and beneficiary premiums. The Part B premium would be increased to cover the new benefit. Beneficiary premiums currently finance 25% of Part B costs. Thus, beneficiaries would pay 25% of the cost of the new drug benefit.

PRESCRIPTION DRUGS COVERED

The Medicare drug benefit covers all FDA approved drugs, biologicals and insulin for their medically accepted indications as found in at least one of the three national compendia, which are the American Medical Association Drug Evaluations, the American Hospital Formulary Service, and the United States Pharmacopeia.

The Medicare drug benefit covers home IV drugs. Current coverage of home IV drugs under the durable medical equipment benefit would be eliminated.

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MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

In addition, the current coverage of immunosuppressive drugs, blood clotting factors and osteoporosis drugs would be made part of the drug benefit.

The Secretary of Health and Human Services has the discretion not to cover certain pharmaceutical products listed in Section 1927(d) of the Social Security Act. Examples include fertility drugs, medications used to treat anorexia and drugs used for cosmetic purposes. However, benzodiazepines and barbiturates would be covered under the Medicare drug benefit.

The Secretary has the authority to establish maximum quantities per prescription and to limit the number of refills in order to discourage waste.

The Secretary has the authority to subject medications to requirements for prior approval, meaning that physicians or pharmacists could be required to obtain prior approval before prescribing or dispensing a particular medication. Particular drugs become subject to prior approval based on evidence that they are subject to clinical misuse or inappropriate use or because the Secretary determines that they are not cost effective.

All new drugs approved by the FDA are covered under the benefit. In the case of new drugs that the Secretary determines are excessively or inappropriately priced, the Secretary has the authority to establish a price for Medicare's purposes based on negotiations with the manufacturers. If a manufacturer refuses to negotiate or the Secretary is unable to negotiate a price that the Secretary determines to be reasonable, the Secretary would have the authority to exclude the drug from coverage under Medicare. & Medicaid

COST CONTAINMENT

As a condition of participation in Medicare and Medicaid, drug manufacturers must sign rebate agreements with the Secretary. Rebates are paid to the Secretary on a quarterly basis. Rebates are required for non-innovator multiple source drugs (generic) but will be less than those currently required under the Medicaid rebate program.

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MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

For single source and innovator multiple source drugs, manufacturers pay a rebate to Medicare for each drug based on the difference between the average manufacturer price (AMP) to the retail class of trade and the weighted average of the prices of the drug in the non-retail marketplace, or 15 percent of the AMP, whichever is greater.

For single source and innovator multiple source drugs, an additional rebate is required on a drug-by-drug basis for manufacturers who increase prices at a higher rate than inflation. The baseline indexed price will be the AMP for the drug between April and June, 1993.

In the case of dual eligibles, to prevent manufacturers from paying rebates to Medicare and Medicaid, Medicare will be the recipient of the rebate.

The Secretary has the authority to conduct verification surveys of the AMP.

A manufacturer is considered the entity holding legal title to or possession of the new drug number (NDC) for the covered outpatient drug.

GENERIC DRUG DISPENSING INCENTIVES

The new program provides incentives to encourage the use of generic drugs. Only generic versions of brand name drugs are covered unless the physician indicates that a brand name medication is necessary. The Secretary also has the authority to subject a brand name product to prior approval requirement if a generic substitute is available.

REIMBURSEMENT TO PHARMACISTS

For brand name drugs, payment to pharmacies is the lower of the 90th percentile of usual and customary charges in a previous period or the estimated acquisition cost for those drugs (EAC) plus a dispensing fee.

For generic drugs, payment is the lower of the pharmacist's usual and customary charge or the median of all generic prices (times the number of units dispensed) plus a dispensing fee.

> what its orig for 3rd party plan?

Or a sale limit something for currently

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MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

For participating pharmacies, the dispensing fee is $5, indexed to the Consumer Price Index. Participating pharmacies are required to accept assignment on all prescriptions. Non-participating pharmacists, receive $2 less per prescription.

CHANGES IN PRIVATE INSURANCE REQUIREMENTS

Private insurance plans provided by former employers are required to either reduce the amount of the premium charged to Medicare beneficiaries to account for the coverage of prescription drugs, or increase coverage of other health services by the actuarial value of the prescription drug benefit under the private plan.

QUALIFIED MEDICARE BENEFICIARIES

Low income beneficiaries receive the same financial protection for out-of-pocket costs associated with the drug benefit as provided for other Medicare cost-sharing amounts.

