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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Mike Lux to Staff Re: Health Care (3 pages)	11/21/94	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Asct)
OA/Box Number: 23754

FOLDER TITLE:
November 1994 HSA [1]

gf154

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]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(1) National security classified information [(b)(1) of the FOIA]
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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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]

November 23, 1994

MEMORANDUM FOR NANCY-ANN MIN

FROM: CHRIS JENNINGS

SUBJECT: Chart for Cost Containment Presentation

Following up on our conversation, I would like to say that I agree with you that we cannot have a solid presentation without showing expenditure levels contrasting Medicare, Medicaid, and the private sector. I do continue to have concerns, however, about the chart that we now are planning to use to illustrate this information. I have two suggested alternatives:

1. Rather than show our current chart, replace it with one that shows the actual spending levels of these categories. Obviously, this would be my first choice.

2. If this can't be done in time for the presentation, to make certain that there is a full and complete explanation as to why this information could be presented in a number of different ways.

I have a meeting at 8:15 with Bob and Carol and will not be able to see any changes you make prior to the 9:00 presentation. If you have any questions, please call Kim.

COST CONTAINMENT -- MEDICARE AND MEDICAID

I. Reform Payment Procedures

1. Medicare prospective payment for outpatient departments and skilled nursing facilities.

II. Promote Competition

1. Permit Medicare to use competitive bidding for purchase of Part B services (such as clinical laboratory services or MRIs).

2. Permit Medicare to pay for durable medical equipment in accordance with local market rates.

III. Managed Care

Medicare: background, issues, and options:

1. Reduce benefits in fee-for-service Medicare as an incentive for beneficiaries to enter HMOs.

2. Strengthen current risk and cost contract program and create additional incentives for participation.

3. Create more flexible managed care options.

Medicaid: background, issues, and options:

1. Increase State flexibility.

2. Remove current prior approval barriers.

3. Mandate managed care.

AGENDA

NOVEMBER 23, 1994

COST CONTAINMENT

I. Introduction

II. Presentation of Health Care Expenditures Data and Projections

III. Review of Previously Proposed Scorable Cost Containment Initiatives

1. Expenditure Caps
2. Premium Caps
3. Traditional Medicare Savings
4. Cost Containment Commission

IV. Market-Oriented/Tax-Incentive Cost Containment Alternatives

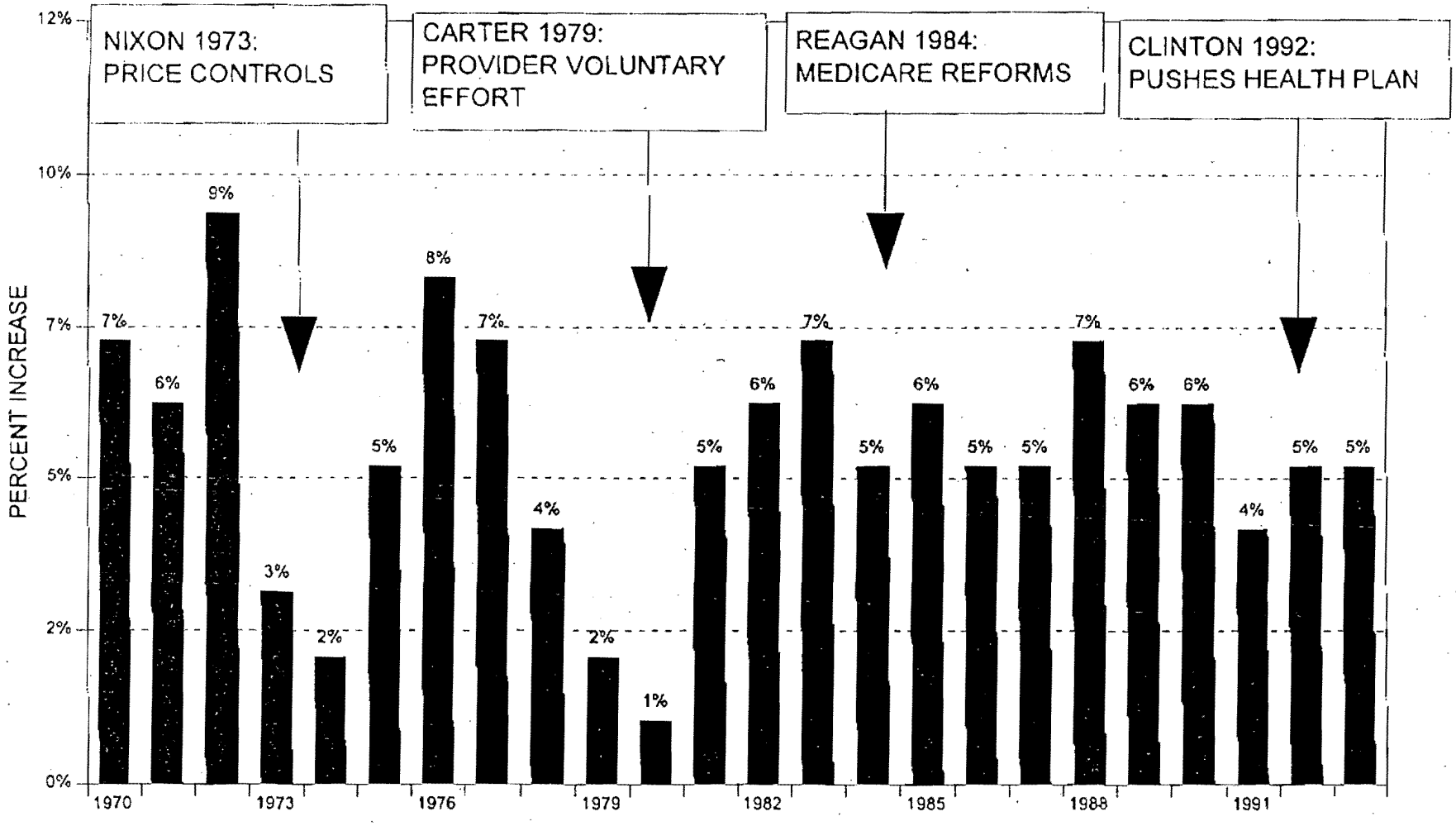
1. Tax Caps
2. High Cost Plans Assessment
3. Medical Savings Accounts

V. Medicare and Medicaid Structural Cost Containment Initiatives

1. Reform Payment Procedures
2. Promote Competition
3. Managed Care: Medicare and Medicaid

VI. Closing Remarks and Description of Meetings to Follow

PERCENT INCREASE IN INFLATION-ADJUSTED NATIONAL HEALTH SPENDING, 1970-1993



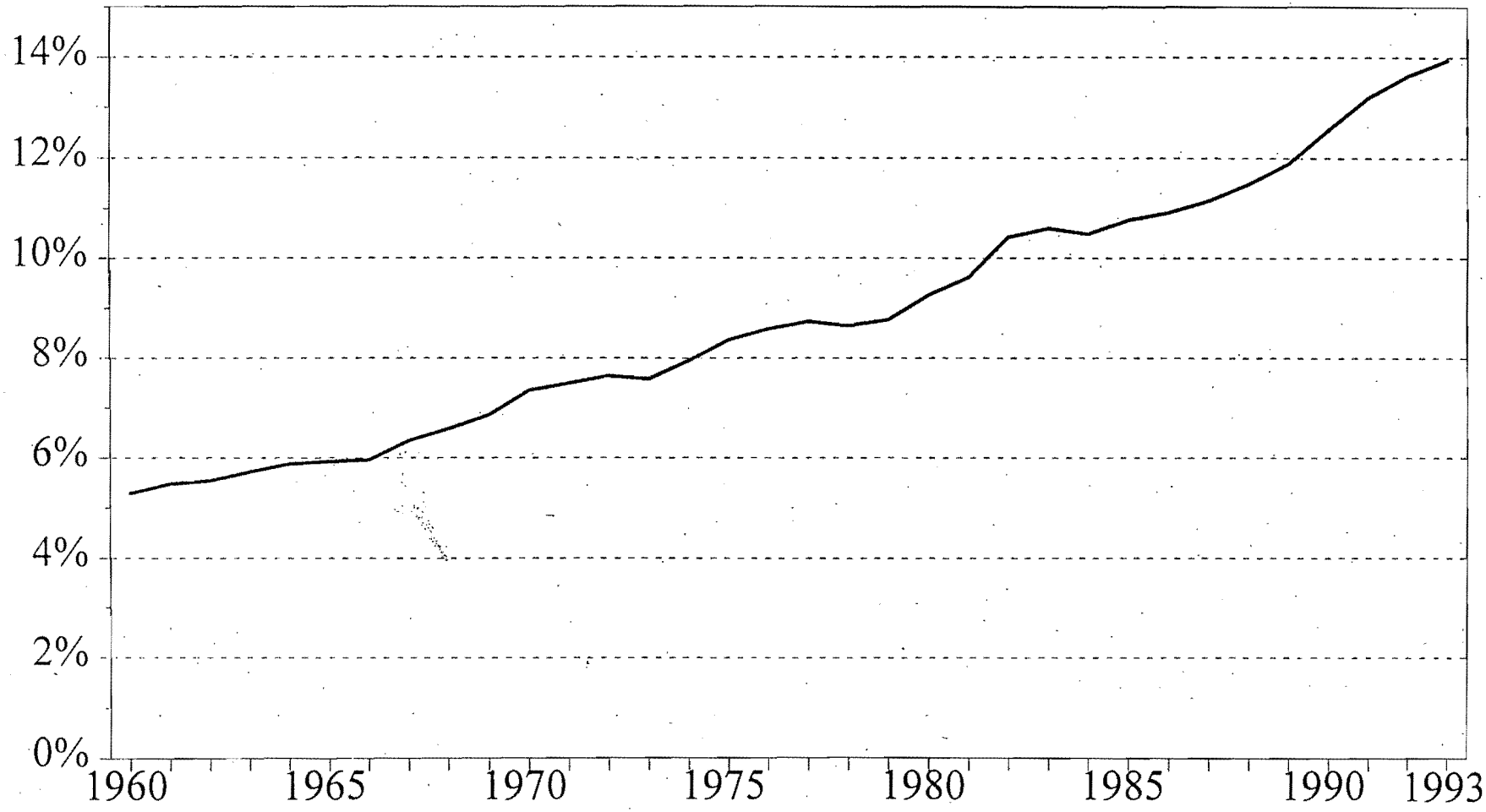
SOURCE: HEALTH CARE FINANCING ADMINISTRATION AND BUREAU OF LABOR STATISTICS. DEFLATOR IS CPI-U

