WEDNESDAY, JUNE 1

8:15 AM – 8:45 AM	COMMUNICATIONS MEETING ROOM 100
8:45 AM – 10:00 AM	INTERNAL POLICY MEETING RE: TRIGGERS ROOM 216
11:00 AM – 12:00 PM	BENEFIT PACKAGE ALTERNATIVES MEETING HEFFLIN'S OFFICE
11:30 AM – 1:30 PM	JOHN HILLY MEETING RE: LATEST MODEL & PREMIUM CAP ALTERNATIVES ROOM S221
2:00 PM – 3:00 PM	DURENBURGER/BAUCUS BRIEFING RE: PREMIUM CAPS
3:30 PM – 4:30 PM	ANDREW PATZMAN MEETING KASSEMBAUM'S OFFICE
5:00 PM – 6:00 PM	LEGISLATIVE MEETING
6:00 PM – 7:00 PM	KEN APFEL MEETING RE: PREMIUM CAP ALTERNATIVES ROOM 731 HART

Premium Cap Alternatives → Judy Feder

-58 Bill

	Comments on Kennedy Mark	VERY ROUGH, Directional, 5 year deficit effect, vs. CBO's HSA
Benefits package	higher cost sharing, more services, esp. preventive	2% below CBO's HSA, per CRS memo
Premium Subsidies	more generous for nonworkers and exempt workers (assumes 25% of HSA level of outsourcing)	-20
Cost-Sharing subsidies	more generous	+46
Corporate Assessments + Other revenue	2% on small firms that don't offer, 1% on 1000+ (assumes fire wall holds perfectly)	-44 (NOT -38 Treasury estimate)
Tobacco taxes	$1.49 per pack (Stark)	-32
Voluntary alliances	IF CBO scores state regulation as effective as mandatory alliance regulation	+0
FEHB	preserve FEHB as an alliance for all	+0.5
LTC	self-funded, IF premium set correctly. There is long term risk of pressure for subsidies.	0
AHC/GME	more generous	+27
State and Local employer subsidies	ballpark based on CBO's estimate of HSA payroll caps	+18
State and Local Employer Assessment revenue	on units 1000+	up to -7
Age rating	VERY preliminary	+10 (not in mark, but strongly preferred)
Fed/st. sharing of savings	forces states to return 25% of their savings in HSA	-14 (not clear how this will work)

-26+20+

	Comments on Kennedy Mark	VERY ROUGH, Directional, 5 year deficit effect, vs. CBO's HSA
New Public Health capped ENTITLEMENT	HSA kept this discretionary and smaller, had offsets	+ 3 (could be 10)
Vulnerable Population Adjustment		+ 2
Health Research Set-Aside – dedicated premium tap		0
NET EFFECT ON 5 YEAR DEFICIT, VIS A VIS HSA		-11

~~70~~ - 63

23 default reduction

~~$8 billion~~

86

State Maintenance of Effort under the Health Security Act, Year 2000

	MOE 2000 (1) ($ millions)	Population 2000 (2) (thousands)	MOE Per Capita 2000	Index to US 2000
UNITED STATES	23,400	273,217	$86	1.00
Alabama	171	4,498	$38	0.44
Alaska	69	568	$122	1.42
Arizona	449	3,954	$113	1.32
Arkansas	101	2,620	$38	0.45
California	3,946	33,588	$117	1.37
Colorado	201	3,568	$56	0.66
Connecticut	537	3,472	$155	1.80
Delaware	33	777	$42	0.49
District of Colum	142	571	$248	2.89
Florida	884	14,804	$60	0.70
Georgia	408	6,977	$58	0.68
Hawaii	98	1,256	$78	0.91
Idaho	53	1,143	$46	0.54
Illinois	857	12,917	$66	0.77
Indiana	427	6,056	$70	0.82
Iowa	115	3,117	$37	0.43
Kansas	149	2,708	$55	0.64
Kentucky	186	3,951	$47	0.55
Louisiana	445	4,540	$98	1.14
Maine	118	1,362	$86	1.01
Maryland	486	5,253	$93	1.08
Massachusetts	638	6,263	$102	1.19
Michigan	629	9,971	$63	0.74
Minnesota	256	4,663	$55	0.64
Mississippi	98	2,900	$34	0.39
Missouri	618	5,485	$113	1.32
Montana	28	889	$31	0.36
Nebraska	85	1,752	$49	0.57
Nevada	146	1,404	$104	1.21
New Hampshire	54	1,240	$43	0.50
New Jersey	657	8,316	$79	0.92
New Mexico	43	1,669	$25	0.30
New York	3,656	19,034	$192	2.24
North Carolina	523	7,185	$73	0.85
North Dakota	20	660	$30	0.35
Ohio	950	11,983	$79	0.93
Oklahoma	160	3,502	$46	0.53
Oregon	124	3,243	$38	0.45
Pennsylvania	882	13,135	$67	0.78
Rhode Island	85	1,041	$82	0.96
South Carolina	268	3,913	$69	0.80
South Dakota	20	767	$26	0.30
Tennessee	465	5,393	$86	1.01
Texas	1,321	18,597	$71	0.83
Utah	71	1,880	$38	0.44
Vermont	30	649	$46	0.53
Virginia	427	6,657	$64	0.75
Washington	297	5,439	$55	0.64
West Virginia	110	1,910	$58	0.67
Wisconsin	148	5,469	$27	0.31
Wyoming	18	508	$35	0.41

(1) HCFA OAct; ASPE; NOTE: State estimates do not sum to U.S. total due to rounding.
(2) CPS 1992 state population projected to 2000 using national growth rate.

VRA - 182 B

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Corporate Assessments + Other revenue	2% on small firms that don't offer, 1% on 1000+ (assumes fire wall holds perfectly)	-44 (NOT Treasury estimate)
Tobacco taxes	$1.49 per pack (Stark)	-32
Voluntary alliances	Assuming lose 1% growth per year (optimistic, IF CBO won't score state regulation as effective as mandatory alliance regulation)	+30
FEHB	preserve FEHB as an alliance for all	+0.5
LTC	self-funded, IF premium set correctly. There is long term risk of pressure for subsidies.	0
AHC/GME	more generous	+27
State and Local employer subsidies	CBO estimates 5-7 per year	~~+24~~
Age rating	VERY preliminary	+10 (not in mark, but strongly preferred)
Fed/st. sharing of savings	forces states to return 25% of their savings in HSA	-14 (not clear how this will work)
New Public Health capped ENTITLEMENT	HSA kept this discretionary and smaller, had offsets	+ 3 (could be 10-+18)

46
0-30
27

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Health Research Set-Aside - dedicated premium tap		0
NET EFFECT ON 5 YEAR DEFICIT, VIS A VIS HSA		+30

The press release claimed $23 billion in absolute deficit reduction. Since CBO estimated the HSA would increase the deficit by $74 between 1995-2000, this very rough ballpark assessment suggests that the press release was optimistic by $127 billion.

8:30
NAM Meeting
is Cancelled

FRIDAY, JUNE 24

8:15 AM - 8:45 AM	COMMUNICATIONS MEETING ROOM 100
11:40 AM - 12:40 PM	MELANNE'S SURPRISE PARTY YELLOW OVAL ROOM-RESIDENCE
6:00 PM - 7:00 PM	POLICY MEETING ROOM 216

PAUL D. WELLSTONE
MINNESOTA

United States Senate

WASHINGTON, DC 20510-2303

456 7431

FROM THE OFFICE OF SENATOR PAUL DAVID WELLSTONE

FAX COVER SHEET

TO: CHRIS JENNINGS

FROM: ELLEN SHAFFER - phone 224 8416

DATE: 6/23

MESSAGE: WD. LIKE SEN. WELLSTONE TO HAND ATTACHED LETTER TO HRC AT BEGINNING OF HLTH RIGHT EVENT TODAY. PLS. CALL ASAP. THX

COVER SHEET + _____ PAGES = _____ TOTAL PAGES

QUESTIONS/PROBLEMS, PLEASE CALL 202-224-5641
FAX 202-224-8438

PAUL D. WELLSTONE
MINNESOTA

MINNESOTA TOLL FREE NUMBER:
1-800-642-6041

United States Senate

WASHINGTON, DC 20510-2303

COMMITTEES:
ENERGY AND NATURAL RESOURCES
LABOR AND HUMAN RESOURCES
SMALL BUSINESS
INDIAN AFFAIRS

June 23, 1994

Dear Mr. President,

Last week several senators and I sent you a letter urging continuing firm support for universal coverage as a key feature of health care reform.

Several organizations of health care consumers and providers expressed their interest in communicating the same message to you.

I am pleased to present you with a list of the groups that offered to sign the letter. I'm certain we are both encouraged that this impressive list of groups support 100% universal coverage, employer mandates, affordable care, cost containment, and the option for states to implement a state single payer system.

Even more encouraging to me was the signal that so many groups and individuals are ready to respond to requests from Washington to show their support for these key issues.