DRUG USE REVIEW

The Medicare DUR program parallels the program established in OBRA 90 for Medicaid. Participating pharmacists are required to offer to counsel Medicare recipients on the use of medications.

The Secretary establishes a national system of Electronic Claims Management as the primary method for determining eligibility, processing and adjudicating claims, and providing information to the pharmacist about the patient's drug use under the Medicare drug program.

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

ELIGIBILITY

1. Proposed change: Strike "subscribe to" and insert "enrolled in". Strike "coverage" and insert "program."

   Rationale: Terminology clarification.

DEDUCTIBLES, CO-PAYMENTS AND CAPS

1. Proposed change: Change "the same NUMBER of beneficiaries" to "the same PERCENTAGE of beneficiaries."

   Rationale: Use of "number" would lead to benefit reaching a smaller percentage of beneficiaries over time.

2. Proposed change: Strike "co-payment" and insert "coinsurance."

   Rationale: Copayment usually refers to a fixed amount while coinsurance refers to a fixed percentage.

3. Proposed change: Index the $1000 out-of-pocket cap in the same manner as the $250 annual deductible.

   Rationale: Assures the same percentage of beneficiaries over time.

FINANCING

1. Proposed change: Strike this entire provision and insert "As with other Part B benefits, the Medicare prescription drug benefit is funded by both general revenues and beneficiary premiums. The Part B premium would be increased to cover the new benefit. Beneficiary premiums currently finance 25% of Part B costs. Thus, beneficiaries would pay 25% of the cost of the new drug benefit."

   Rationale: Beneficiaries will not pay the same amount for new coverage as they do for current coverage. They will pay the same percentage -- 25%.

PRESCRIPTION DRUGS COVERED

1. Proposed change: Reference to compendia should read "as found in at least one of the three national compendia, which are..."

   Rationale: Current language requires that the medically accepted indication for a drug or biological be listed in all

three compendia.

2. Proposed change: Insulin should be covered under the new benefit.

   Rationale: Insulin needs to be explicitly listed since it is neither a drug or biological. Including insulin is consistent with the Medicare Catastrophic Coverage Act of 1988 (MCCA).

3. Proposed change: A home IV therapy benefit should be covered under the new drug benefit. Drugs provided through the home IV benefit would be subject to the new benefit's deductible and co-payment. Current coverage of home IV therapy under the DME benefit would be eliminated.

   Rationale: Including home IV therapy is consistent with the MCCA and eliminates quality assurance concerns under the DME program.

4. Proposed change: Current coverage of immunosuppressive drugs, blood clotting factors and osteoporosis drugs should be covered under this new benefit.

   Rationale: Medicare currently covers immunosuppressive drugs for the first year after a covered transplant. After the first year of immunosuppressive therapy, the beneficiary would then be covered under the new drug benefit. Covering the beneficiary under the new benefit from the outset would be administratively simpler. Medicare also currently covers blood clotting drugs for hemophiliacs and osteoporosis drugs.

5. Proposed change: The Secretary would have the discretion to exclude from coverage drugs listed in Section 1927(d) of the Social Security Act, except for benzodiazepines and barbiturates.

   Rationale: Under Medicaid, the statutory exclusions are permissive; states may or may not cover the drugs listed in the categories. Applying the statutory exclusion to Medicare implies mandatory exclusion of the listed drugs.

6. Proposed change: Add a provision that gives the Secretary the authority to establish maximum quantities per prescription and limits on the number of refills.

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Rationale: This provision will discourage wasteful dispensing of pharmaceuticals.

7. Proposed change: Either physicians and PHARMACISTS may be required to obtain approval before prescribing and/or dispensing a particular medication.

   Rationale: In the Medicaid program, pharmacists rather than physicians generally request prior approval before dispensing a pharmaceutical product.

8. Proposed change: Add "on" before "evidence."

   Rationale: Word omission.

9. Proposed change: In the case of new drugs that the Secretary determines are excessively or inappropriately priced, the Secretary has the authority to establish a price for Medicare's purposes based on negotiations with the manufacturers. If a manufacturer refuses to negotiate or the Secretary is unable to negotiate a price that the Secretary determines to be reasonable, the Secretary would have the authority to exclude the drug from coverage under Medicare.