National Health Expenditures

As a Percent of Gross Domestic Product

1960 to 1993

$884 billion - actual 1993
$903 billion estimated in 1992 for 1993

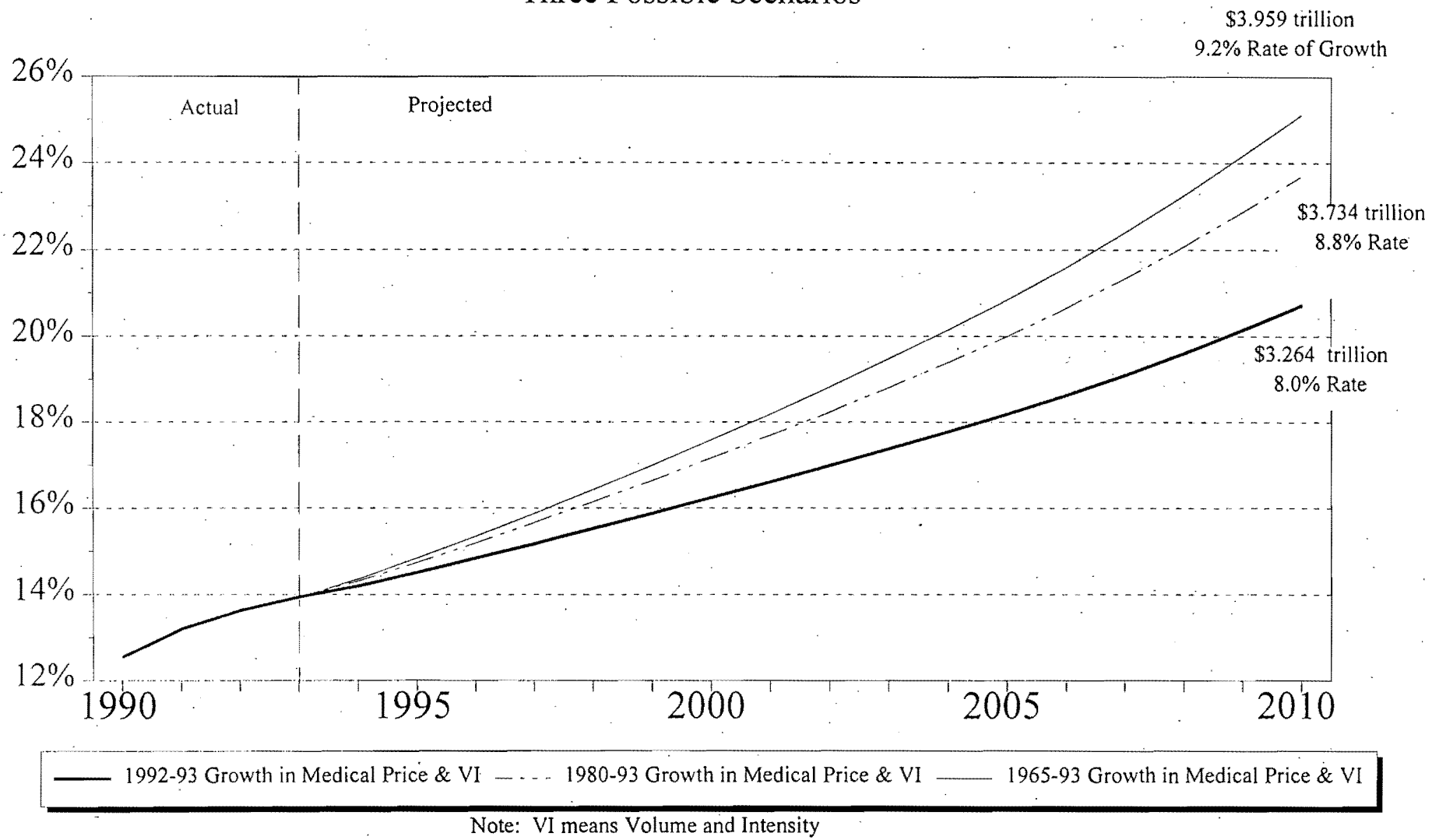


Source: HCFA/Office of the Acutary & OMB; Analysis: OMB/Health Finance Branch

Growth in National Health Expenditures

As a Percent of Gross Domestic Product

Three Possible Scenarios



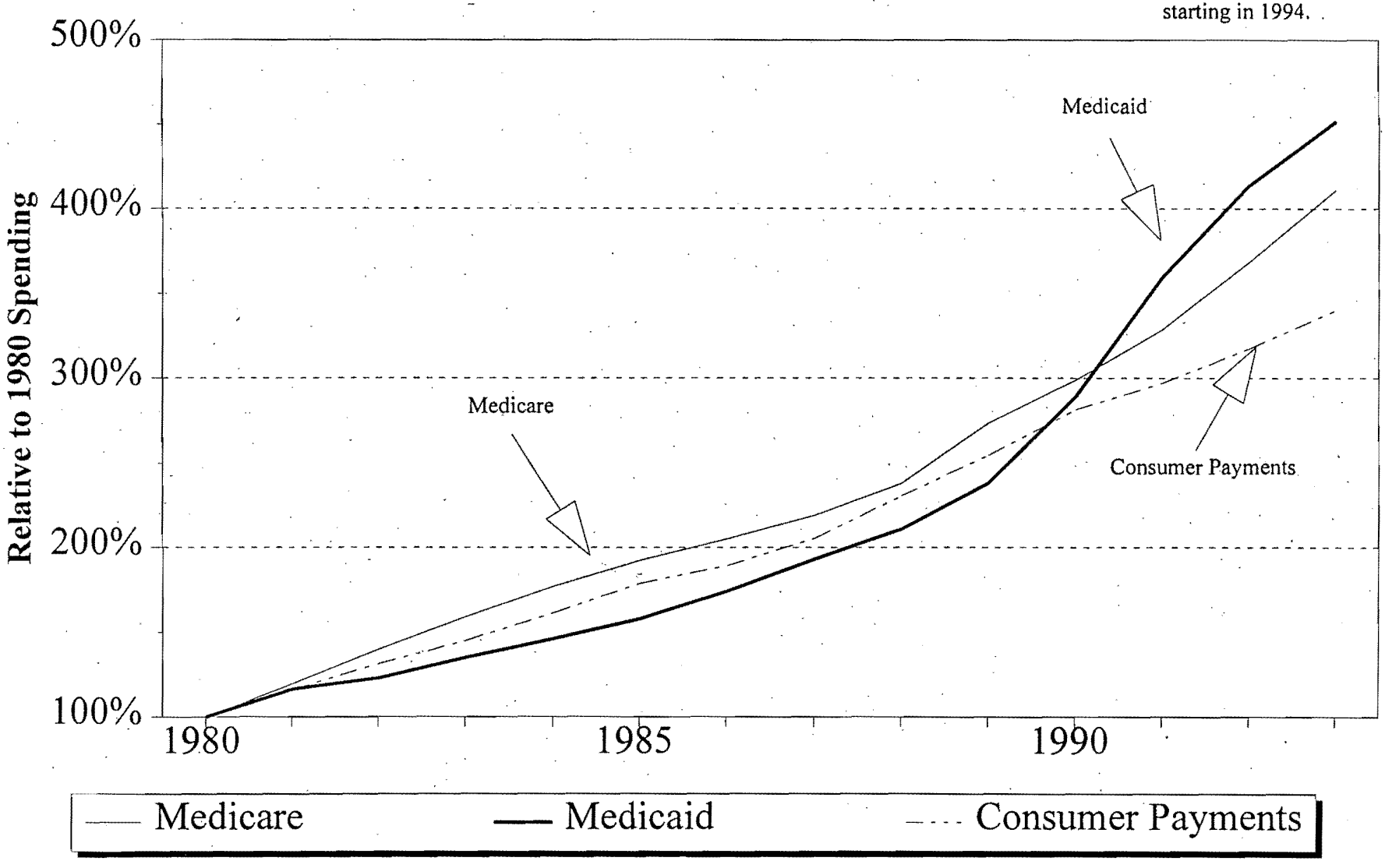
Note: VI means Volume and Intensity

Source: HCFA/Office of the Actuary & OMB; Analysis: OMB/Health Finance Branch

Private & Public Health Spending

Relative to their 1980 Levels

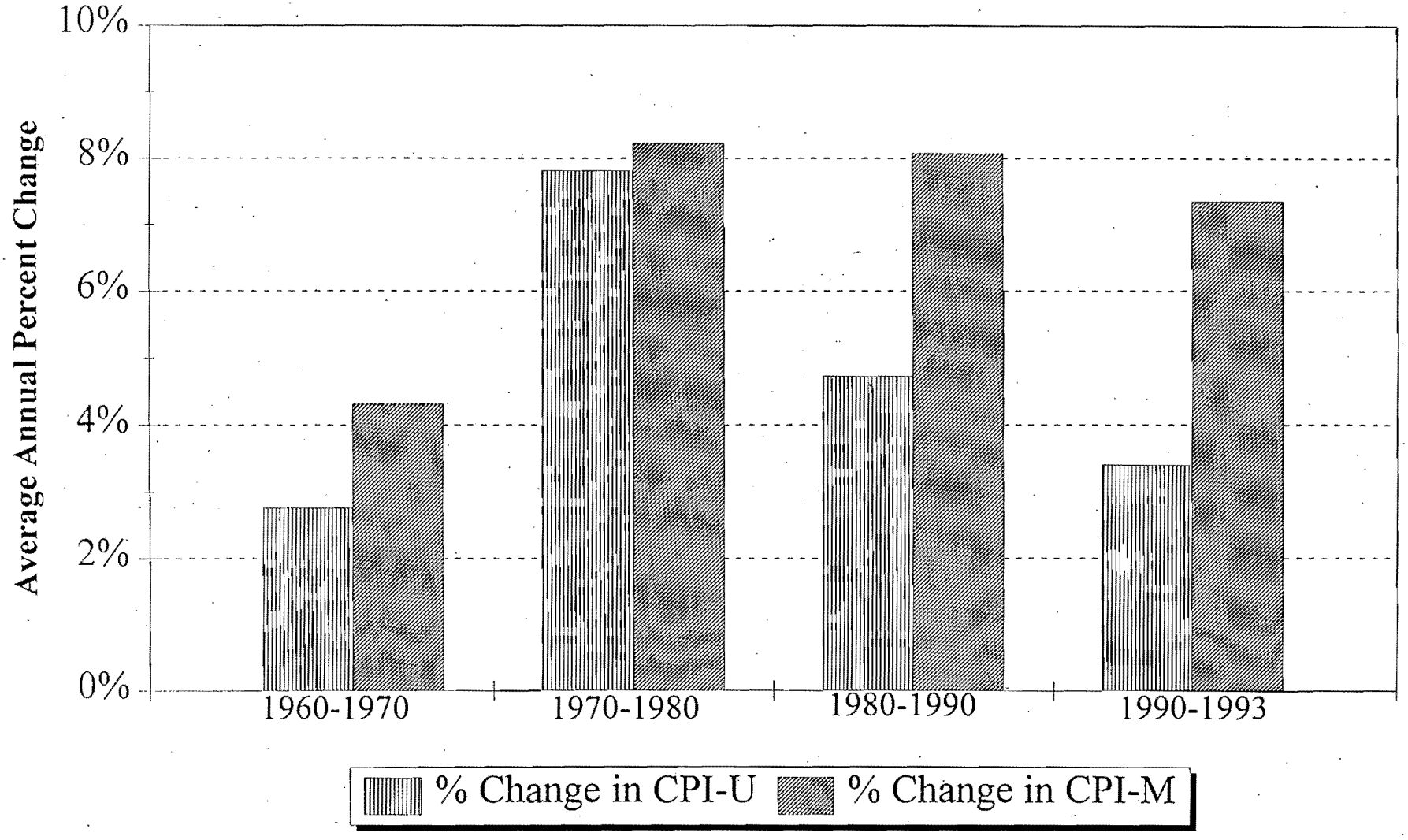
The Office of the Actuary expect the growth rate for Medicaid to slow significantly starting in 1994.