Health care reform cannot be hijacked by big ticket special interests. Many of us in Congress, and millions of Americans around the country, are ready to stand up and make sure that health care reform will not be hijacked by big ticket special interests.

We know that we need health care reform, and we need it this year.

All of us appreciate the most recent comments you and Mrs. Clinton have made on the importance of passing a bill that is unequivocal on the issue of universal coverage. I know that I speak for us all in offering any help we can provide in assuring that we accomplish that goal in the 103rd Congress.

Sincerely,

Paul David Wellstone
United States Senator

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WASHINGTON, DC 20510-2303
(202) 224-6841

☐ 2550 UNIVERSITY AVENUE, WEST
COURT INTERNATIONAL BUILDING
ST. PAUL, MN 55114-1025
(612) 645-0323

☐ POST OFFICE BOX 281
105 2D AVENUE, SOUTH
VIRGINIA, MN 55792
(218) 741-1074

☐ 417 LITCHFIELD AVENUE, SW
WILLMAR, MN 56201
(612) 231-0001

June 23, 1994

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

Dear Mr. President:

Our organizations have always shared with you a commitment that universal coverage must be the cornerstone of health care reform. That commitment cannot waver as we continue our progress in Congress to enact comprehensive health care reform legislation.

We are troubled by comments from the press and some Members of Congress that universal coverage is not a realistic goal.

Universal coverage is impossible unless it meets several critical tests. First, it must include meaningful, employer-based financing. Unworkable proposals that would put the burden on individuals to pay most of the costs of their care, or project employer contributions into some distant future, cannot achieve the health care reform that Americans are counting on.

Second, all Americans must be covered. Suggestions that universal coverage should be defined as something less than total coverage, such as 90% or 95%, would continue to leave millions of Americans vulnerable to the double plagues of illness and impoverishment. Anyone could lose the lottery: people who work and those at risk of losing their jobs, the elderly and people with disabilities and their families, people with cancer and people with AIDS, people in rural areas, women, men, children.

Third, coverage must be affordable. Meaningful cost containment must be included to protect businesses, individuals, and government entities contributing to the system.

Finally, states must have the ability to adopt a single-payer system if they determine through their own legislative processes that would be a fairer or more cost-effective approach to universal coverage.

Universal coverage is not only a humane goal, one which most industrialized countries have attained. It is also key to making health care affordable because it would end wasteful and inflationary cost-shifting, encourage preventive care, and allow more appropriate use of resources. Suggestions that we waste

more years and more lives tinkering around the edges of almost covering everyone, trying to make health care almost affordable, are a diversion from the fair and workable framework you have presented. In addition, it would send an unwelcome signal to the country that its elected leaders are unwilling to take the long overdue step of guaranteeing that every American enjoys health security.

We ask that you remain strong in your commitment to universal coverage, affordable for all and fairly financed. While there will be areas for compromise during the legislative process, assuring universal and affordable coverage must not be among them. We will assist efforts toward the goal of true universal coverage for health care in any way that we can.

Sincerely,

Actors' Equity, Ron Silver, President
ACTUP Washington
AIDS Action Council
American Association of Children's Residential Centers
American Association for Marriage and Family Therapy
American Association of Pastoral Counsellors
American Association of Physicians for Human Rights
American Association of University Women
American College of Physicians
American Counselling Association
Americans for Democratic Action
American Federation of State, County and Municipal Employees
American Medical Students Association, Terrence Steyer, National President
American Psychological Association
American Public Health Association, Eugene Feingold, President
Association of Maternal and Child Health Programs
Association of Mental Health Administrators
Judge David L. Bazelon Center for Mental Health Law
California Society for Clinical Social Work
Campaign for Women's Health
Children's Defense Fund
Churchwomen United
Citizen Action
Consumers Union
Creative Coalition, Blair Brown, Co-President
Family Service America
Gray Panthers
Health Access
InterHealth, St. Paul, Minnesota
International Association of Pyschosocial Rehabilitation
International Brotherhood of Teamsters
International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers (IUE), William H. Bywater, International President

Legal Action Center
Lutheran Medical Center, Brooklyn, N.Y., Jim Stiles, Executive Vice President
National Association of Community Health Centers
National Association of Homes and Services for Children
National Association of Protection and Advocacy Systems
National Association of Public Hospitals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Community Mental Health Care Council
National Council of Churches of Christ in the U.S.A.
National Council of La Raza
National Education Association
National Federation of Societies for Clinical Social Work
National Mental Health Association, Mike Saenza, Chief Executive Officer
National Rainbow Coalition
National Women's Health Network
New York StateWide Senior Action Council, Inc., Ruby Sills Miller, Member of the Board
Oil, Chemical and Atomic Workers International Union
Older Women's League
Protestant Health Alliance
Screen Actors Guild, Barry Gordon, National President
Service Employees International Union
Sigerist Circle of Medical Historians, Elizabeth Fee, President
Unitarian Universalist Association of Cognregations
United Auto Workers

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UNIVERSAL COVERAGE

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

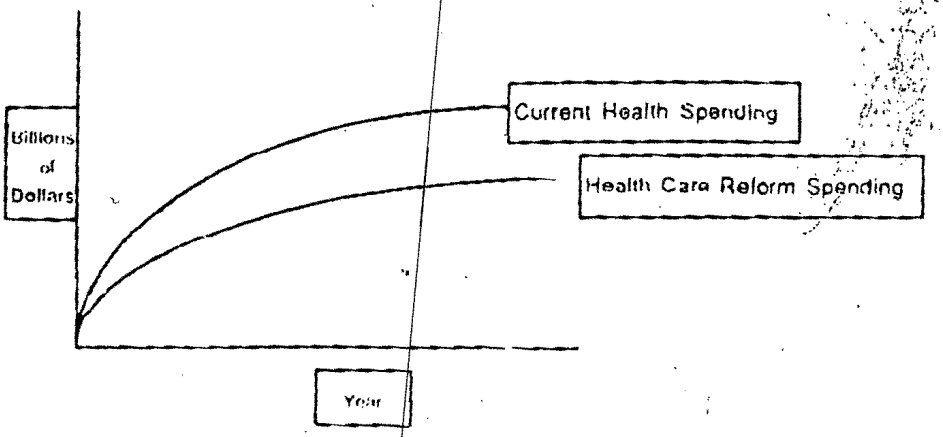
In the event 96% of all Americans do not have health insurance by 2001, the Commission will develop a package of recommendations to Congress designed to reach universal coverage. Special procedural provisions (similar to fast-track) would be included for fast consideration of this package.

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

- Individuals who do not procure coverage (a special provision will be included allowing childless individuals under 30 to purchase catastrophic coverage instead of the uniform benefit plan);

- *??? Businesses that do not provide insurance coverage ???*

AUTOMATIC FAIL-SAFE BUDGET PROTECTION PROCESS



Current Baseline Health Spending Estimates Include:

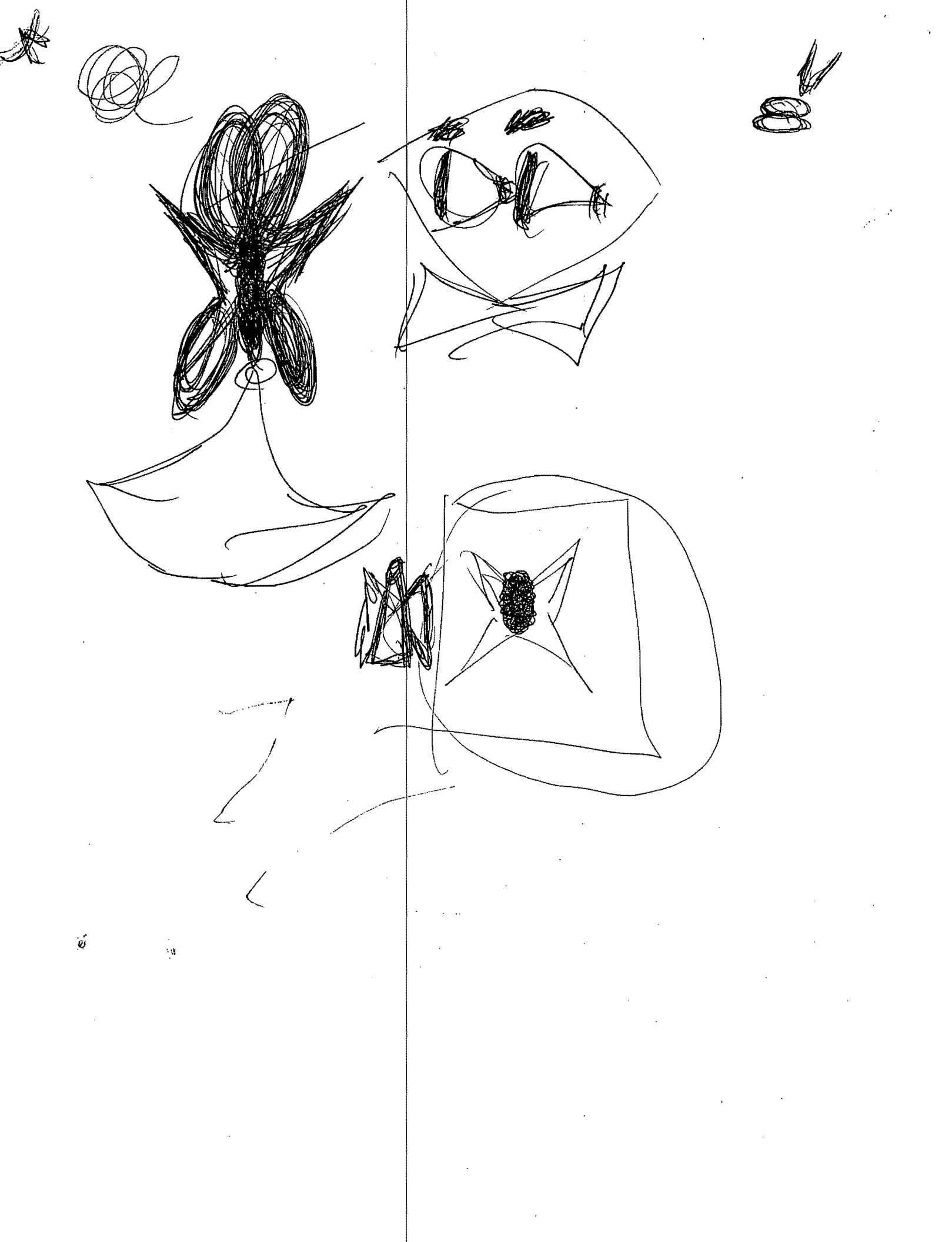
- Medicare
- Medicaid
- Tax Spending
  - Employer Provider Health Insurance to Employee
  - Cafeteria Plans