   Rationale: Mandating that ALL of a manufacturer's drug products not be reimbursed by any federal program is too punitive and as such will never be enforced. In addition, a manufacturer may agree to negotiate but not negotiate in good faith.

COST CONTAINMENT

1. Proposed change: As a condition of participation in Medicare AND MEDICAID, drug manufacturers must sign rebate agreements with the Secretary to be reimbursed for covered drugs under Medicare.

   Rationale: This provision increases likelihood that manufacturers will sign rebate agreements when both Medicare and Medicaid participation included.

2. Proposed change: Include rebates for generic as well as brand name drugs. The rebates for generic drugs would be at a lower level than is currently mandated under the Medicaid program (currently 10% of AMP, 11% of AMP in 1994). The Medicaid generic rebate percentage would be reduced. The reductions in

savings would be offset by stricter enforcement of state laws mandating generic substitution. Medicare's generic rebate percentage would equal the revised Medicaid percentage.

Rationale: Mandating generic drug rebates is consistent with the current Medicaid drug rebate program. Not mandating generic drug rebates would substantially reduce the total rebates that could be collected by the Federal government. Not including generic rebates could also make the manufacturing of generic drugs too attractive relative to the manufacturing of innovator drugs.

3. Proposed change: Delete reference to carriers or intermediaries.

   Rationale: Having drug claims processors also administer the rebate program raises conflict of interest and confidentiality issues.

4. Proposed change: The rebate formula should use a weighted average of the prices offered by the manufacturer of a given drug in the non-retail market rather than the median price of the drug in the non-retail market.

   Rationale: Using the median rather than the weighted average may result in significantly reduced rebates. For example, if a few HMOs and hospitals receive substantial discounts from drug manufacturers but the majority of other providers receive minor discounts, the median will be skewed towards the lower discounts.

5. Proposed change: Change "average price charged" to "average manufacturers price."

   Rationale: Consistency of terminology.

6. Proposed change: The baseline index price will be the average manufacturers price (AMP) for the prescription from April through June 1993.

   Rationale: A span of several months is desirable to calculate the AMP to get the most accurate estimate of price.

7. Proposed change: A provision for dual eligibles must be included with Medicare serving as recipient of the rebate when Medicare is the primary payor.

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

8. Rationale: Avoids situations in which drug manufacturers would pay double rebates.

9. Proposed change: Add a provision which allows the Secretary to conduct verification surveys of the AMP.

   Rationale: Drug manufacturers provide the Secretary with the AMP. Oversight is required to determine that the information supplied is accurate. This provision is consistent with the Medicaid rebate program.

10. Proposed change: A manufacturer is considered the entity holding legal title to or possession of the new drug number (NDC) number for the covered outpatient drug.

    Rationale: This provision clarifies the responsible manufacturer. This definition is consistent with the Medicaid rebate agreement.

GENERIC DRUG DISPENSING INCENTIVES

1. Proposed change: Strike "high quality" before "generic substitutes."

   Rationale: Not clear what high quality means in relation to generic drugs or whether this reference is meaningful given current FDA practice.

REIMBURSEMENT TO PHARMACISTS

1. Proposed change: Insert "in a previous period" after "charges."

   Rationale: More precise.

2. Proposed change: Change "actual acquisition cost" to "estimated acquisition cost."

   Rationale: Actual acquisition cost is very difficult to administer, requiring a survey of acquisition costs of pharmacists. Estimated acquisition cost could be simply calculated as a percentage of average wholesale price (AWP).

3. Proposed change: Separate discussion of dispensing fees from costs of drugs.

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Rationale: Clarity.

MEDICARE HMOS

1. Proposed change: Omit this section.

   Rationale: Since outpatient drugs are added to the benefit package, HMOs would be required to provide such benefits.

CHANGES IN PRIVATE INSURANCE REQUIREMENTS

1. Proposed change: This provision should be limited to policies paid for by former employers.

   Rationale: The new benefit's impact on Medigap policies would be dealt with through loss ratio requirements. NAIC would have to revise the standard benefit package to account for the new benefit.

QUALIFIED MEDICARE BENEFICIARIES

1. Proposed change: Replace this provision with "Low income beneficiaries receive the same financial protection for out-of-pocket costs associated with the drug benefit as provided for other Medicare cost-sharing amounts."