Source: HCFA/Office of the Actuary; Analysis: OMB/Health Finance Branch

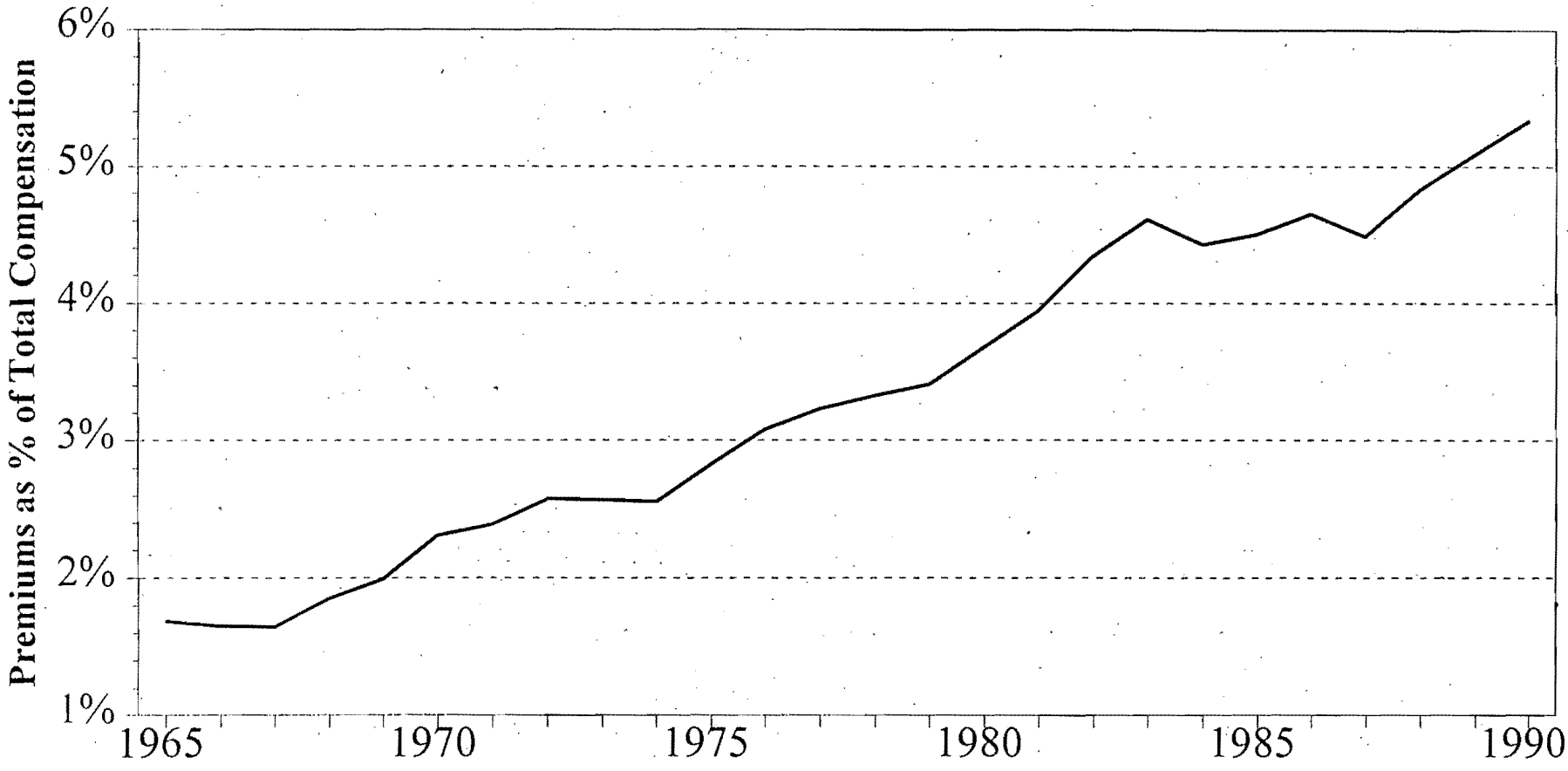
Consumer Price Index

All Goods v. Medical



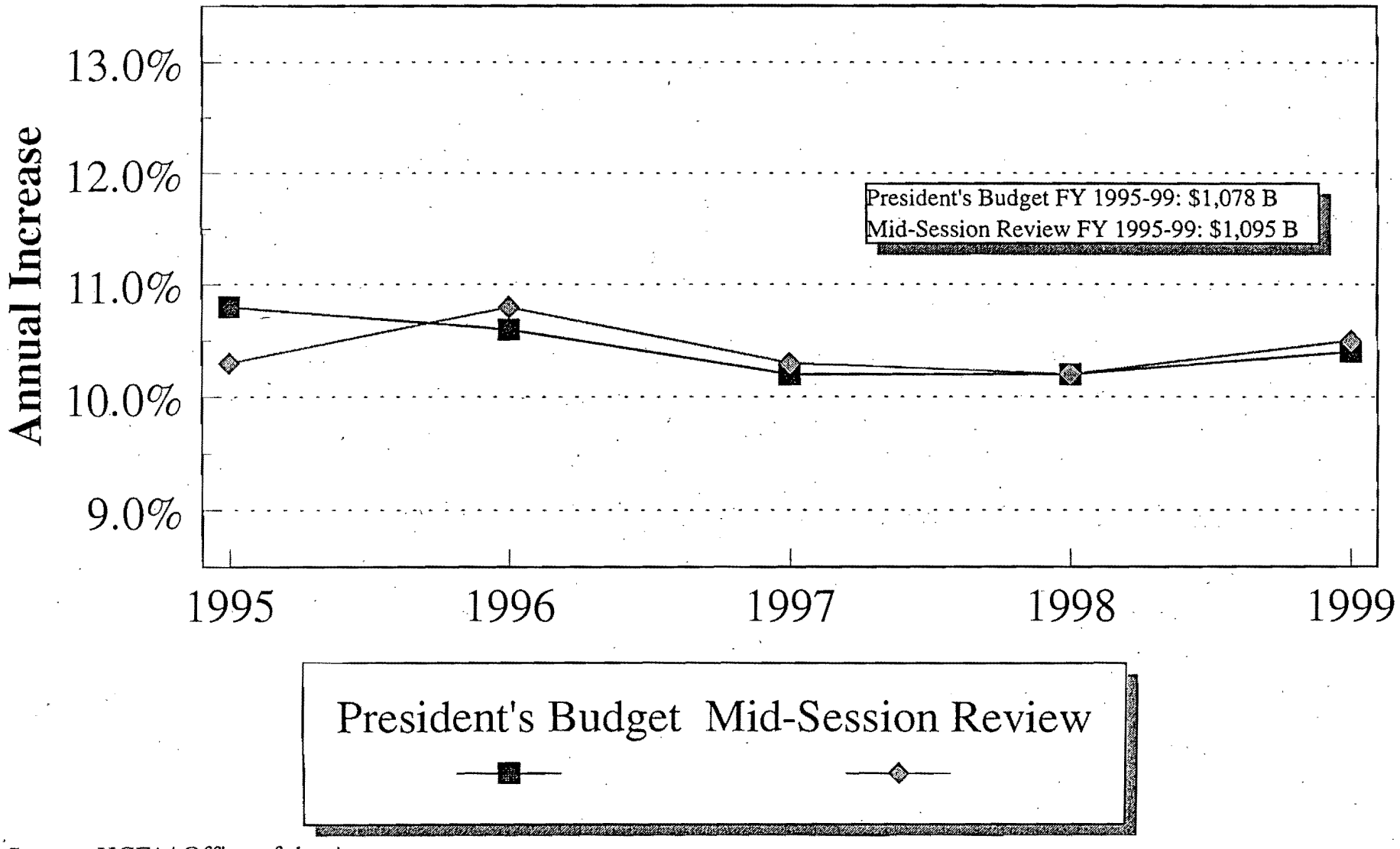
Source: OMB; Analysis: OMB/Health Finance Branch

Ratio of Employer Paid Premiums to Compensation of PrivateWorkers



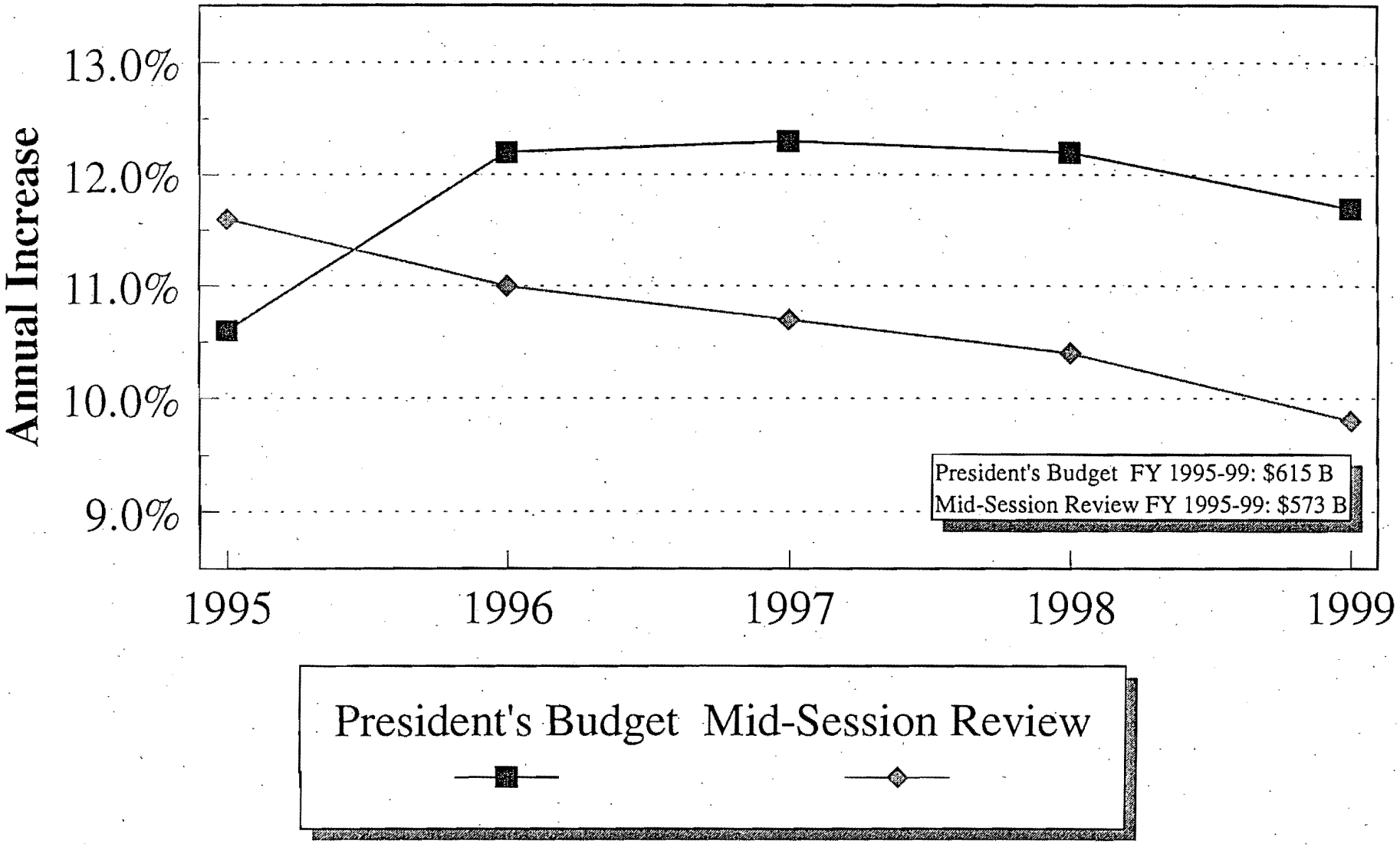
Source: HCFA/Office of the Actuary; Analysis: OMB/Health Finance Branch

MEDICARE BENEFIT OUTLAYS
1995 President's Budget v.
1995 Mid-Session Review



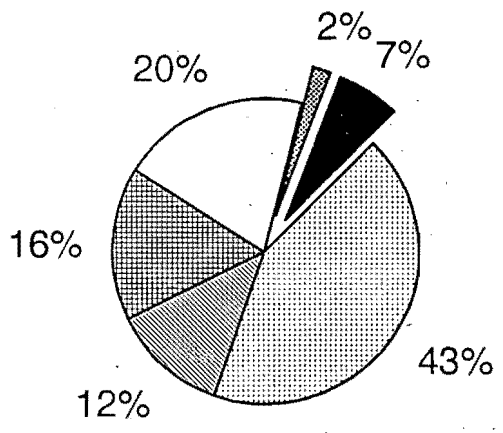
Source: HCFA/ Office of the Actuary
Analysis: OMB/ Health Finance Branch