Health Care Reform Spending Estimates Include:

- Medicare (including reductions)
- Medicaid (including reductions)
- Tax Spending
  - Employer Provided Health Insurance to Employee
  - Expanded Deduction for Individually Purchased Insurance
  - Cafeteria Plans
- New Revenues for Health Care (i.e., cigarette tax)
- New Entitlement Spending (Subsidies)

In any year, if health care reform spending would exceed the current baseline health spending, the following automatic actions (each set to contribute a designated amount of the shortfall) will occur to prevent deficit spending:

1. Increased tax on high cost insurance plans
2. Subsidies to purchase insurance slowed down
3. Expanded tax deduction phase-in slowed down
4. Out-of-Pocket limit increased for health insurance
5. *??Medicare??*



TAX CAP SUBSTITUTE
AND ALTERNATIVE APPROACH TO CAPS ON PREMIUMS

PURPOSE: To retain the economic incentives of a tax cap -- allowing a high degree of individual choice of plans, but imposing a limit on how much the government will subsidize; and to impose a penalty on higher cost insurance plans.

1. A Commission will be established to evaluate health care spending and market trends in areas throughout the country. The Commission will study how the competitive market works in high and low cost areas and will make recommendations to Congress on changes in health care reforms to reflect its findings. It will establish performance measures to determine whether market reforms are effective in holding down the rate of growth in health care costs in individual market areas.

2. An assessment will be placed upon high cost insurance plans. A high cost plan is one that exceeds the average of the lowest cost two-thirds of plans offered in an area. A plan above the two-thirds average will be subject to a 25% premium tax on the difference between its premium and the average. (Working on rule for rural and frontier areas.)

3. A plan offered in an area where the average exceeds the National average will be subject to an additional tax if it cost is above the two-thirds average and its rate of increase is above an inflation factor set in the statute.

4. Applies to all health plans including self-insured.

FINANCING
(Estimated 5 year financing, $ in billions)

Medicare Cuts	
Change Hospital Inpatient Update Formula	$13.8
Hospital Inpatient Capital	6.7
Phase Down Hospital DSH	13.2
Reduce Hospital IME	14.1
Extend OBRA 93 SNF Savings	0.8
MD Fees: Real Per Capita GDP	5.1
MD Fees: Cumulative Targets	15.3
MD Fees: Conv. Factor	2.5
Income-Related Premiums	8.0
Extend 25% Part B Premiums	4.9
Extend OBRA 93 Home Health	2.2
10% Home Health Copay	7.6
Extend Secondary Payor	3.7
Home Health Median Limit	1.5
Part B Deductible	1.5
Interaction effects	-15.2
Subtotal Medicare	$86.0
Medicaid Cuts	
Medicaid DSH Phase-down	$43.7
Medicaid Capitation	12.0
Subtotal Medicaid	$55.8
Postal Service Retirement	$13.0
Subtotal Spending Reductions	$154.7
Revenues	
Premium Assessment	$37.5
Tobacco Tax	$54.0
HI State/Local	7.6
Subtotal Revenues	$61.6
TOTAL FINANCING	$253.8

Questions to ask Finance Staffers:

1. Are subsidies tied to the average of lowest 1/2 (2/3?) of all bids or just bids inside the HIPC?

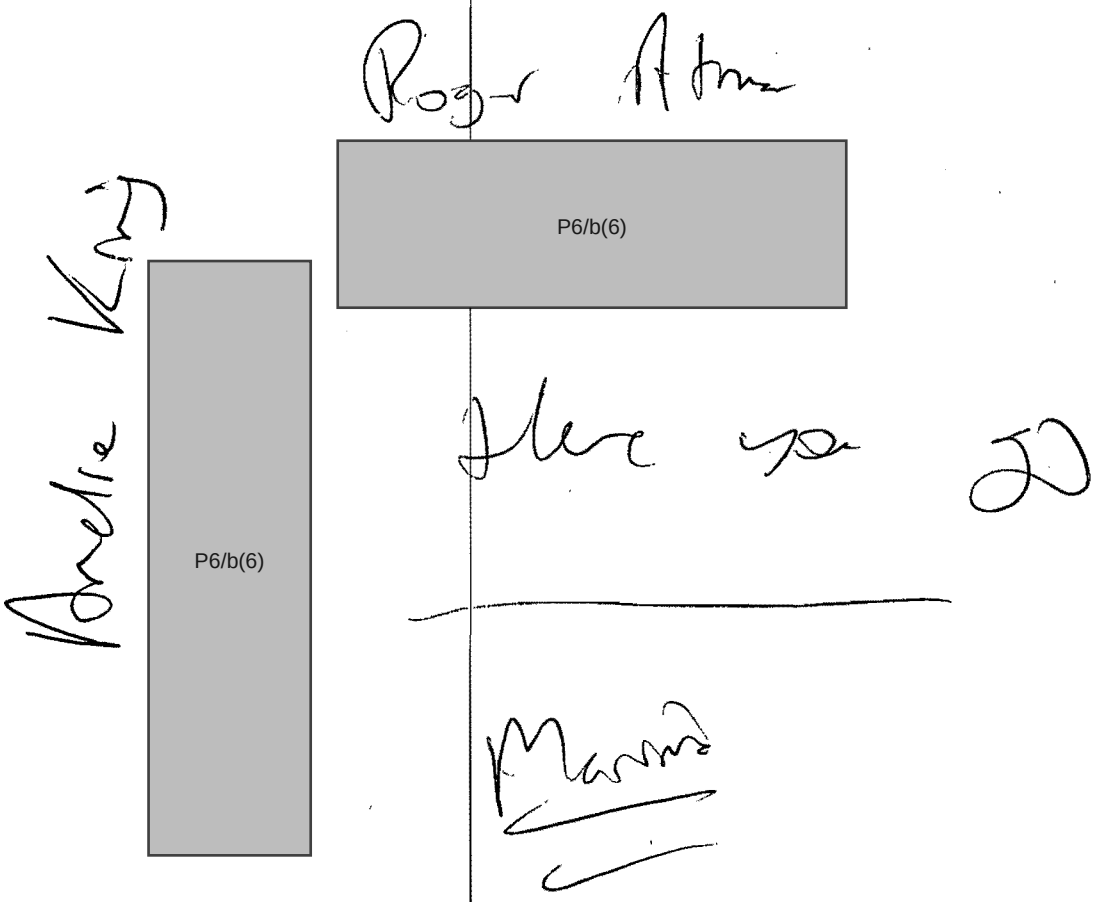
2. Is premium tax levied on bids above the average of the lowest 1/2 (2/3?) of all bids or just bids inside the HIPC or something else altogether?

3. Is the high cost plan premium tax rate set to "fill the revenue hole" or just a flat rate to collect revenue? If flat, what? (25%, 35%?) If to "fill the hole," please define the hole.

4. Is there also a tax cap? If so, is it pegged to the average of lowest 1/2 (2/3?) of all bids or just bids inside the HIPC?