2. Rationale: This provision clarifies the provision's intent. Also, financial assistance implies a cash payment.

DRUG USE REVIEW

1. Proposed change: Strike "and medical history" and insert "use."

2. Rationale: The pharmacist will not have access to the patient's entire medical history.

News from
SENATOR JOHN CHAFEE
RHODE ISLAND

567 DIRKSEN BUILDING WASHINGTON D.C. 20510-3902 (202) 224-2921

SPEECH BY SENATOR JOHN H. CHAFEE
Meet the Health Care Policy Makers
Washington, D.C. June 25, 1993

Good morning. I appreciate the opportunity to discuss my work on health care reform with you.

I have studied your program. The word comprehensive seems an understatement. To be honest, I am not sure I can think of twenty minutes concerning health care reform that won't be repetitive for you.

You have heard from two Administration representatives. You know, I would be curious whether you feel they agreed on anything!

You have heard from two of my Republican colleagues in the Senate, who have been deeply embroiled in the efforts of the Senate Republican Task Force on Health Care.

You are hearing from three Democratic Senators, who hold a wide range of positions on reform -- some are advocates of the Canadian-style, single-payer system.

You have heard from one of the leaders of the Conservative Democratic Forum in the House of Representatives, who has introduced a very credible proposal, based on managed competition.

And, you have heard from the Chairman of the Ways and Means Committee, who has been through numerous drills like this one before. He has a unique sense of history concerning how such contentious and far-reaching issues can be resolved through the Congressional process.

You have certainly gotten a thorough schooling. I must say I am grateful to the conference organizers for giving me this slot on the schedule. You have had a good night's sleep, and plenty of time to get a second cup of coffee -- so there may be some hope for my speech!

Now, to outline for you the Republican solution to the health care crisis in this country. You may know that twenty-three members of the Senate Republican Task Force on Health Care, which I chair, introduced an initial reform bill in 1991. We are firmly committed to many of the elements of that bill, and have included them in the measure that we are now poised to introduced. Among them are:

1. Insurance market reform. No longer will insurance companies be able to select only the healthy for coverage.

2. The establishment of small group purchasing organizations, to allow individuals and small businesses to pool their risks and resources -- giving them the same clout as large companies when buying health insurance.

3. Medical liability reform. Doctors and hospitals have to carry backbreaking malpractice premiums -- and we ultimately bear those costs in our health insurance or doctors' fees. We have to change the way malpractice litigation works.

4. Repeal of state mandated benefits and state anti-managed care laws, to encourage the development of managed care initiatives -- ranging from simple hospital pre-admission screening to full scale HMOs.

5. Creating equity in the tax code, to guarantee that all individuals, and the self-employed, can deduct 100% of their health insurance costs. As it stands, employer-provided health insurance is tax-free, while health insurance purchased individually must be bought with after-tax dollars. The self-employed can deduct only 25%. This is a glaring inequity which absolutely must be corrected.

6. Reduction of administrative costs. It is estimated that 17 cents on the health care dollar goes to paperwork, and the time health professionals spend filling out forms in triplicate. It stands to reason that we can save a bundle by paring down these costs -- even with a simple solution like creating a standard insurance form.

7. Expansion of community health centers -- to get needed care to those in underserved areas.

8. Greater emphasis on preventive care. This is the principle on which Health Maintenance Organizations operate: if you keep people healthy with routine check-ups, immunizations, and screenings, you avoid costly health crises.

Regardless of the complexion of the ultimate reform package, one thing is certain. In order to bring national health spending down, we need to bring about a much greater emphasis on preventive medicine, including education about healthy behaviors. I know you will agree with me that we absolutely have to convince people not to abuse alcohol and drugs, not to smoke, not to drive fast, not to own guns, always to wear seat belts and motorcycle helmets. The gargantuan expenditures caused by these avoidable practices have to be curbed. Any health care legislation must certainly reflect such a shift in focus.

Let me digress for a moment to discuss two areas of particular concern to me -- which I think we absolutely have to start thinking of in the context of health care reform.

First, let us recognize the alarming impact of handguns on the health care system.

Handgun violence is nothing less than a national public health emergency. More than any other weapon, easily concealed, readily available handguns are wreaking havoc on our society.

Each year, handguns are used to commit 80 percent (11,400) of gun homicides, and 70 percent (12,600) of gun suicides. Countless individuals, many of them children, are killed accidentally by handguns. Moreover, for each gun death, there are an estimated <u>seven</u> gun injuries.