MEDICAID OUTLAYS
1995 President's Budget v.
1995 Mid-Session Review

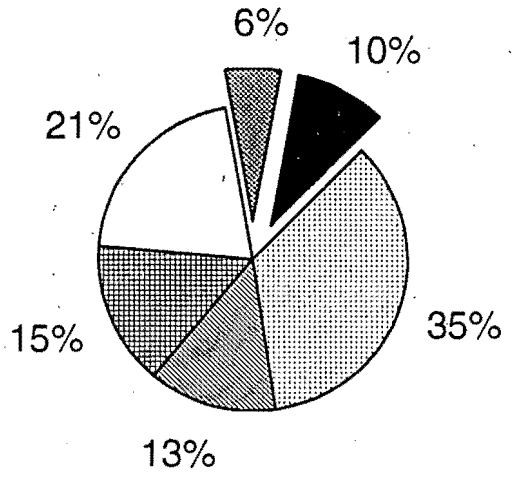


Source: HCFA/ Office of the Actuary
Analysis: OMB/ Health Finance Branch

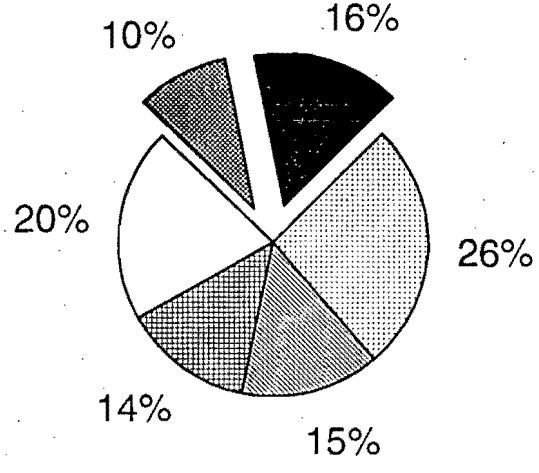
Medicare & Medicaid As Percentage of Total Federal Outlays



1984: Total Outlays=$852 B



1994: Total Outlays=$1,467 B



2004: Total Outlays=$2,488 B

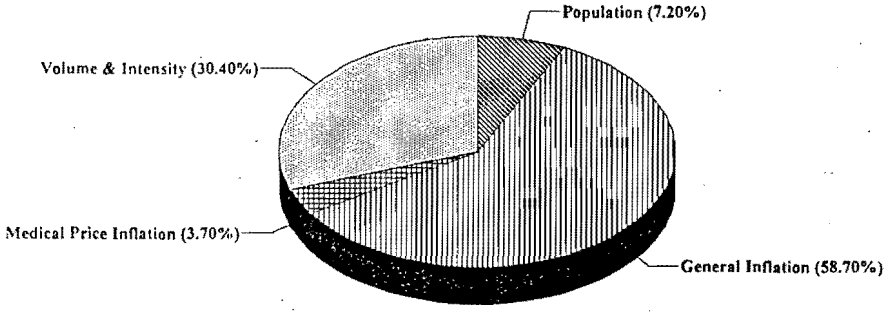
Medicare | Medicaid | Social Security | All Other Mandatory | Net Interest | Discretionary

Data: CBO, "The Economic and Budget Outlook," February 1985 and August 1994. Analysis: OMB/HFB.

