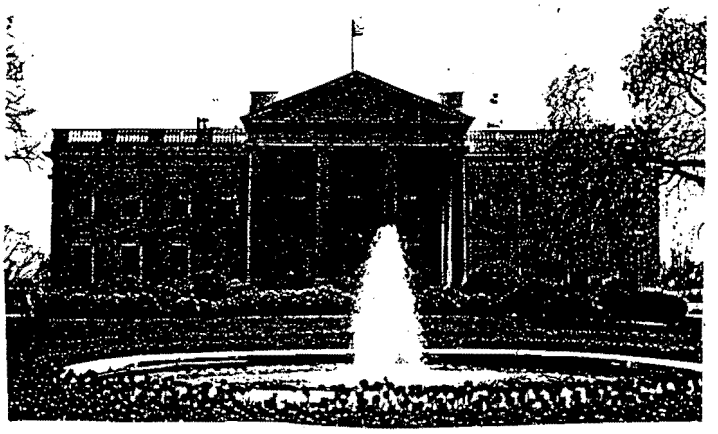
THE WHITE HOUSE

WASHINGTON



Fax Cover Sheet

DATE: 6/6 **TIME:** 12:25 pm

TO: Nancy Ann Min, Len Nichols, Judy Feder, Ken Thorpe

PHONE: _____ **FAX:** 5-7289 5-3980 690-7383 401-7321

FROM: Chris Jennings

PHONE: 202-456-_____ **PAGES AFTER COVER:** 5

COMMENTS: Jane Horvath is asking us for last minute help for possible alternatives for the Medicaid formula issue. Please review and let me know if and when such an analysis can be completed (very important -- because it's very important to Moynihan).

DANIEL P. MOYNIHAN
NEW YORK

United States Senate

WASHINGTON, DC 20510-3201

(202) 224-4451

FAX COVER SHEET

456-7431

TO: Chris Jennings

FROM: Jocelyn Guyer per request of Dave Hamm

SUBJECT: Attached are 2 memos sent to CBO on alternative Medicaid formulas.

COMMENT: At this point the priorities — the alternatives for which we need info ASAP — are Option I and Option II (second memo)

TOTAL PAGES INCLUDING COVER: 5

DATE: 6/6/94

TIME: 9:45

MEMORANDUM FOR PAUL VAN DE WATER

FROM: JOCELYN GUYER & JANE HORVATH

SUBJ: COST ESTIMATES ON MEDICAID FORMULA CHANGES

DATE: JUNE 2, 1994

We would like CBO to provide information on the effect on States and the Federal Government of various changes to the Medicaid formula. The scenarios fall into two general categories: (1) variations on GAO's recommended changes to the formula, and (2) enhanced FMAPs exclusively for home and community based care services. In addition, we would like to know what would happen if all States were given the same FMAP.

We realize that GAO has conducted similar analyses in the past, but their database does not contain any Medicaid expenditure data from after Fiscal Year 1991.

If you have questions about this request, please call Jocelyn Guyer at 224-9573.

Variations on GAO's Medicaid formula recommendations

For each of the options described below, please provide at a minimum information on the following:

- Matching rates for each of the States
- Federal Medicaid expenditures in each of the fifty States under the proposed versus the current formula
- Total Federal Medicaid expenditures under the proposed versus the current formula
- The cost of giving States the option of selecting whether they want their FMAP based on the current formula or the proposed formula

Option 1

- Replace per capita income in the formula with a measure of poverty
- Replace per capita income with a measure of total taxable resources
- Assume no increase in Federal spending
- Maintain the existing 50% floor on FMAPs

Option 2

- Same as option 1, except allow for a 5% increase in Federal spending

Option 3

- Replace per capita income in the formula with a measure of poverty
- Allow per capita income to remain in the formula as a measure of States' fiscal capacity (i.e, do not substitute total taxable resources)
- Assume no increase in Federal spending
- Maintain the existing 50% floor on FMAPs