5. What do you do with Medicaid noncash in interim and after mandate is triggered?

- AGI?
- How to?
- Affording tax deductibility?
- Corporate assessment
- Does individual tax deduction come in immediately or is it phased in. If latter, how?
- Employer assessment.
- Above the line or below the line in the deduction for the premium
  Anything other than premiums covered?
- Tax cap in both employer & employee? — (preference or individual or ...)
  (Designated Social Tax Cap on the supplemental?) (or employer gross receipts or excise tax)
- Definition of income for subsidies
  Does this AGI? Money income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Draft June 23, 1994

ALTERNATIVE HEALTH REFORM PROPOSAL

SUMMARY

Under this proposal, universal coverage is phased–in between 1995 and 2000.

Prior to the year 2000, insurance market reforms and premium subsidies are implemented to encourage more employers and families to voluntarily purchase coverage. To provide access to affordable coverage, small employers and families are permitted to purchase the same health plans selected by the Federal Employee Health Benefit Program for federal workers. A new public program, Medicare Part C, also offers affordable coverage to certain small employers and families.

Universal coverage is assured by 2000 through shared employer, familiy and government responsibility. Employer responsibility is phased–in by employer size. Employers with 100 or more employees are required to cover their workers and their families in 1998. For smaller employers, if they do not cover a specified percentage of their currently uninsured workers by 2000, an employer requirement to provide coverage is triggered.

In 2000, families not covered by employer–provided coverage are required to purchase coverage.

REFORMS PRIOR TO THE YEAR 2000

Insurance Market Reforms

- Upon passage, immediate transition provisions (similar to those in Title XI of the Health Security Act ("HSA")) take effect to assure that existing coverage remains in place until more comprehensive market reforms can be implemented.
    - Insurers are prohibited from terminating coverage for groups and individuals, except in cases of nonpayment, fraud or misrepresentation. Insurers wanting to leave the market immediately can transfer their business to another carrier (subject to state or federal standards).
    - Insurers that increase premiums must assess the same percentage increase to all their policyholders.
- Comprehensive insurance reforms are implemented nationally by January 1, 1997.
    - Insurance and market reforms are implemented by the federal government unless a state passes consistent state reform laws and it is certified by the National Health Board.

- All insurers intending to offer health benefits in a state must be certified.

- All certified insurers are required to offer two standard health plans -- a comprehensive package and a catastrophic package -- to employers and uninsured families. The comprehensive package is similar in value to the Blue Cross and Blue Shield standard option in the Federal Employees Health Benefit Program ("FEHBP"). The catastrophic benefit package is available only to employers and families that currently have a similar level of coverage.

- Coverage is provided on a guaranteed issue basis. Insurers are permitted to impose limited waiting periods for preexisting conditions for previously uninsured applicants. Portability of coverage is guaranteed.

  Insurers may require that a minimum percentage of employees be insured before offering coverage to an employer. Participation requirements must be applied uniformly and may not specify the manner by which the employees are insured.

- Insurers offer age-adjusted community rates (with standard age bands and factors) to all employers up to a defined size and to otherwise uninsured families. Insurers use the same age-adjusted community rates throughout defined health care coverage areas.

  Employers above the defined size cannot select community-rated health plans. These employers can purchase experience-rated insurance or can self-fund.

  (Experience-rated and self-funded plans are subject to reforms similar to those for community-rated health plans).

- All certified insurers (including Medicare Part C) participate in a risk adjustment and reinsurance system established pursuant to federal standards.

Availability of Coverage

♦ Employers that offer coverage to their employees must offer either the comprehensive package or the catastrophic package.

- Employers can offer one health plan or several plans.

- Employers are not required to contribute any specified percentage toward any plan. Employers must contribute a minimum percentage toward the comprehensive package in order to receive federal premium subsidies (see below).

- Families in which both spouses work for employers offering coverage ("dual-earner families") may choose coverage through either employer.

- *OPTION: Except in the case of low-income families eligible for Medicare Part C, families with a full-time worker working for an employer that offers and contributes a minimum percentage toward the comprehensive package may purchase coverage only through the plan(s) offered by the employer.*

- Employers offering the comprehensive package may also provide supplemental benefits to their employees, but may not require them to purchase supplemental benefits as a condition of being covered under a comprehensive package.

♦ Nonworking families and families whose employers do not offer them the comprehensive benefit package may purchase coverage from any certified insurer. Guaranteed availability for these families would be limited to annual open enrollment periods. Families with changes in job status or location would be provided with special open enrollment periods.

♦ Medicaid cash and non-cash recipients enroll in health plans with comprehensive benefit packages (similar to HSA provisions).

- Medicaid cash recipients are permitted to enroll in any health plan at or below the average premium. The federal and state governments make a per capita payment (based on 100% of current state spending) to the health plan for the enrollees. Payment adjustments across health plans assure that all health plans participate fairly in covering this population.

- Medicaid non-cash recipients are permitted to enroll in any health plan at or below the average premium. The federal and state governments pay an age-adjusted community rate to plans that enroll them.

- Health plans charge only nominal cost-sharing to cash and non-cash recipients.

Premium Subsidies

♦ Employers begin receiving federal premium subsidies when comprehensive insurance reforms are implemented in 1997.

- To be eligible for subsidies, employers must provide the comprehensive benefit package to their full-time workers and their families and must contribute at least 80% of the premium. Employers that offer more than one plan to their workers must contribute at least 80% of the premium of the lowest cost plan that they offer to be eligible for subsidies.

- Employer subsidies are based on the wage level of each employee. Employers receive greater subsidies for lower wage workers than for higher wage workers.

Employer subsidizes are provided up to the average current premium ("ACP") in each area.

The ACP is the estimated national per-capita cost (calculated similar to HSA average per capita target) for the comprehensive benefit package, adjusted for each health care coverage area.

The ACP increases at the growth rates provided in the HSA, delayed one year (i.e., baseline in 1996, CPI plus 1.5% in 1997).

- Employer subsidy levels are reduced prior to achieving universal coverage in the year 2000. Employers that previously have not offered insurance to their employees (or have offered only very low value coverage) receive 50% of the subsidy they would receive after 2000. Currently insuring small employers receive 25% of the subsidy that they would receive after 2000.

  Large employers receive reduced subsidies in 1997 (as above) and full subsidies beginning in 1998 (when they are required to provide coverage).

♦ Families that purchase the comprehensive benefit package also are eligible for premium subsidies beginning in 1997.

- For the family ("20%") share of the premium, the family contribution is subsidized so that the family pays no more than 3.9% of family adjusted gross income ("AGI"). The subsidies are capped at the ACP.

- Nonworking families and families whose employers do not offer them the comprehensive benefit package also are eligible for subsidies for the employer share of the premium. Subsidies are available (based-on a sliding scale basis) to families with AGI of less than 250% of poverty.

  For families whose employers offer a comprehensive health plan but pay less than 80% of the premium, the family is subsidized as a nonworking family for the unpaid portion of the employer share.

- Self-employed people generally receive subsidies based on the same sliding-scale subsidy schedule.

Medicare Part C

♦ A new public insurance program, Medicare Part C, is established to assure that employers and families have coverage available that is priced no higher than the ACP.

- The premium for Medicare Part C is set at the ACP in each area.

- Provider rates adjust over time to assure that the premium is sufficient to support the costs of the program.

♦ Eligibility for Medicare Part C and its administration are generally as described in the Ways and Means Mark. AFDC and SSI beneficiaries and non-cash Medicaid participants are covered as described above.

♦ Eligibility for Medicare Part C is extended to larger employers (up to employers with fewer than 100 employees) in areas where there are not a sufficient number of health plans offer the comprehensive benefit package at or below the ACP.

♦ If the Secretary of HHS determines that a significant number of larger employers (e.g., 100 or more employees) cannot provide the comprehensive benefit package at premiums consistent with the ACP, the Secretary must develop and submit a proposal to Congress regarding how Medicare Part C can be provided as an option to larger employers.

♦ Eligible employers and families can enroll in Medicare Part C directly or through a referral from FEHBP.

Making FEHBP Available to Employers and Families

♦ As under current law, FEHBP contracts with a variety of health plans in each area. Federal employees, including Members of Congress, choose from among the health plans selected by FEHBP.

♦ Beginning in 1997, the health plans selected by FEHBP are available to other employers and families.

- Community-rated employers (i.e., those below a certain size) may arrange for coverage through FEHBP. Their employees can choose any of the FEHBP health plans (and by referral, Medicare Part C).

- Families not covered by employer-provided insurance can obtain coverage through FEHBP.

- Age-adjusted community rates apply to employers and families obtaining coverage through FEHBP in a manner similar to the market outside of FEHBP. Health plans charge the same age-adjusted community rated premiums inside FEHBP as they charge in the outside market (except potentially for differences in marketing fees as under the Education and Labor Mark).

♦ To provide access to affordable coverage for federal employees and other employers and families, FEHBP is provided with additional authority to selectively contract with health plans.