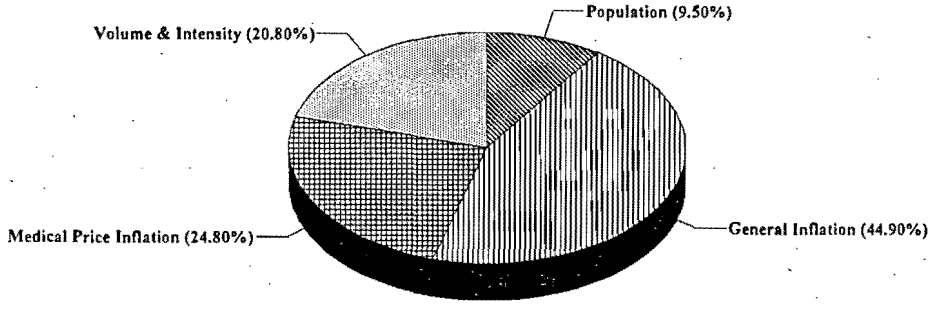
Factors Accounting for Growth

in PHCE, 1970-93

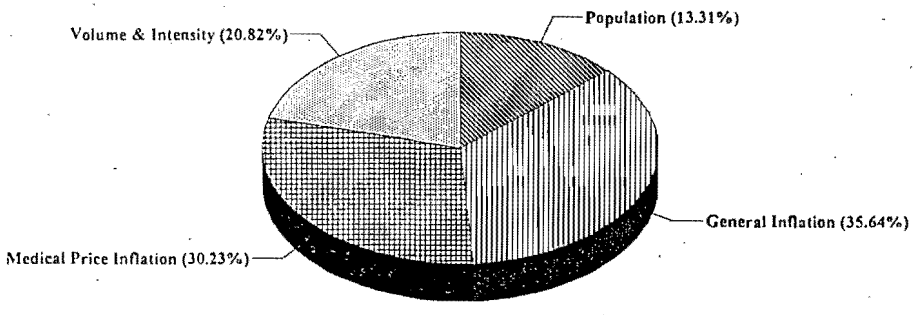
1970-1980
13.0% Growth



1980-1990
10.8% Growth



1990-1993
8.5% Growth



ource: HCFA/Office of the Actuary

TAX CAP AND HIGH COST PLAN ASSESSMENTS

I. Background.

A. Current law for employer-provided health insurance.

B. Other tax preferences for medical expenditures.

1. 25% deduction for self-employed.
2. Itemized deduction for medical expenses above 7.5% of adjusted gross income.

II. Reasons to tighten current law treatment of employer contributions for health insurance.

A. Cost containment.
B. Revenue.

III. Tax cap options.

A. Supplementals.

B. Co-payments and deductibles.

C. Dollar caps.

1. Equity issues.
2. Administrative issues.

D. Additional issues.

1. Need for basic benefit package.
2. Employer vs. employee cap.

IV. High cost plan assessment.

A. 1994 Senate proposals.
B. Similar problems in designing base.
C. Additional concerns.

Tax Cap

Comparison of Excise Tax Vs. Inclusion in Individual Taxable Income

	Income Tax 15%	Income Tax 28%	Excise Tax 48.81%	IncomeTax 20%
Employer Taxes				
Excise Tax	0.00	0.00	48.81	0.00
Employer FICA Tax	7.11	7.11	-3.47	7.11
Sub-total	7.11	7.11	45.34	7.11
Loss in Wages	7.11	7.11	45.34	7.11
Employee Taxes				
FICA Tax	7.11	7.11	- 3.47	7.11
Income Tax	13.93	26.01	- 9.07	18.58
Total Loss in After-Tax Income	28.15	40.23	32.80	32.80

Notes:

Assumes $100 taxable benefits.

Excise tax rate applies to all individuals.

MEDICAL SAVINGS ACCOUNTS

I. Overview of why we are considering Medical Savings Accounts (MSAs).

- A. On the surface they sound good even though they may have undesirable effects that outweigh their desirable effects.
- B. Support in Congress for MSAs.
- C. Need for cost-containment.

II. What is an MSA?

- A. Description of how it works in general.
- B. Variety of proposals.
- C. Different designs lead to different magnitudes of effects.

III. What is the problem that supporters claim MSAs will solve?

- A. Bias against catastrophic plans.
  1. Tax-exclusion of employer-provided health insurance.
  2. Limited deductibility of out-of-pocket health costs.
- B. Do catastrophic plans reduce costs?
  1. Empirical evidence.
  2. Catastrophic plans vs. HMO type managed care.
  3. Total spending vs. out-of-pocket costs.
- C. Other ways to encourage catastrophic plans.
  1. Tax caps.
  2. Expanded deductibility of medical expenses.

IV. Effects of MSAs.

A. Expansion of coverage.

B. Cost containment.

C. Impact on health insurance market and distributional effects.

1. Healthy and upper income benefit.
2. Less healthy and lower income lose.

D. Tradeoff between cost containment and distributional effects.

1. Outcomes depend on participation rates.
2. Examples.

V. Ways to reduce adverse effects.

A. Risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

B. Tax instead of, or in conjunction with, risk adjustors.

1. Political feasibility.
2. Likely effectiveness.

C. Other design features.

1. Contribution limits.
2. Tax treatment of earnings in MSAs.
3. Availability of funds for nonmedical purposes and tax treatment.
4. Definition of medical withdrawals.

MSA Example Under Identical Risk Pools

	Comprehensive Plan	Catastrophic Plan
	$500 Deductible	$3,000 Deductible
Premium	$3,350	$1,950
MSA Contribution		$1,400
Change in Deductible		$2,500
Out-Of-Pocket Exposure	$500	$1,600

Notes:

Premiums are for a family plan.
Assumes increase in deductible results in 10 percent reduction in total health spending.

MEDICARE AND MEDICAID STRUCTURAL COST CONTAINMENT INITIATIVES

1. Reform Payment Procedures

    a. Medicare prospective payments for outpatient departments and skilled nursing facilities.

2. Promote Competition

    a. Competitive bidding for Part B services.

    b. Market rate reimbursement for durable medical equipment.

3. Managed Care: Medicare

    a. Reduce benefits in fee-for-service Medicare as an incentive for beneficiaries to enter HMOs.

    b. Strengthen current risk and cost contract program and create additional incentives for participation.

    c. Create more flexible managed care options.

4. Managed Care: Medicaid

    a. Increase State flexibility.

    b. Remove current prior approval barriers.

    c. Mandate managed care.

issues in general (as in the Crime Bill), and the fight against health care fraud and abuse in particular. The widespread acceptance of the HSA's fraud and abuse provisions may be a good barometer on this question.

The Administration's Position

The Health Security Act's principal features are described below (see also, Outline, attached):

A. All-Payor Fraud and Abuse Control Program

Proposal: HHS and DOJ would jointly be mandated to coordinate the federal and state law enforcement effort against health fraud and abuse. The agencies would be responsible to identify vulnerable areas, establish enforcement priorities, and share information and resources.

Rationale: A mandate to coordinate the many Federal, State and local law enforcement activities aimed at health care fraud and abuse would make these dispersed activities more effective. Task force approaches to priority areas would be promoted. DOJ, which has primary law enforcement responsibility for the federal government, and HHS, which has the most experience in enforcement of health care civil, criminal and administrative remedies, are the ideal agencies to direct such a program.

Criticisms: None voiced last year, and this proposal was included in virtually all health reform bills.

B. All-Payor Fraud and Abuse Control Account

Proposal: An All-Payor Fraud and Abuse Control Account would be created to recycle monies recovered from wrongdoers, to finance additional fraud and abuse containment. Deposits into the account would include monies recovered through criminal, civil or administrative health care fraud proceedings (other than the money lost by a particular program, which would go back to that program). Disbursements would be jointly controlled by HHS and DOJ to fund additional investigations, vulnerability studies, etc.