Option 4

- o Same as option 3, except allow for a 5% increase in Federal spending

Enhanced FMAP for home & community based care services

For each of the options described below, please provide information on the following:

- o Each State's new FMAP for home & community based care services
- o Federal expenditures in each State for home & community based care services
- o The total cost to the Federal government of providing the enhanced match

We also would like to know what assumptions CBO would make about the behavior of States if an enhanced match were provided for home & community based long term care services. In particular, to what extent would States be expected to increase (or decrease) their expenditures on home and community based care as a result of a higher FMAP. If they increased spending on home & community based care services, would they also be expected to decrease funding in other areas (e.g., institutional care).

Option 6 --

- o Provide an enhanced FMAP for home & community based long term care services equivalent to the current FMAP + 10%
- o Set minimum FMAP at 60% and maximum at 85%

Option 7

- o Provide an enhanced FMAP for home & community based long term care services equivalent to the current FMAP + 10%
- o Set minimum FMAP at 60% and maximum at 75%

Option 8

- o Provide an enhanced FMAP for home & community based long term care services equivalent to either a State's current FMAP or 80%, whichever is higher

Option 9

- o Provide an enhanced FMAP for home & community based long term care services equivalent to either a State's current FMAP or 75%, whichever is higher

Providing all States with the same FMAP

Finally, we would like a CBO analysis of the effects of giving all States the same FMAP. The FMAP should be set at a level that would not cause Federal spending to increase above the Medicaid baseline. What would the new FMAP be? How would each State fare under such a proposal?

MEMORANDUM FOR JEAN HEARN

FROM: JOCELYN GUYER & JANE HORVATH

SUBJ: ADDITIONAL INFORMATION ON FMAP REQUEST

DATE: JUNE 6, 1994

We had sent a memo to Paul Van De Water on Friday, June 3 regarding cost estimates for various changes to the Medicaid formula. We would like a CBO cost estimate on one additional version of the formula, a description of which is attached. Also, in terms of establishing priorities among these various formulas, we would like to see as soon as you finish them cost estimates for option 1 and for the formula described in the attachment. Finally, we should have clarified the following in the original memo:

1. For option 1, 2 and 3, the multiplier in the formula needs to be changed (i.e, the current multiplier is .45). It should be set at a rate that would result in the total amount of payments to states for 1994 through 1998 being equal to what they would have been without a formula change. (In option 2, it would need to be set at a level that generates payments 5% above the baseline).
2. By "home and community based care" we mean personal assistance services and Medicaid spending on home and community based care waivers. In the cost estimates, please break out the cost of providing the enhanced FMAP to these two areas.

Option 11

Enhanced FMAP for home & community based care services based on the GAO's recommended changes & the Clinton Administration's long term care FMAP

- o Provide an enhanced FMAP for home & community based care services
- o The "base" FMAP should be based on total taxable resources & the poverty rate for each State. The multiplier should be changed as necessary.
- o To the base, should be added 28 percentage points
- o The range of FMAPs should be restricted to 78% to 95%

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

June 1, 1994

MEMORANDUM TO: IRA MAGAZINER
LAURA D'ANDREA TYSON
ALAN BLINDER
PAMELA SHORT
ROGER ALTMAN
LES SAMUELS
MARINA WEISS
ERIC TODER
KEN APFEL
JUDY FEDER
KEN THORPE
BO CUTTER
GENE SPERLING
JODY GREENSTONE
JACK LEW
CHRIS JENNINGS
OLENA BERG
JONATHAN SILVER

FROM: ALICE M. RIVLIN

SUBJECT: HEALTH REFORM POLICY GROUP MEETING

This will remind you of our weekly policy meeting on Thursday, June 2, at 5:00PM in room 248/Old Executive Office Building. The topic will be the three-tiered "trigger" for coverage that is being discussed by Senator Breaux and others. Enclosed is a description of this policy provided by Senator Breaux's staff.

If you cannot attend this meeting, please notify Karen Dooley at 395-5178.