- FEHBP would be required to contract with health plans that have premiums below the ACP and that meet specified quality and service criteria.

- FEHBP would not be required to contract with health plans that have premiums above the ACP, giving FEHBP additional bargaining leverage. FEHBP would have the authority to freeze or limit new enrollment in health plans with premiums above the ACP.

♦ Federal employees are held harmless from the effects of community rating until the year 2000.

- Unlike today, FEHBP pays age-adjusted community-rated premiums for federal employees instead of experience rates. That is, health plans would charge the same premiums to FEHBP as they would to other employers below a certain size.

- As they do today, all federal employees pay the same premium to enroll in the same health plan, regardless of age.

- Prior to the year 2000, the federal contribution in an area increases to the extent that premiums for federal employees are higher due to rating changes. The federal contribution towards health coverage rises to at least 80% beginning in 1998 (when the requirement for employers with 100 or more employees takes effect).

Revenues

♦ Beginning in 1995, the tobacco tax is increased by $X.

♦ Beginning in 1997, all firms with 100 or more employees are required to pay an assessment equal to 1% of payroll.

♦ Prior to achieving universal coverage (or after, if an employer requirement for firms with fewer than 100 workers is not triggered), firms not providing coverage pay phased in assessments equal to:

- 0.5% of payroll in 1997.

- 0.75% of payroll in 1998.

- 1.0% of payroll beginning in 1999.

UNIVERSAL COVERAGE AND REFORMS AFTER 2000

Employer Requirements

- Universal coverage is assured by 2000 through shared employer, familiy and government responsibility.

  Employers with 100 or more employees are required to cover their workers and their families in 1998.

  An employer requirement to provide coverage is triggered for small employers if they do not cover a specified percentage of their currently uninsured workers by 2000.

  In 2000, families not covered by employer-provided coverage are required to purchase coverage.

- When the employer requirement for firms with 100 or more employees is initiated in 1998, those employers are required to:

  - Contribute at least 80% towards at least one health plan offering the guaranteed benefits package.

  - Make pro-rated contributions for part-time workers.

- When universal coverage is achieved in 2000:

  - All employers are required to offer a choice of plans, including at least one lower cost sharing plan and one plan offering an unlimited choice of providers (as in Ways and Means Mark).

    If the small employer requirement is not triggered because the market achieved the specified coverage goals, small employers would be required to offer, but not contribute toward, a choice of health plans.

  - Employers receive a "dual earner credit" that shares the cost of dual earner families across employers (as in Ways and Means Mark).

  - Full subsidies are available to all employers (see below).

  - If no employer requirement is triggered for employers with fewer than 100 employees, certain non-discrimination rules apply, meaning that employers making voluntary contributions for full-time workers must make pro-rated contributions for part-time workers.

Employer and Family Subsidies

- Full subsidies are available to all employers when universal coverage is achieved. For employers with 100 more employees, full subsidies become available when they are required to provide coverage (see above).
    - Employer subsidies are based on each individual worker's wage, and therefore are greatest in firms with the largest number of low-wage workers.
    - For each worker, the employer pays the lesser of the premium for that worker of the following caps based on the worker's wage: 5.5% for workers earning $12,000 or less, 8.0% for workers earning $12,001–$15,000, 10.0% for workers earning $15,001–$18,000, and 12.0% for workers earning more than $18,000.
    - Employer subsidies are provided up to the level of the ACP for an area.
- As during the transition period, families are required to pay no more than 3.9% of income for their 20% share of the premium. Further subsidies are available for families with income up to 150% of the poverty level (same as HSA).
- When an individual requirement is initiated (year 2000), non-working families are required to pay the 80% employer share of the premium for the period of time they are not working. Subsidies are available for families with unearned income up to 250% of the poverty level (same as HSA).

Insurance Reforms

When universal coverage is achieved in 2000, insurance reforms are strengthened:

- Health plans are no longer permitted to vary rates by age.
- Pre-existing condition exclusions are prohibited.
- The catastrophic benefits package is no longer available.

Cost Containment

- Premium caps are triggered in the year 2000 if the rate of growth in premiums nationwide exceeded target rates of growth from 1997 to 1999. Caps are enforced at the premium level that would have been achieved if caps had been met beginning in 1996.
- Medicare Part C remains available, with its premium priced at the premium target for each area.

- FEHBP continues to make health plans available to small employers and nonworking families.

State Flexibility

- Effective in 1997, states may exercise flexibility in structuring their health care systems.
  - Certain elements may not be changed (including the guaranteed benefits, coverage requirements and subsidies, and insurance reforms).
  - States may establish voluntary or mandatory purchasing cooperatives (as in Education and Labor Mark). Voluntary purchasing cooperatives may operate in place or or alongside the FEHBP option.
  - States can adopt alternative methods of cost containment that are equivilent in effectiveness (similar to Ways and Means Mark).
  - States may establish alternative administrative structures for premium collection and enrollment.
- States have the option of implementing a single payer system.

✓ Eric Toth (311) 229-3765

Health Care Reform model parameter/assumption checklist

	Moderate Finance
benefit package	standard option: HSA-8% (assumed, tbd by National Board) catastrophic option: HSA-26%
premiums	age rating (2:1) pre-trigger adjustments: adverse selection voluntary (8%) catastrophic option uncompensated care (DSH DSH phases out faster than uncompensated care; S&L spending stays, etc. no AHC add-on (Mark) (for NET see attached year by year adjustments)
employers	no mandate firms with 100+ must offer but not contribute to coverage firms with ≤ 100 must provide payroll deductions firms will reduce their current payments commensurate with the household's subsidy.
individual mandate	as of 2002
firm subsidies	none

individual subsidies	pegged to standard package; Assume a Chaffee voucher percentage formula, but phase-in of subsidy eligibility will be faster, and subsidies stop at 240%. 1997: 90% 1998: 120% 1999: 150% 2000: 180% 2001: 210% 2002: 240% HH ≤ 100% pay nothing when eligible. HH between 100-240% pay a fixed fraction of the premium determined by formula on attachment. Subsidies are tied to mean of lowest priced 1/2 of plans. This is equal to 95% of the mean premium on the year by year attachment. Assume that 100% of those under 100% of poverty take-up insurance pre-mandate. Pre-mandate, assume the Cooper take-up rate for all others. If unit has current coverage, assume they maintain current coverage. Individual tax exemption phases up to 100% by 2002. Starts at 10% in 1997, 20% in 1998, 40% in 1999, 60% in 2000, 80% in 2001. Exemption tied to mean of lowest 1/2 of plans.

Deduction

alliances/community rating pools	firms with ≤ 100, nonworkers, etc., + MCD non-cash; voluntary; premium outside HIPC x% lower
tax cap	employer payments exempt only up to avg. of lower 1/2 of bids; individuals can claim this (phased-in) if firms pay less than this amount
Cost Containment	baseline - 1% from tax cap
high cost plan assessment	Premium tax on high cost plans, where a high cost plan is defined as a plan whose premium exceeds the mean of the lowest 2/3 of plans. Assessment is equal to 25% of difference between premium and average of lowest 2/3 of plans. Tax exempt medical savings accounts available to those choosing the catastrophic option; exemption capped at difference between catastrophic and standard premiums (average of bottom half of plans)
Medicare	savings from program are $86 (?) billion over 5 years

Medicaid	lower growth rate on federal capitation payments $12 (?) billion over 5 years Fixed percentage of enrollees allowed in HIPC with private enrollees -- 15% per year in 1st 3 years and additional 10% per year after that. Medicaid DSH phase-down: $43.7 (?) billion over 5 years
Other Federal Programs	lose savings from slowing the rate of increase in federal spending (FEHB)
Other Savings	No long term care program $60 billion over 5 years; No Medicare drug benefit $73 billion over 5 years; Postal service retirement spending reductions: $13 (?) billion over 5 years.
Other Revenue	premium assessment: tobacco tax: 54 (?) billion over 5 years HI state/local: 8 (?) billion over 5 years

✓ Eff Tolv (301) 229-3765

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Other Revenue	premium assessment: tobacco tax: 54 (?) billion over 5 years HI state/local: 8 (?) billion over 5 years

Proposal: 6.25.94

1. All individuals would receive coverage by 2001.

2. All individuals categorically eligible for Medicaid would be covered by 96-97 through the AFDC/SSI capitation payments. We would purchase private insurance under the same terms as other Medicaid eligibles (we need to find new rules here to divorce the welfare/insurance link)

--this reduces the number of uninsured immediately among vulnerable populations

--this reduces uncompensated care, therefore the premium add-on.

--this reduces the ultimate federal costs as most would be fully federally paid as nonworkers/or other low-income individuals

--states share in the costs

3. We would extend the Medicaid transitional health insurance payments from 1 to 2 years (or more--perhaps as long as the voluntary insurance program). (Medicaid currently pays for health insurance for those former recipients that work for 1 year).

--This greatly assists the welfare reform work incentives--they currently only have 1 year of coverage, which increases the likelihood of re-entry into AFDC. In this case, we pay Medicaid for them anyway.