Rationale: The Control Account would be used, in addition to appropriated amounts, to supplement the costs of efforts to combat health care fraud and abuse. This proposal is the linchpin of the entire package, since with declining appropriations, it is not practical for HHS and DOJ to take on the other new duties of the package without additional resources. In the past, every dollar devoted to investigation and prosecution of health care fraud and abuse has yielded at least eight dollars paid into the federal Treasury. Thus, the Control Account will result in significant additional resources for anti-fraud enforcement.

Criticisms: Some interest groups have contended that the Control Account would amount to a "bounty" system, whereby Federal investigators would be motivated to bring marginal cases in

hopes of obtaining extra money for their agency. This criticism did not have much success on Capitol Hill, as we argued that (1) the Federal justice system has too many checks and balances (hearings, judicial review, etc.) for an agency to get very far bringing meritless cases, and (2) disbursements are at the discretion of the Attorney General and the HHS Secretary, and are not proportional to what an agency contributes.

Perhaps a greater problem for the Control Account is that in the closing days of the last session, CBO scored it at a negative $25 million. This was the amount CBO figured would be lost to the Treasury if recoveries from wrongdoers in current proceedings would be redirected to the Control Account. In doing so the CBO chose to ignore the theory of the Control Account, which is that "priming the pump" of the enforcement engine with this money would generate increasing recoveries from wrongdoers in the future. This theory is based on the fact that HHS/Inspector General investigators generate average recoveries of eight times the expense of maintaining themselves. Methods of dealing with this CBO issue are being assessed.

C. Extension of certain criminal and civil authorities to all payors

Proposal: A new health care fraud criminal statute would be created, and the civil False Claims Act would be extended to apply to claims submitted to all health plans. In addition, some existing criminal statutes (false statements, theft and embezzlement), which apply only to Federal health programs, would be extended to all payors.

Rationale: Few criminal statutes directly address health care fraud. A new criminal health care fraud statute, modelled after existing mail and bank fraud statutes, would specifically penalize schemes to defraud either public or private health care programs.

The extension of the civil False Claims Act to claims submitted to private health plans would give the government a powerful new civil enforcement tool.

Criticisms: There was little criticism of the new basic health care fraud statute. Most of the other new criminal statutes called for in this section related to the creation of alliances, and were criticized for that reason. In a scaled-back health reform plan, this section should be shortened considerably.

The final element of this section, the extension of the civil False Claims Act to all payors, was opposed by industry groups due to the existence of the qui tam "private attorney general" aspect of this statute.

D. Revision of controls on health care kickbacks and physician self-referral, and extension of same to all payors

Proposal: Kickbacks -- the payment or receipt of anything of value as an inducement for the referral of any type of health care business -- are a very serious and endemic problem (some

exceptions are appropriate). The Federal authorities to control this practice, which currently apply to Medicare and Medicaid, should be revised to close certain loopholes, and be extended to all payors. In addition, a new administrative remedy of a civil monetary penalty should be established for kickback violations.

Physician self-referral is a large part of the overall kickback problem, and the "Stark Amendment," which currently limits self-referral with respect to Medicare and Medicaid claims, would be revised to close certain loopholes and be extended to all payors. In summary, payment for any type of item or service to an entity should be prohibited (subject to certain exceptions) where the ordering physician has a "financial relationship" with the entity and where the physician does not directly render that item or service.

Rationale: Ten published studies on kickbacks and self-referral show a predominant overutilization risk anytime a doctor refers a patient for an item or service to a facility where the physician has a financial relationship. The financial interest can affect the number of items or services ordered, the quality of care and competition among providers. The overutilization risk and other inappropriate behavior attributable to kickbacks and self-referral applies to private payors as well as to Medicare and Medicaid.

Criticisms: The kickback statute is controversial because it is broad. Industry groups contend it is vague. But the damage to the health care system (overutilization and patient steering) has been empirically demonstrated. The self-referral statute is criticized on grounds that it makes some of the new, integrated delivery system arrangements more difficult to construct. Our response is that the goal and effect of these statutes is to prohibit only unhealthy structures, i.e., those which offer improper inducements to physicians.

E. Revision of certain administrative Civil Monetary Penalties (CMPs) and administrative exclusion authorities and extending some to all payors

Proposal: The current CMP and exclusion authorities, which apply only to Medicare and Medicaid, would be revised, and the more serious offenses extended to all payors. The federal government currently has the authority to assess civil monetary penalties in an administrative proceeding against health care providers who submit false or improper claims to the Medicare or Medicaid programs. There is no similar authority to assess CMPs against health care providers who submit false or improper claims to private health care plans (e.g., Blue Cross/Blue Shield). HHS should be given this authority.

Section 1128 of the Social Security Act contains two mandatory and a number of permissive authorities under which the Secretary of HHS may (or, in the case of the mandatory exclusions, must) exclude individuals or entities from participation in Medicare and State health care programs. The exclusions do not currently apply to a provider's participation in private health care programs. The HSA proposed that HHS be given the authority to exclude providers from participation in all health plans.

Rationale: The current basic authority to impose administrative CMPs for Medicare and Medicaid was enacted in 1981 due to the inadequacy of federal criminal and civil court enforcement activities, and has been an invaluable weapon to fight fraud and abuse in those programs. While the civil False Claims Act, 31 U.S.C. § 3729, et seq., as employed by the Civil Division, DOJ, will continue to be the primary civil enforcement mechanism for attacking health care fraud involving any direct or indirect federal funding, an intermediate, administrative remedy is needed to supplement the federal court remedies available to the federal government.

Criticisms: Some of the HSA's proposed new CMPs were criticized as being too regulatory in nature, such as a CMP for failing to cooperate with a peer review body, or a plan which discriminates against (poor) communities.

All payor exclusions were criticized on grounds they would deprive a provider of his or her livelihood in the health care business. In a scaled back health reform plan, a less aggressive approach with respect to these administrative sanctions would be advisable. The all payor exclusions should be dropped, since support for them is weak.

Outlook for the Next Session

Senate: Senator Cohen, soon to be Chair of the Aging Committee, developed by far the most intense and personal interest of any Senator in the fraud issues. He became the lead proponent of most of the fraud concepts put forth in the HSA. His staff became very knowledgeable and able to fend off efforts to weaken those positions by the provider interest groups. Senators Dole and Chafee (among others) relied on Cohen on these issues, and thus, the HSA concepts fared extremely well in the Dole bill and the so-called "mainstream coalition" bill.

Senator Cohen's staff on the Aging Committee says that he intends to champion these issues in the next Congress. He would appear to be in a strong position to do so. The primary risk would be the pro-provider Republicans, but Cohen has the upper hand (as of now) with Dole.

As the attached chart shows, both the Dole and "mainstream coalition" bills accepted the following major elements of the HSA fraud and abuse package:

- All-Payor Fraud and Abuse Control Program;
- All-Payor Fraud and Abuse Control Account;
- revision of some current Medicare/Medicaid CMPs and extension of some to all payors (fewer than in the original HSA);
- revision of some current Medicare/Medicaid exclusions (but no expansion of same to all payors);

- creation of new CMP for kickback violations, revision of some of the statutory exceptions, and perhaps (HSA and Dole agree) extension to all payors;

- creation of new health fraud criminal statute, injunctive authority against health fraud schemes, and revision of certain forfeiture provisions, and perhaps (HSA and Dole agree) extension of civil False Claims Act to all payors;

- modest amendments to the physician self-referral statute (Although these amendments were not proposed in Dole and the mainstream coalition bills, Cohen and Dole reportedly intended to defer to some of the work done on the House side by Rep. Stark, the acknowledged expert on this topic. Cohen will probably tackle this issue in the new Congress); and

- strengthening of the Medicare Peer Review Organization sanctions.

House We have little basis to predict how House Republicans will view a fraud and abuse package. While they are vocally anti-crime, many of them are apparently aligned with the provider interest groups. We know of no Republican with a particular interest in a strong fraud and abuse package, although Senator Cohen is said to be looking hard for support in the House.

The Rowland/Bilirakis/Cooper bill contains only a few of the provisions that were in the Administration's bill, and there are problems with some of the provisions. The bill includes:

- All-Payor Fraud and Abuse Trust Fund: The vast majority of money recovered in health care fraud cases results from civil fines and forfeitures obtained in federal court. However this bill limits deposits only to penalty amounts collected through certain administrative authorities. Limiting the money in the Trust Fund to only administrative recoveries would result in a very small trust fund (perhaps $3 million) and would not provide the resources necessary to operate the All-Payor program. In addition, the bill requires 60% of the disbursements from the Trust Fund to be devoted to "education" of providers, as opposed to using the money to pay for increased enforcement.

In addition, the Rowland/Bilirakis/Cooper bill does little in the way of expanding Federal authority. For example, the bill:

- does not extend any CMP authorities to all payors, nor does it create any new CMPs;

- does not strengthen the enforcement of the Peer Review Organization (quality of care) Medicare sanction provisions; and

- does not extend a number of criminal statutes or the civil False Claims Act to all payors (although the bill would create a new health care fraud statute similar to the one proposed by the Administration).

The bill's kickback and self-referral provisions could also create serious loopholes:

- the bill does not extend either the kickback statute or the self-referral statute to all payors; and

- the bill would provide new exceptions for undefined "managed care" organizations. This would create a huge exception to the statutes since almost any group of doctors or organization of health care providers could theoretically qualify for the exceptions and be free of all kickback and self-referral prohibitions. It is important to note that some new exceptions for managed care organizations should be made; however, the approach outlined in this bill is too braod and may do more harm than good.