The health care costs associated with gunshot wounds are staggering. Researchers calculate that the per-patient cost of hospitalization for gunshot wounds averages $13,200, with costs ranging from $800 all the way to $495,000. And there are additional costs: ambulance services, follow-up care, medication, and rehabilitation treatment. If the bullet nicks the spinal cord, and the patient suffers paralysis, costs can run $1,500 per day for basic rehabilitation. Depending on the extent of paralysis, three months of treatment can cost up to $270,000.

In each case, a staggering 80 percent of the charges for treatment of gunshot wounds are borne by government sources -- i.e., the taxpayer. The overall cost of firearms injury to the U.S. health care system? More than $4 billion, according to the Chair of the 1991 Advisory Council on Social Security. I believe that figure is low.

If we are serious about health care cost containment, then we should ban handguns altogether.

Let me turn your attention to another grave public safety matter: injuries related to motor vehicle accidents. The amount of public funds consumed by gun violence is surpassed only by the health care costs attributable to motor vehicle accidents -- which are estimated at $14 billion annually.

Most of those injuries -- and costs -- could be prevented. The National Highway Traffic Safety Administration estimates that, if we could increase seat belt use from the current 62% to 85%, and make some modest gains in motorcycle helmet and child restraint use, an additional 7,800 lives could be saved each year and innumerable injuries prevented.

Last year, I was successful in including language in the highway bill to pressure states to enact seat belt and motorcycle helmet laws. I considered that a major triumph in the area of prevention.

The statistics in my home state of Rhode Island make a compelling case for universal motorcycle helmet laws. The State Hospital in Rhode Island is now caring for five individuals who are comatose from head injuries suffered while riding motorcycles without a helmet, at a cost to the State of nearly $350 per patient, per day. That is $125,000 per patient, per year. One of these persons has been in this condition for over 18 years, at a total cost to taxpayers, thus far, of nearly $2 million.

This year, twenty of my Senate colleagues, even some who are involved in the health arena, have introduced legislation to repeal the mandatory seat belt and helmet law. To me, this is a discouraging development. This is no time to allow such a setback to prevention efforts. I could certainly use your help in defeating that measure.

Back to health care reform. The current Republican Health Care Task Force plan adopts a "managed competition" approach, as a way to contain health care costs even further. If you didn't know before you got to this conference, you certainly know now, that the term "managed competition" means different things to different people -- so I will describe briefly how it would work under the Republican plan.

A national, uniform health benefit package would be developed. Individuals and small businesses would be able to purchase this benefit package through large purchasing groups. They would therefore have the same purchasing power as do large companies such as GM or Chrysler. Individuals, the self-employed, and employees of small business, would select from a menu of health insurance plans that would be offered through the purchasing group.

These plans would all offer the same benefits, and would compete on the basis of price, and on the array of doctors and hospitals with whom they contract. But there would be an incentive to select a lower-cost plan, because of favorable tax treatment. Tax exemptions only for the value of the standard benefit package are at the heart of the managed competition model. Republicans are working on an acceptable way to implement that premise.

Thus, there would be strong competition among health plans and providers to keep costs low, in order to attract patients. Plans that were unable to do so, would be at a competitive disadvantage. Furthermore, information about the track record of a given plan -- or doctor -- would be much more readily available than it is now.

I know that many health care providers, particularly physicians, are opposed to the concept of managed competition, because managed competition could force providers into managed care. I'd like to warn those opponents, however, that if this fails, you will almost certainly see government price controls. The American public's perception of our health care crisis is that fees charged by physicians, hospitals, drug companies, and insurance companies must be controlled. They see the biggest problem as waste, fraud, and abuse. They want it cut from the hides of insurance companies, hospitals, doctors, and government.

Republicans are wary of many of the details of the Clinton plan as they become evident in the daily news leaks. But, we are eager to work with the Administration to fashion a plan that will be good for our country.

I have discerned some major differences between what we are working on, and what Mrs. Clinton's task force is rumored to be developing.

The first issue is whether a contribution will be required from the employer. President Clinton has advocated that employers pay the price of health insurance -- seven percent of payroll is what is usually mentioned. That will have a serious impact on small business. I do not think that we can afford health care reform at the cost of jobs. After all, one of the major reasons we need to reform the system is that health care costs are weighing down business, impeding job creation. Thus, Republicans are averse to levying what is, in effect, yet another payroll tax on business.