--Reduces ultimate federal cost as increases the prob that AFDC eligibles will remain in the workforce.

4. We provide 25% of ultimate employer subsidies for those employers that meet all coverage rules; no subsidies for others that do not.

5. Newly insuring firms would receive X% of ultimate employer subsidies. Both of these phase-in over time.

6. Cost Containment. An assessment is placed on plans that bid above the target. The tax rate is designed to recover lower tax receipts resulting from premium growth above the target as well as household subsidies.

7. We use the "net" premium price charged by health plans is calculating the average weighted premium. The net price is defined as the premium bid less the tax. This lowers the average weighted premium compared to previous scenarios that subsidize the tax as well as the no tax case. It also provides additional incentives for

consumers to choose lower cost plans. In concept, one could argue that it could also result in slower growth over time since it creates a trend of average premiums that are lower in any given year than the pure managed competition world.

8. An individual subsidy schedule exists that allows individuals to purchase insurance. It is similar to the HSA nonworker schedule. Those individuals not covered by 2001 would pay according to this schedule (or another one we construct).

MEMORANDUM FOR PAT GRIFFIN
STEVE RICCHETTI
JACK LEW
CHRIS JENNINGS

FROM: CAREN WILCOX

SUBJECT: WASHINGTON REPS GROUP

DATE: JUNE 22, 1994

A group of Washington representatives of companies and trade associations and some independent lobbyists have formed a working group under the leadership of former Congressman Jim Moody (D.WI) and Letitia Chambers of Chambers Associates, and Bob Diamond of Whitten and Diamond.

These individuals are working in support of many of the President's principles, most especially universal coverage and employer responsibility/mandates.

They have acted as an umbrella group to invite companies not in their group to a meeting with Senator Daschle, Representative Gephardt and now Secretary Shalala on June 23.

Their next small core meeting will be on June 29 at Head's at 8:00 a.m. in the Truman Room.

They then plan meetings on July 13, July 27 and August 8, and others as needed.

A large group of administration representatives including Steve Ricchetti, Alexis Herman, Greg Lawler, Ed Knight, Matt Gorman and I attended the first meeting of the group.

As the committees complete their work, I understand that the group will approach others who may support final passage, and will continue to pull together a group which can work for this result.

From time to time they will be inviting representatives of the administration to attend the first part of their meetings for a briefing on our positioning on the bills. I hope you will accept as your schedule permits.

cc: Alexis Herman
Steve Hilton
Greg Lawler

BAKER & HOSTETLER

COUNSELLORS AT LAW

Washington Square, Suite 1100 • 1050 Connecticut Avenue NW • Washington, DC 20036 • (202) 861-1500
Fax (202) 861-1783 • Telex (650) 2357276

TELECOPIER COVER SHEET

DATE: June 22, 1994 LAW#:0081

CLIENT CODE: 82169-88001

TO: Chris Jennings
Congressional Liaison to the First Lady

FROM: Fred Graefe

MESSAGE: I will call to discuss.

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H.R. 4610

IN THE HOUSE OF REPRESENTATIVES

Mr. LaFALCE introduced the following bill; which is referred to the Committees on Ways and Means and Energy and Commerce jointly.

A BILL

To amend Title XVIII of the Social Security Act to provide for coverage of self-administered Betaseron treatments for Multiple Sclerosis under the Medicare program, and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Multiple Sclerosis Home Treatment Equity Act of 1994".

SEC. 2. COVERAGE AND PAYMENT OF SELF-ADMINISTERED BETASERON UNDER MEDICARE.

Section 1861(s)(2) of the Social Security Act [42 U.S.C. 1395x(s)(2)] is amended--

(a) By striking "and" at the end of subparagraph (P);

(b) By striking the period at the end of subparagraph (Q) and adding in lieu thereof, "; and"; and

(c) By adding at the end the following new subparagraph:

"(R) betaseron (Interferon beta-1b) for patients with multiple sclerosis competent to use such biological without medical or other supervision with respect to the administration of such biological, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such biological, and items related to the administration of such biological."

SEC. 3. REGULATIONS.

The Secretary of Health and Human Services shall, not later than 150 days after the date of enactment of this Act, issue final regulations setting forth standards and methods for safe and effective use of bateseron for purposes of payments under Section 2 of this Act.

SEC. 4. EFFECTIVE DATE.

The amendments made by section 2 of this Act shall apply to payments for items and services furnished on or after October 1, 1994.

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 103d CONGRESS, SECOND SESSION

Vol. 140 WASHINGTON, TUESDAY, JUNE 21, 1994 No. 79

House of Representatives

LEGISLATION TO PROVIDE MEDICARE COVERAGE FOR BETASERON

HON. JOHN J. LaFALCE

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 21, 1994

Mr. LAFALCE. Mr. Speaker, I am today introducing a bill, the Multiple Sclerosis Home Treatment Equity Act of 1994, to provide Medicare reimbursement of Betaseron, the only approved biological treatment developed specifically for persons suffering from multiple sclerosis.

It has been estimated that more than 300,000 people in the United States have been diagnosed with multiple sclerosis, or MS. The disease usually strikes at the prime of productive life—most people are diagnosed with MS between age 20 and age 40. MS attacks the central nervous system, producing an inflammation in the brain and spinal cord, which in turn causes scarring lesions on the nerves and a multitude of debilitating symptoms. The symptoms of MS are highly individual, but may include fatigue, impaired vision, loss of muscle coordination, tremors, and bladder and bowel problems.

The most serious symptom of MS is the occurrence of periodic flareups, called exacerbations, of symptoms. Without treatment many individuals experience a progressive worsening of these exacerbations, generally leading to steady physical deterioration and permanent disability.

Of the estimated 300,000 people affected with MS, approximately 25 percent have been diagnosed with relapsing/remitting MS. In relapsing/remitting MS, the exacerbations occur less frequently, and recovery from the exacerbations is generally complete or partial. Although individuals experience plateaus of stable impairment, during which they are generally able to perform the functions of normal daily life, they are often partially impaired and are at risk of further progression of the disease.

FDA APPROVED TREATMENT

The Food and Drug Administration has recently approved a treatment called Betaseron for use by those with relapsing/remitting MS. Betaseron is a revolutionary biological agent which has been shown in clinical tests to be effective in decreasing the frequency and severity of exacerbations in relapsing/remitting patients.

The most significant aspect of Betaseron is that it reduces the formation of lesions on the nerves. Since these lesions are widely thought to be related to the progression of the disease, Betaseron could very well be slowing the physical deterioration of the individual. Individuals afflicted with relapsing/remitting MS may therefore lead more productive lives with Betaseron, and avoid many of the health care costs associated with advancing MS.

Recognizing the profound potential of Betaseron, the FDA used a new accelerated approval process to speed consumer access to the treatment. The Agency approved Betaseron as a generally self-administrable biological agent, meaning that patients who are able can inject themselves with Betaseron at home. Betaseron must be injected under the skin every other day. Unfortunately, the injections, even performed at home, are very expensive, costing approximately $1,000 every month. Without health care coverage which provides reimbursement for home injections, most people with MS would not be able to afford Betaseron.

There are approximately 17,000 people eligible for Medicare who have relapsing/remitting MS. Currently, Medicare only covers treatments received in a physician's office. Medicare does not cover prescription drugs or self-administered injections, and therefore does not cover Betaseron. This presents a problem for people diagnosed with relapsing/remitting MS who become eligible for Medicare. Many beneficiaries are forced to give up their private insurance upon eligibility, only to find that they are no longer reimbursed for the treatment that is so beneficial. They are then forced to find ways to cover the large expense of Betaseron on their own, although they are unable to work, or forego its beneficial effects.

The tragedy of this situation was highlighted for me by the experiences of a man from my district, Mr. Kevin Cloy. Mr. Cloy is 31 years old, and was diagnosed with relapsing/remitting MS in 1990. Mr. Cloy was forced to quit his job due to the disabling effects of MS. In March, Mr. Cloy became eligible for Medicare, losing his private insurance coverage.

Last December, Mr. Cloy became one of the first people to receive Betaseron after FDA approval. Betaseron treatment has done wonders for Mr. Cloy. He is now able to walk, whereas before Betaseron he was confined to a wheelchair. His wife is now able to go to work without worrying about what might happen to him during the day. Mr. Cloy wants to eventually return to work, to again be a productive member of society. With Betaseron this may be possible.

However, Mr. Cloy and his family can no longer afford to pay for Betaseron. The community of Middleport, NY, recently organized a successful fundraiser. But this offers only a temporary solution.

NEED FOR MEDICARE COVERAGE

We must change the inequity in the Medicare system, in which some beneficiaries are covered for Betaseron treatments and some are not. Medicare coverage of Betaseron is needed so that all of those afflicted with relapsing/remitting MS can have the potential of returning to a more normal, productive life.