Proposal

It is suggested that the HSA fraud and abuse provisions be re-evaluated from the perspective of minimizing the potential charge of over-regulation, and removing other portions for which support was thin on Capitol Hill. In addition, there are a couple of topics which surfaced last year in the Congressional deliberations which might be added, such as a data bank on adverse actions (convictions, loss of license, etc.) taken against health care providers, and possible expansion of the jurisdiction of the State Medicaid Fraud Control Units.

Attachments:

Health Security Act -- Fraud and Abuse Provisions -- Outline
Chart: Comparison of HSA to Leading Republican/Bipartisan Bills -- Senate
Chart: Comparison of HSA to Leading Republican/Bipartisan Bills -- House

File 1994 Insurance Reform

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Carol Rasco and Bob Rubin

From: Chris Jennings

Date: November 8, 1994

Re: Memo from Erskine Bowles regarding John Galles and Purchasing Cooperatives

cc: Jennifer Klein
Sylvia Mathews
Jeremy Ben-Ami

Following up on the note from Sylvia, I have drafted the enclosed response to John Galles. As you will note, I have drafted it to be from both of you and have copied the reply to Erskine.

In summary, the attached simply acknowledges his concerns and outlines how the Administration will be responsive. If you have any questions or want to edit this document in any way, please notify me.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: John Galles

From: Carol Rasco and Bob Rubin

Date: November 8, 1994

Re: Memo to Erskine Bowles regarding Purchasing Cooperatives

cc: Erskine Bowles

Erskine Bowles has advised us of your interest in developing innovative ways to establish purchasing groups for small businesses. As you know, we are extremely interested in arrangements that have potential to expand choice and access of health insurance to businesses and their employees.

We were pleased to learn of your conversation with Chris Jennings from yesterday. He has informed us that representatives from the Treasury Department and the Department of Health and Human Services will be meeting with you and your technical assistants next Wednesday, November 16th. We think that you will find Mark Iwry (Treasury) and Gary Claxton (HHS) to be informed and interested in your proposal.

Because of our interest, we will ask Chris to keep us advised of the status of your proposal. Again, thank you for making us aware of your work in this area. Erskine sends his regards.

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To ERSKINE BOWLES	From JOHN GALLES
Co. WHITE HOUSE	Co. NSBU
Dept. CHIEF OF STAFF	Phone # 293-8830
Fax # 456-2883	Fax #

NATIONAL SMALL BUSINESS UNITED

1155 15TH STREET, N.W.
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WASHINGTON, D.C. 20005
202-293-8830
FAX: 202-872-8543

MEMORANDUM

TO: Erskine Bowles **DATE:** October 28, 1994

FROM: John Galles

RE: Health Care Purchasing Cooperatives

Bob Rubin - Carol Rasco - HG has a good point - this group could be very supportive. Plus our new ... How would you like me to follow? Erskine

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Erskine, I really need your help.

As you may recall, we have been struggling to establish health care purchasing cooperatives. So far, we have made attempts in California and Texas. We hit a roadblock in California when state bureaucrats refused to recognize our cooperative because of the California HIPC. They wanted a single, exclusive entity. Since it started, they have done well. They have sold policies to about 80,000 lives in a year and a half of operation. However, there are 6 million people in the state. We had thirteen carriers prepared to participate in our purchasing cooperative until the state sent the negative signals. And so, we are still looking for an opening to do business in California.

When we learned about legislation in Texas which authorized privately organized cooperatives, we took our prototype there. We believed that we had a "level playing field" and that we could fairly compete in the health care marketplace. We raised about $1,000,000 to get this up and running. We received 24 proposals in response to our RFP and chose 11 carriers for our Texas HIPC. However, the Texas Insurance Commissioner has determined that the state's purchasing alliance can offer HMO coverage that is age and gender rated and that our cooperative cannot. And so, the playing field is not level and our carriers are backing away from our project.

As I mentioned to you in the past, we want to use a VEBA, a Voluntary Employee Benefit Association, as established under IRS Code 501(c)6 so that we can move forward with these entities and not be trapped by state regulation which puts us in a disadvantageous position. We sought technical advice from IRS and were told that a VEBA required "an employment-related bond" to establish a VEBA. There is no statutory foundation for that requirement. That requirement was written when VEBA's were first created because that is the way insurance carriers rated employers and employees, by industry sector. Now that many states have community-rating, it makes more sense to build community purchasing groups. The insurance environment has changed. The regulation should now allow for diverse businesses to collectively purchase coverage. We are not talking about self-insured coverage; we are talking about fully insured products–HMOs, PPOs, and indemnity products–individually chosen by employees of employers participating in the purchasing cooperative.

Erskine, now that health care reform is not a hot topic, a simple expansion of an outdated regulation would help us get several of these cooperatives up and running. We know how hard it is to get these started. We have experience dealing with carriers and state governments.

We will be attempting to start one in Colorado next under their law. I was even invited to North Carolina and encouraged to start one there. We could move much more skillfully with a classification as a VEBA.

This change requires a "will" to change. Your help to establish that "will" within this administration could make this happen.

Please give me a chance to make these purchasing co-ops happen.

I hope we can meet soon.

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

PHONE: (202)690-8794 FAX: (202)690-6518

Date: _____

From: CJ To: JW

Division: _____ Division: _____

City & State: _____ City & State: _____

Office Number: _____ Office Number: _____

Fax Number: _____ Fax Number: _____

Number of Pages + cover 8

REMARKS: _____

11/30/94

HEALTH CARE FRAUD AND ABUSE:

A FRAMEWORK FOR REFORM IN THE NEXT CONGRESS

Background

As the Administration makes the decisions on a health care reform proposal for the next Congress, the Federal law enforcement community continues to recommend inclusion of a comprehensive fraud and abuse package. The fraud and abuse portion of the Health Security Act (HSA) gained wide support in both the House and the Senate, among Senate Republicans in particular. Interestingly, the Senate bills which were closest to the Administration's were the Dole bill and the "mainstream coalition" bill.

Need to address the problem. Law enforcement experts agree that the scope of fraud and abuse in the health care system is very large and growing larger. In 1992, the GAO estimated the annual costs of fraud and abuse at 10% of health care expenditures, or almost $100 billion last year. The basic reasons are:

- the sheer volume of money passing through the system: almost a trillion dollars;
- the numbers of people involved: virtually every U.S. resident is a patient, serviced by about two million health care providers;
- the complexity of the payment process: over 1000 major payors process over 4 billion claims a year; payors use differing claim forms, coding, and payment processes;
- the separation of payor (insurance plan) from patient gives easy opportunities to mislead payor;
- patients not knowledgeable about what medical services they need, or the differences between competing providers; thus, the potential for overutilization and patient steering in exchange for financial rewards is great.

Polls and focus groups reveal that the scope of the health care fraud problem is a significant concern of the general public. For example, a recent Republican poll (Public Opinion Strategies) reported that 21 percent of the public believes that the most important health care problem in the country is, "money wasted because of fraud and greed."

Criticism: One could argue that a fraud and abuse reform package contributes to the impression of a "big government" or "overly regulatory" approach to health reform. However, these arguments appear to have much less weight when applied to law enforcement

issues in general (as in the Crime Bill), and the fight against health care fraud and abuse in particular. The widespread acceptance of the HSA's fraud and abuse provisions may be a good barometer on this question.

The Administration's Position

The Health Security Act's principal features are described below (see also, Outline, attached):

A. All-Payor Fraud and Abuse Control Program

Proposal: HHS and DOJ would jointly be mandated to coordinate the federal and state law enforcement effort against health fraud and abuse. The agencies would be responsible to identify vulnerable areas, establish enforcement priorities, and share information and resources.

Rationale: A mandate to coordinate the many Federal, State and local law enforcement activities aimed at health care fraud and abuse would make these dispersed activities more effective. Task force approaches to priority areas would be promoted. DOJ, which has primary law enforcement responsibility for the federal government, and HHS, which has the most experience in enforcement of health care civil, criminal and administrative remedies, are the ideal agencies to direct such a program.

Criticisms: None voiced last year, and this proposal was included in virtually all health reform bills.

B. All-Payor Fraud and Abuse Control Account

Proposal: An All-Payor Fraud and Abuse Control Account would be created to recycle monies recovered from wrongdoers, to finance additional fraud and abuse containment. Deposits into the account would include monies recovered through criminal, civil or administrative health care fraud proceedings (other than the money lost by a particular program, which would go back to that program). Disbursements would be jointly controlled by HHS and DOJ to fund additional investigations, vulnerability studies, etc.

Rationale: The Control Account would be used, in addition to appropriated amounts, to supplement the costs of efforts to combat health care fraud and abuse. This proposal is the linchpin of the entire package, since with declining appropriations, it is not practical for HHS and DOJ to take on the other new duties of the package without additional resources. In the past, every dollar devoted to investigation and prosecution of health care fraud and abuse has yielded at least eight dollars paid into the federal Treasury. Thus, the Control Account will result in significant additional resources for anti-fraud enforcement.

Criticisms: Some interest groups have contended that the Control Account would amount to a "bounty" system, whereby Federal investigators would be motivated to bring marginal cases in

hopes of obtaining extra money for their agency. This criticism did not have much success on Capitol Hill, as we argued that (1) the Federal justice system has too many checks and balances (hearings, judicial review, etc.) for an agency to get very far bringing meritless cases, and (2) disbursements are at the discretion of the Attorney General and the HHS Secretary, and are not proportional to what an agency contributes.