The second difference is the question of raising taxes to finance care to those who remain uninsured. This point is especially critical given the tax increases that are part of the Clinton budget plan, which Congress is in the midst of considering. That proposal envisions $270 billion in new taxes over the next five years. These increases do not include funding for health care reform, which has been projected to cost as much as $100 billion per year when fully implemented. Republicans are working with a "pay-as-you-go" concept: as the savings from the initial reforms are realized, we propose to use those funds to bring more people into the system. We worry that an abrupt, massive expenditure will be a disastrous jolt to the economy. Thus, we favor a long phase-in period.

Finally, although President Clinton has embraced the concept of managed competition, he has stated that he will also use a nationwide budget to contain health care costs. One concern Republicans have about price-setting is that it conjures up the word "rationing." Furthermore, Republicans do not believe that global budgets or price freezes will necessarily achieve the goal of keeping costs down. As we have seen with Medicare reimbursement -- providers will charge as much as they know they can get back from the government. It's hardly the incentive to keep costs low that managed competition is supposed to create.

I am one who has believed all along that it is possible -- in fact, imperative -- to put political partisanship aside, in order to develop a sensible health reform package that will meet the compelling needs of our nation. This is a thrilling moment in our country's history. There is a clear will to do something momentous and worthwhile -- we must not allow this opportunity to pass. Thank you.

WASH POST: 06/26/93

Senate GOP Health Care Bill to Include Elements of Clinton Plan

By Dana Priest
Washington Post Staff Writer

Senate Republicans plan to introduce a health care bill that is similar to one favored by conservative House Democrats and includes many elements of President Clinton's plan but would not include most government mandates and price controls.

Although substantial differences exist among the three plans, it has been decades since such diverse congressional blocs agreed on even a general structure for health care reform. That apparent consensus may make it easier to pass comprehensive legislation in the near future.

"They're really all talking about the same framework," said John Rother, legislative director for the American Association of Retired Persons. "This is incredible progress since a year ago."

During the last session of Congress, the leading Democratic and Republic bills varied widely in their approach—from liberal Democratic proposals to extend Medicare coverage to the entire population to the incremental insurance market reforms that the Bush administration favored.

Sen. John H. Chafee (R-R.I.) yesterday gave the most detailed outline to date of what probably will be the Republicans' most prominent legislative counterproposal to Clinton's plan. He said the bill is being developed by a group of 23 Republican senators, including Minority Leader Robert J. Dole (R-Kan.).

"We're very interested in working with the administration to fashion a plan that would be good for the country," Chafee said. "This is a thrilling moment for our country."

All three proposals call for pooling consumers' purchasing power to negotiate better prices from private, competing health plans. All would establish a standard minimum package of health benefits that any plan would have to offer. All would prohibit insurers from denying coverage to individuals because of their health condition, sex or occupation. Each would provide consumers with information to use in judging and choosing a health plan.

But the Senate Republican plan—like the one under development by Rep. Jim Cooper (D-Tenn.) that is supported by conservative House Democrats—parts company with the administration over the government's role in guaranteeing universal coverage and controlling health care costs.

The Clinton plan would require all employers eventually to pay part of their employees' health coverage. Since most of the uninsured live in working households, the administration believes that the mandate would go a long way toward financing coverage for the estimated 37 million Americans without coverage and would end the hidden cost-shifting that occurs when hospitals bill policyholders for the cost of uninsured people's care.

Both alternative proposals oppose an employer mandate in any form. "Clearly this would have a serious impact on small business," said Chafee. "I don't think they can afford health care reform at the cost of jobs."

Under the Clinton plan, a national health board would set an annual national health spending limit that would be enforced by price controls on insurance premiums or fees paid to doctors, hospitals or other providers if competition alone did not keep costs down.

"We don't think these price freezes will necessarily keep down the costs," said Chafee, who noted Medicare's inability to control cost increases through fee controls.

The administration is tentatively planning to finance coverage for uninsured and poor people gradually, through savings from reform, a tax on cigarettes and methods of recovering from hospitals the amount they charge paying patients to compensate for losses on the uninsured.

Chafee said that under the Republican plan government subsidies would be available to the uninsured and poor who do not receive Medicaid only "as savings from initial reform are realized. . . . We would start at the poverty level and work upwards."

Each of the three plans would allow self-insured companies to opt out of the insurance-purchasing pools. Chafee's proposal would allow companies with over 125 employees to do so. Cooper's bill may put the threshold at 1,000, and the latest version of the administration plan sets it at 5,000. Self-insured companies, however, would be required to offer the standard benefit package.