Mr. Speaker, in this historic time when Congress is actively addressing national health care reform, it is clear that our system must provide better care to more people at a lower cost. One way to accomplish these goals is to focus on preventive care.

I believe that providing access to Betaseron for those afflicted with MS is an excellent example of the financial benefits of preventive care. In slowing the progression of the disease, and allowing these individuals to return to productive lifestyles, Betaseron provides benefits which, in the long term, may far exceed the cost of providing the treatment.

I believe that it is time we act to make this critical treatment available to all eligible Medicare beneficiaries. I urge the Congress to adopt this important legislation.

Chris ——— ———

Here is a list of
what my notes say
we promised at
our sunday meeting
with CF, et al.

-Larry +
Gary

1. Look at Durenberger "medical necessity" language. Does it add costs or cost less; what are the implications?

   From Jennifer: Very bad; disturbing. Defines medical necessity in statute as a "clinically meaningful" benefit. Only one-half of what medical necessity is. Lightening rod for discussions. Defines in terms of outcomes; should look at things like length of illness; patient satisfaction. Does not deal well with assistance in functioning (only deals with changes in health status; not assistance).

   Jen knows of no reason why CBO would say it costs less.

2. Estimate the premium in the first five years under the following:

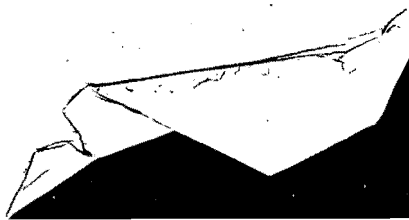
   Benefits package actuarially equivalent to BCBS low option.
   Voluntary market.
   Insurance reforms (guaranteed issue; portability; age-adjusted community rating)
   Medicaid is outside of community pool.
   Assume early retirees with employer provided coverage remain part of employer's pool.
   Public employees in the community pool.
   Firewall at firm size 100 for community rating and self-insurance.

3. Medicaid related issues.

   a. What are issues of leaving Medicaid recipients outside of the community pool?
   b. What are the implications of the Moynihan Medicaid managed care bill?
   c. What are issues related to requiring states to give AFDC recipients the option to join a plan or remain in Medicaid?
   d. What are the issues associated with full or partial integration of SSI into plans?

      -- How do you set the proper capitated payment?
      -- How are wrap around services handled?
      -- What type of care/services would they receive in a capitated environment?

4. Analysis of individual wage caps (presumably off the shelf).



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

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

TO: Judy Wherry / Chris Jennings *FROM:* Budget Taylor

NAME: *NAME:*

OFFICE: *OFFICE:*

ROOM NO.: *ROOM NO.:*

PHONE NO.: *PHONE NO.:*

FAX NO.: 456-7431 *DATE:*

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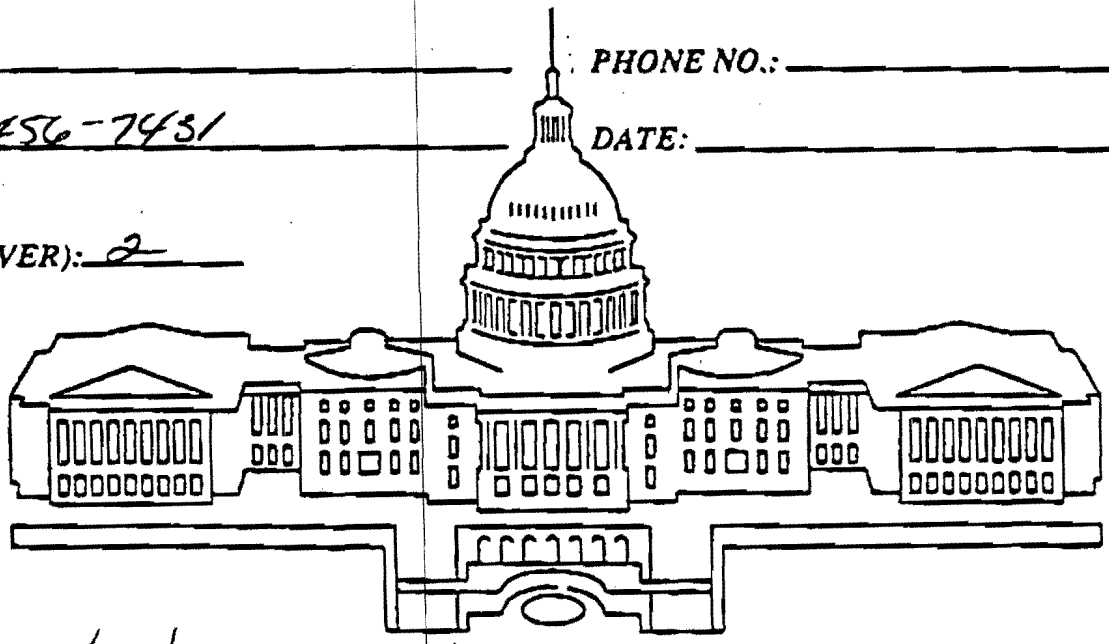

REMARKS:

Another request!

BT

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: Bridget Taylor

DATE: 6/22/94

PRIORITY:

SAME OR NEXT DAY: [redacted]
2 TO 3 DAYS: X
WITHIN 1 WEEK: _____
WITHIN 2 WEEKS: _____
OTHER: _____

REQUEST FROM: DEBBIE CHANG

COMMITTEE: SFC

PHONE: 224-3612 FAX: [redacted]

REQUEST: SEE ATTACHED — JUDY — THIS NEED TO BE ASSIGNED — KEN OR DON?! — YOU PICK! TBT

ASSIGNMENT:

TO: _____

DATE: _____

DUE DATE: _____

STATUS:

ASSIGNED _____ OMB REVIEW _____ COMPLETED _____

NOTE: _____

June 13, 1994

NOTE TO: Chris Jennings
Judy Whang
Ken Thorpe

FROM: Bridgett Taylor

SUBJECT: Request from Senate Democratic LAs (Debbie Chang) on community rates.

Debbie Chang has requested that we run numbers for her on what would happen to the community rate if the Medicaid population (excluding SSI) were integrated into the community rated pool in businesses below:

1) 500
2) 250
3) 100

Debbie would also like to know what the current per capita spending (national average) on Medicaid is broken out into AFDC/SSI and noncash groups.

Let me know if I can provide further information on these subjects.

cc: Jerry Klepner
Karen Pollitz
Don Johnson

MAINSTREAM COALITION PROPOSED AGREEMENT JUNE 24, 1994

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I. COVERAGE

A. Expanded Tax Deductibility

The health insurance deduction for self-employed persons is extended permanently and phased in to cover 100% of the cost of qualified health plans.

A medical expense deduction for health insurance premiums for individuals is added and phased in to permit the deduction of 100% of the taxpayer's cost for a qualified health plan.

B. Low Income Assistance

Low-income individuals will receive subsidies to purchase health insurance. By 1997, individuals and families with incomes below 90% of the federal poverty level (who are not eligible for Medicaid) will receive a subsidy to purchase health care insurance through accountable health plans.

By 2002 the subsidy will be phased-in for those with incomes up to 240% of poverty. At 100%, the subsidy covers the full premium, up to the "applicable dollar limit". Federal assistance phases out at 240% of poverty.

Federal Subsidies for low-income families and individuals will be based on the standard benefit package. For individuals and families with incomes above 200% of the federal poverty level, subsidies could be used for the purchase of the standard benefit package, or the basic benefit package.

C. Mechanism to Assure Full Coverage

The Health Commission will report to Congress every 2 years on the demographics of the uninsured, and its findings on why those individuals are uninsured.

In the event 95% of all Americans do not have health insurance by 2002, the

The package will be reported to Congress. Any legislation resulting from the package must be considered within a limited time period and would be fully amendable on the floor.

Commission will develop a package of recommendations to Congress designed to reach universal coverage.

~~At the end of six months, if Congress fails to act on the Health Commission recommendations or defeats their recommendations without enacting an alternative, a requirement that individuals have insurance coverage is automatically imposed and can be satisfied by coverage under either a standard package or a basic package.~~

~~Those residing in Health Care Coverage Areas where coverage is at or above 95% will be exempt from this requirement.~~

II. EXPANDED ACCESS TO HEALTH COVERAGE

A. Insurance Market Reforms and Standards for Accountable Health Plans

The Secretary shall, in consultation with private expert entities, develop standards for health plans within six months of enactment. Whenever a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or health plan sponsor.

States will enforce the standards set forth in this Act pursuant to regulations issued by the Secretary.

These requirements apply to all certified health plans. Special rules regarding the application of these requirements to large employers and the self-insured are in the sections relating to employers.

- Guarantee availability throughout the entire HCCA in which the plan is offered;
- Guarantee eligibility to all applicants;
- Guarantee renewal to all enrollees, except in instances of non-payment of premiums, fraud or misrepresentation, or relocation outside the area.
- No denial, limitation, or condition of coverage based on health status, claims experience, or medical history during the annual open enrollment period.