Perhaps a greater problem for the Control Account is that in the closing days of the last session, CBO scored it at a negative $25 million. This was the amount CBO figured would be lost to the Treasury if recoveries from wrongdoers in current proceedings would be redirected to the Control Account. In doing so the CBO chose to ignore the theory of the Control Account, which is that "priming the pump" of the enforcement engine with this money would generate increasing recoveries from wrongdoers in the future. This theory is based on the fact that HHS/Inspector General investigators generate average recoveries of eight times the expense of maintaining themselves. Methods of dealing with this CBO issue are being assessed.

C. Extension of certain criminal and civil authorities to all payors

Proposal: A new health care fraud criminal statute would be created, and the civil False Claims Act would be extended to apply to claims submitted to all health plans. In addition, some existing criminal statutes (false statements, theft and embezzlement), which apply only to Federal health programs, would be extended to all payors.

Rationale: Few criminal statutes directly address health care fraud. A new criminal health care fraud statute, modelled after existing mail and bank fraud statutes, would specifically penalize schemes to defraud either public or private health care programs.

The extension of the civil False Claims Act to claims submitted to private health plans would give the government a powerful new civil enforcement tool.

Criticisms: There was little criticism of the new basic health care fraud statute. Most of the other new criminal statutes called for in this section related to the creation of alliances, and were criticized for that reason. In a scaled-back health reform plan, this section should be shortened considerably.

The final element of this section, the extension of the civil False Claims Act to all payors, was opposed by industry groups due to the existence of the qui tam "private attorney general" aspect of this statute.

D. Revision of controls on health care kickbacks and physician self-referral, and extension of same to all payors

Proposal: Kickbacks -- the payment or receipt of anything of value as an inducement for the referral of any type of health care business -- are a very serious and endemic problem (some

exceptions are appropriate). The Federal authorities to control this practice, which currently apply to Medicare and Medicaid, should be revised to close certain loopholes, and be extended to all payors. In addition, a new administrative remedy of a civil monetary penalty should be established for kickback violations.

Physician self-referral is a large part of the overall kickback problem, and the "Stark Amendment," which currently limits self-referral with respect to Medicare and Medicaid claims, would be revised to close certain loopholes and be extended to all payors. In summary, payment for any type of item or service to an entity should be prohibited (subject to certain exceptions) where the ordering physician has a "financial relationship" with the entity and where the physician does not directly render that item or service.

Rationale: Ten published studies on kickbacks and self-referral show a predominant overutilization risk anytime a doctor refers a patient for an item or service to a facility where the physician has a financial relationship. The financial interest can affect the number of items or services ordered, the quality of care and competition among providers. The overutilization risk and other inappropriate behavior attributable to kickbacks and self-referral applies to private payors as well as to Medicare and Medicaid.

Criticisms: The kickback statute is controversial because it is broad. Industry groups contend it is vague. But the damage to the health care system (overutilization and patient steering) has been empirically demonstrated. The self-referral statute is criticized on grounds that it makes some of the new, integrated delivery system arrangements more difficult to construct. Our response is that the goal and effect of these statutes is to prohibit only unhealthy structures, i.e., those which offer improper inducements to physicians.

E. Revision of certain administrative Civil Monetary Penalties (CMPs) and administrative exclusion authorities and extending some to all payors

Proposal: The current CMP and exclusion authorities, which apply only to Medicare and Medicaid, would be revised, and the more serious offenses extended to all payors. The federal government currently has the authority to assess civil monetary penalties in an administrative proceeding against health care providers who submit false or improper claims to the Medicare or Medicaid programs. There is no similar authority to assess CMPs against health care providers who submit false or improper claims to private health care plans (e.g., Blue Cross/Blue Shield). HHS should be given this authority.

Section 1128 of the Social Security Act contains two mandatory and a number of permissive authorities under which the Secretary of HHS may (or, in the case of the mandatory exclusions, must) exclude individuals or entities from participation in Medicare and State health care programs. The exclusions do not currently apply to a provider's participation in private health care programs. The HSA proposed that HHS be given the authority to exclude providers from participation in all health plans.

Rationale: The current basic authority to impose administrative CMPs for Medicare and Medicaid was enacted in 1981 due to the inadequacy of federal criminal and civil court enforcement activities, and has been an invaluable weapon to fight fraud and abuse in those programs. While the civil False Claims Act, 31 U.S.C. § 3729, et seq., as employed by the Civil Division, DOJ, will continue to be the primary civil enforcement mechanism for attacking health care fraud involving any direct or indirect federal funding, an intermediate, administrative remedy is needed to supplement the federal court remedies available to the federal government.

Criticisms: Some of the HSA's proposed new CMPs were criticized as being too regulatory in nature, such as a CMP for failing to cooperate with a peer review body, or a plan which discriminates against (poor) communities.

All payor exclusions were criticized on grounds they would deprive a provider of his or her livelihood in the health care business. In a scaled back health reform plan, a less aggressive approach with respect to these administrative sanctions would be advisable. The all payor exclusions should be dropped, since support for them is weak.

Outlook for the Next Session

Senate: Senator Cohen, soon to be Chair of the Aging Committee, developed by far the most intense and personal interest of any Senator in the fraud issues. He became the lead proponent of most of the fraud concepts put forth in the HSA. His staff became very knowledgeable and able to fend off efforts to weaken those positions by the provider interest groups. Senators Dole and Chafee (among others) relied on Cohen on these issues, and thus, the HSA concepts fared extremely well in the Dole bill and the so-called "mainstream coalition" bill.

Senator Cohen's staff on the Aging Committee says that he intends to champion these issues in the next Congress. He would appear to be in a strong position to do so. The primary risk would be the pro-provider Republicans, but Cohen has the upper hand (as of now) with Dole.

As the attached chart shows, both the Dole and "mainstream coalition" bills accepted the following major elements of the HSA fraud and abuse package:

- All-Payor Fraud and Abuse Control Program;
- All-Payor Fraud and Abuse Control Account;
- revision of some current Medicare/Medicaid CMPs and extension of some to all payors (fewer than in the original HSA);
- revision of some current Medicare/Medicaid exclusions (but no expansion of same to all payors);

- creation of new CMP for kickback violations, revision of some of the statutory exceptions, and perhaps (HSA and Dole agree) extension to all payors;

- creation of new health fraud criminal statute, injunctive authority against health fraud schemes, and revision of certain forfeiture provisions, and perhaps (HSA and Dole agree) extension of civil False Claims Act to all payors;

- modest amendments to the physician self-referral statute (Although these amendments were not proposed in Dole and the mainstream coalition bills, Cohen and Dole reportedly intended to defer to some of the work done on the House side by Rep. Stark, the acknowledged expert on this topic. Cohen will probably tackle this issue in the new Congress); and

- strengthening of the Medicare Peer Review Organization sanctions.

House We have little basis to predict how House Republicans will view a fraud and abuse package. While they are vocally anti-crime, many of them are apparently aligned with the provider interest groups. We know of no Republican with a particular interest in a strong fraud and abuse package, although Senator Cohen is said to be looking hard for support in the House.

The Rowland/Bilirakis/Cooper bill contains only a few of the provisions that were in the Administration's bill, and there are problems with some of the provisions. The bill includes:

- All-Payor Fraud and Abuse Trust Fund: The vast majority of money recovered in health care fraud cases results from civil fines and forfeitures obtained in federal court. However this bill limits deposits only to penalty amounts collected through certain administrative authorities. Limiting the money in the Trust Fund to only administrative recoveries would result in a very small trust fund (perhaps $3 million) and would not provide the resources necessary to operate the All-Payor program. In addition, the bill requires 60% of the disbursements from the Trust Fund to be devoted to "education" of providers, as opposed to using the money to pay for increased enforcement.

In addition, the Rowland/Bilirakis/Cooper bill does little in the way of expanding Federal authority. For example, the bill:

- does not extend any CMP authorities to all payors, nor does it create any new CMPs;

- does not strengthen the enforcement of the Peer Review Organization (quality of care) Medicare sanction provisions; and

- does not extend a number of criminal statutes or the civil False Claims Act to all payors (although the bill would create a new health care fraud statute similar to the one proposed by the Administration).

The bill's kickback and self-referral provisions could also create serious loopholes:

- the bill does not extend either the kickback statute or the self-referral statute to all payors; and

- the bill would provide new exceptions for undefined "managed care" organizations. This would create a huge exception to the statutes since almost any group of doctors or organization of health care providers could theoretically qualify for the exceptions and be free of all kickback and self-referral prohibitions. It is important to note that some new exceptions for managed care organizations should be made; however, the approach outlined in this bill is too braod and may do more harm than good.

Proposal

It is suggested that the HSA fraud and abuse provisions be re-evaluated from the perspective of minimizing the potential charge of over-regulation, and removing other portions for which support was thin on Capitol Hill. In addition, there are a couple of topics which surfaced last year in the Congressional deliberations which might be added, such as a data bank on adverse actions (convictions, loss of license, etc.) taken against health care providers, and possible expansion of the jurisdiction of the State Medicaid Fraud Control Units.

Attachments:

Health Security Act -- Fraud and Abuse Provisions -- Outline
Chart: Comparison of HSA to Leading Republican/Bipartisan Bills -- Senate
Chart: Comparison of HSA to Leading Republican/Bipartisan Bills -- House

11/30/94

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