Such differences, said former Bush health care adviser Deborah Steelman, can amount to "huge" discrepancies in the way each proposal defines "managed competition."

Cooper, however, said the apparent similarity between his plan and the Republican proposal "was cause for rejoicing." Conservative Republicans disagree, calling the Chafee bill "Clinton II."

"Clinton's plan is managed competition with an emphasis on 'managed' and Chafee's is an emphasis on 'competition,' " said Merrill Matthews of the conservative National Center for Policy Analysis. "Chafee is trying to out-Clinton Clinton."

None of the proposals has been submitted as legislation.

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Charles J. Lynn to Hilllary Clinton/Jeff Eller Re: Health Care University (8 pages)	6/28/93	P5

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APPENDIX
HEALTH CARE UNIVERSITY
DETAILED LIST*

Coverage

- Working Population
- Part-time Workers
- Nonworking Population
- Medicaid
- Early Retirees
- Undocumented Persons

Benefits Package

- Cost sharing
- Preventive Services
- Mental Health
- Abortion
- Updating benefits through Board

New System Design

- National Health Board
- National Administration
- State role
- Regional Health Alliances/
- ERISA/Corporate Alliances
- Health plans
- Rural
- Urban
- Risk adjusters
- Inter-alliance trust fund

Long-term Cost Containment

Transition

- Insurance Reforms
- Short-term cost controls
- State phase-in
- Enforcement

Costs and Financing

Structure of mandate
Cost of reform
Other Revenue Sources

Quality Management and Improvement

Performance Report
Accountability
CLIA
Practice Guidelines

Information Systems/Administrative Simplification

Medical Malpractice

Anti-trust

Fraud and Abuse

Medicare

- Managed care (AAPCC reform)
- Point of service option
- Prescription drug benefit
- Waiver option - Medicare integration

Medicaid

- Managed care incentives
- Maintenance-of-effort
- Budgets
- Eligibility requirements
- Wrap-around benefits

Long-Term Care

Disabled

Prescription Drugs

Other Federal Programs

Veterans Affairs
FEHB
Indian Health
Military: DoD/CHAMPUS

Medical Research Initiatives

PHS

Essential Providers
Population-based Prevention

Workforce Development/Medical Education

Primary Care Incentives
Graduate Medical Education
Academic Health Centers

Ethics

cc: Shirley, Melanne, Patti

4th Lady scheduling

MEMBER:
COMMITTEE ON ENERGY & COMMERCE
COMMITTEE ON VETERANS' AFFAIRS
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SUBCOMMITTEE ON COMPENSATION, PENSION, AND INSURANCE

Congress of the United States
House of Representatives

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June 28, 1993

yes

The Honorable Hillary Rodham Clinton
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

Dear Hillary:

I am writing to request a July meeting for you and Ira Magaziner with leaders of children's hospitals, including Children's Mercy Hospital in Kansas City, to talk about key issues in health care reform essential to ensuring chronically and congenitally ill children's access to the specialized care they need.

In recent years, I have given increasing attention to the health care needs of children. I am especially proud to have been the House sponsor of legislation, which Congress enacted in 1990, to ensure Medicaid will extend its coverage to all poor children. I look forward to giving close attention to children's needs in health care reform, too.

I know you share my strong support both for improving health care coverage for children and for ensuring access to the kinds of essential services provided by children's hospitals. As you may know, Lawrence McAndrews, who was the CEO for Children's Mercy Hospital in Kansas City for several years, has become the CEO of the National Association of Children's Hospitals and Related Institutions. He has been suceeded at Children's Mercy by its new President Randall O'Donnell, with whom you worked as a trustee for many years when he was President of Arkansas Children's Hospital.

Now that the broad outline of the President's plans for health care reform has been somewhat defined, it would be helpful to discuss details critical to children, particularly those chronically ill or disabled, who require the services of tertiary level pediatric teaching hospitals. It also would be helpful to discuss how children's hospitals best can compete in markets shaped by managed care, given the hospitals' roles in medical education, research, and service to low income children.

I would envision the meeting including the leaders of five to 10 children's hospitals as well as myself. I will have my staff contact your office to follow up on this request. Thank you very much for your consideration.

Sincerely,

JIM SLATTERY
Member of Congress