- Individuals enrolling in a plan for the first time or after a long gap in coverage may be subject to a pre-existing condition limitation of no more than six months.

- Comply with all rating requirements, including age adjustment and family class, established within the coverage area. Special rules apply to large employers not eligible for the HCCA pool.

- Comply with open enrollment process established by the state and establish enrollment processes consistent with the requirements of this act;

- Comply with financial solvency requirements, premium and collection criteria.

- Participate in a risk adjustment program designed by the Secretary and administered by the states, in accordance with the factors and rules set forth in this act; States may apply for a waiver from the Secretary to establish alternative risk adjustment mechanisms;

- Collect and provide standardized data collection and reporting requirements, and comply with confidentiality standards;

- Establish dispute resolution processes in accordance with this act;

- Provide written information to all enrollees regarding a patient's right to
self-determination in health care services;

- Meet requirements for designated underserved areas.

The following state laws relating to health plans are preempted.

- State laws that have the effect of prohibiting or restricting plans from:

  - limiting the number and type of providers who participate in the plan;
  - requiring enrollees to obtain health services from participating providers;
  - requiring enrollees to obtain referral for treatment by a specialist

or health institution;
- establishing different payment rates for participating providers;
- creating incentives to encourage the use of participating providers;

- State corporate practice acts;

- State mandated benefit acts.

B. Other Qualified Health Plans

Employer Sponsored and Group Health Plans

Employer-sponsored health plans (risk-bearing) and group health plans (a combination of risk-bearing and commercial insurance) must meet the same insurance reform requirements as other accountable health plans, including no pre-existing conditions, open enrollment, guaranteed issue, guaranteed renewal, etc. They must offer the standard and basic benefit packages. They also must meet solvency requirements for risk-bearing plans that will be developed by the Department of Labor.

Qualified Association Health Plans

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

"Qualified Association Plans" must be organized and maintained in good faith, with appropriate by-laws that specifically state the purpose, as a trade association, industry association, professional association, Chamber of Commerce, a religious organization, or a public entity association and that the entity has been established and maintained for substantial purposes other than to provide the health care required under this section; and the sponsoring entity is and has been in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years and receives the active support of its membership.

Any arrangement that, as of June 1, 1994, has been in effect for not less than 18 months and with respect to which there is pending application with the State insurance commissioner for a certificate of operation as a health plan, shall be treated for purposes of this subtitle as a qualified health plan (if such a plan otherwise meets standards under this subtitle) unless the State can demonstrate that –

(1) fraudulent or material misrepresentations have been made in the application which are hazardous to the State;

(2) a disqualification of the sponsor of the applicant entity has occurred;

(3) the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or

(4) a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operations.

Rural Cooperatives and Multi-Employer Plans (Taft-Hartley)

Existing Rural Cooperatives must meet the same rules as qualified association plans . They must meet solvency requirements developed by DOL and take all comers in their cooperative. Otherwise, all accountable health plan insurance reform requirements apply.

Multi-Employer (Taft-Hartley) plans must meet the same rules as large employers. They must meet the same insurance reform requirements as other health plans, including no pre-existing condition, open enrollment, guaranteed issue, guaranteed renewal, portability, etc. They also must offer the standard benefit package. They also must meet solvency requirements for risk-bearing plans that will be developed by the Department of Labor.

C. State Responsibilities

Within one year of the promulgation of this act, states must carry out the following responsibilities:

establish the HCCAs, including interstate HCCAs, consistent with the requirements of this act; states may submit waiver applications,

according to HHS criteria, in the drawing of boundaries for HCCAs.

provide procedures for the establishment and operation of individual and small business purchasing groups, rules governing sales by agents or direct sales of health plans, rules for the annual open enrollment period, and other oversight responsibilities;

oversee standardization of information about health plan performance consistent with the requirements of this act;

implement a ~~establish a~~ risk adjustment program developed by the federal government to ensure the ~~fair~~ allocation of risks among health plans operating with each coverage area;

certify that health plans comply with the requirements of this act, and provide monitoring of health plan standards;

establish (monitor) dispute resolution processes consistent with the health plan standards.

The bill divides employers into two classes, based on employer size.

Small Employers: 100 full-time employees or less. May purchase an accountable health plan at the adjusted community rate through either independent brokers or insurance agents, cooperatives or private, non-profit purchasing groups or public enrollment sights.

Large Employer Group Purchasers: More than 100 full-time employees. Large employer group purchasers may offer either accountable health plans for which the employer negotiates the rate (experience-rated), employer-sponsored health plans (risk-bearing plan) or a combination of the two as a group health plan. Large employers may group together to negotiate and purchase accountable health plans or to offer employer-sponsored plans. Large employers are not part of the community-rated pool.

All employers must provide their employees with information regarding their health plan options. If the employee requests, employers must enroll them in their choice of health plan and deduct the amount of the premium from wages, minus any employer contribution. Employers are neither required, nor precluded from contributing to the cost of employee health coverage.

Nondiscrimination provisions that apply to all employers:

Employers cannot discriminate in the provision of health insurance to either full- or part-time employees based on their eligibility for low-income subsidies.

Employers who contribute to the purchase of any full-time employee's health insurance must make an equal contribution on behalf of all full-time employees. Employers who contribute to the purchase of any part-time employee's health insurance must make the same dollar contribution for all part-time employees.

A full-time employee is defined as an individual who is employed for 30 or more hours per week. A part-time employee is defined as an individual who is employed for at least 10 but less than 30 hours per week.

For purposes of the nondiscrimination rules, an individual does not qualify as a full-time or part-time employee if the individual is a seasonal employee and/or until the individual has been employed for six months.

An employer who contributes to the purchase of an employee's health insurance must make the same dollar contribution regardless of the health plan chosen by the employee.

Accomodation for collectively-bargained plans will be considered.

~~In order to prevent employers from "dumping" employees into the community-rated pool, employers must offer—but not pay for—health coverage for all full-time employees, part-time employees, and pre-medicare retirees. Large employers are also prohibited from creating subsidiaries or otherwise segmenting their workforce based on health status, health risk, or anticipated need of health care services.~~

Small employers will pay any qualified health plan selected by the employee an amount equal to the contribution they would make on the employee's behalf to the employer-selected health plan. A point of service option plan will be offered in the small group market, if available. Large employers must offer their employees (including part-time and seasonal workers) a choice of at least three health plans--one of which is a point of service option plan, if available in the area. Employers may meet

this obligation by offering qualified association plans.

E. Individual and Small Employer Purchasing Groups

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

Purchasing groups would be permitted to contract selectively with qualified health plans. If a cooperative negotiates a price lower than the community rate, that price becomes the plan's new community rate.

F. Allowing Access to Federal Employee Health Benefit Plans

Any plan under the Federal Employee Health Benefit plan offered to federal employees in a State-designated community-rated area must be available for purchase by individual and small group purchasers in that area. Non-federal employee purchasers shall pay a premium amount based on the local community rate for that plan, and shall not be a part of the FEHB insurance pool. Plans offered nationally through FEHB shall not be required to be open to non-federal employee enrollment.

G. Improving Access in Underserved Areas

Community-Based Primary Care Grant Program

The HHS Secretary will establish a program to administer grants to the states for the purpose of creating or enhancing community-based primary care entities that provide services to low-income or medically underserved populations.

Enhanced Assistance for Community Health Centers and Federally Qualified Health Centers

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

additional provisions on rural working group should be expected.

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

Physicians practicing in rural, frontier, or underserved urban areas are allowed a tax credit equal to $1,000 a month, up to a total of $36,000. Nurse practitioners and physician assistants would also be eligible for a similar credit equal to $500 per month.

Loan repayments under the National Health Service Corps Loan Repayment Program are excluded from taxable income.

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

Interest, up to $5,000 annually, paid on education loans of a physician, registered nurse, nurse practitioner, or physician's assistant is allowed as an itemized deduction if the individual agrees to practice in a rural community.

Development of Networks of Care in Rural and Frontier Areas

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

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

Rural and Frontier Emergency Care

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

Rural community hospitals meeting eligibility criteria may qualify as Rural Emergency Access Community Hospitals (REACHs). This program will permit existing rural community hospitals participating in the Medicare program to maintain their current status if they meet standards of eligibility

as a rural emergency access facility. Current special reimbursement to small rural Medicare-dependent hospitals enacted in Omnibus Budget Reconciliation Act of 1989 will be extended.

H. Long Term Care

Tax Provisions

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

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

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

A structure will be provided for home and community-based care.

I. Accelerated Death Benefits

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

III. FISCAL RESPONSIBILITY

A. Financing (Estimated Over 5 years; $ in Billions)

Medicare Savings (must be increased to accomodate for decrease in tobacco tax	~~$54~~
Medicaid Savings	$55.8
Postal Service Retirement	$13.0
SUBTOTAL SPENDING REDUCTIONS	$154.7