Enclosure

		(fax #)
FAX TO:	IRA MAGAZINER	Room 216/OEOB
	LAURA D'ANDREA TYSON	x56958
	ALAN BLINDER	x56958
	PAMELA SHORT	x56853
	ROGER ALTMAN (Joan)	9-622-0404
	LES SAMUELS	9-622-0646
	MARINA WEISS (or Nancy)	9-622-2633
	ERIC TODER	9-622-0646
	KEN APFEL (or Azalie)	9-690-5405
	JUDY FEDER (or Megan)	9-690-7383
	KEN THORPE (or Veronica)	9-401-7321
	BO CUTTER	Room 231/OEOB
	GENE SPERLING (or Paul)	x62878
	JODY GREENSTONE	62216
	JACK LEW (Hans)	x67431
✔	CHRIS JENNINGS	x67431
	OLENA BERG (or Rico)	9-219-5526
	JONATHAN SILVER (or Rona)	9-482-2741
	MARJORIE TARMEY	Room 214/OEOB

NO EMPLOYER MANDATE, BUT ALL EMPLOYERS SUBJECT TO HARD TRIGGER

FIRMS WITH 100 OR MORE EMPLOYEES: three years after enactment, if market reforms in a voluntary system do not result in 85% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...11%
# of uninsured employees in this category.....7.4 million
(85% of 7.4 million = 6.3 million)

% of all firms.....1.6%
% of all employees.....60.8%

FIRMS WITH 25 TO 99 EMPLOYEES: four years after enactment, if market reforms in a voluntary system do not result in 80% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...21%
# of uninsured employees in this category.....3.3 million
(80% of 3.3 million = 2.6 million)

% of all firms.....6.5%
% of all employees.....15.9%

FIRMS WITH FEWER THAN 25 EMPLOYEES: five years after enactment, if market reforms in a voluntary system do not result in 75% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...26%
# of uninsured employees in this category.....9.8 million
(75% of 9.8 million = 7.4 million)

% of all firms.....91.9%
% of all employees.....23.0%

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

URGENT

June 1, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2855

TO: Legislative Liaison Officer -

DEFENSE - Samuel T. Brick, Jr. - (703)697-1305 - 325
HHS - Frances White - (202)690-7760 - 328

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

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

SUBJECT: VA Proposed Testimony RE: S 1757, Health Security Act

DEADLINE: NOON June 2, 1994

COMMENTS: Senator Packwood's Field Hearing (Portland, Oregon) on VA's future under health care reform. The hearing is on Friday, June 3rd. The VA witness will be Barry Bell, Director of the Portland VAMC.

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

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

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew
Lynn Margherio
Jennifer Klein
Greg Lawler
Jason Solomon
Meeghan Prunty
Frank Reeder
Todd Grams
Shannah Koss
Barry Clendenin
Janet Forsgren

LRM #I-2855

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

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

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

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

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: VA Proposed Testimony RE: S 1757, Health Security Act

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

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

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

DRAFT

OCA Draft # 5

STATEMENT OF
BARRY. L. BELL, DIRECTOR
PORTLAND VETERANS AFFAIRS MEDICAL CENTER
BEFORE
SENATOR PACKWOOD'S FIELD HEARING ON
HEALTH CARE REFORM
JUNE 3, 1994

Good afternoon. It is a pleasure to be here today and to have this opportunity to speak to you about the Department of Veterans Affairs' future under national health care reform. And it is especially fitting now, as we pause to reflect on the 50th anniversary of the end of World War II, to reiterate our commitment to the millions of brave Americans who served so valiantly on our behalf each time the nation called upon them to do so.

When the President submitted his proposal for health care reform to Congress on November 20, 1993, he set forth the goal of a future in which all Americans would be guaranteed access to affordable health care. The President's proposal also gives VA the opportunity to enter into a new era in delivering health care services for veterans.

To help usher in that change, in October of last year, VA established a National Health Care Reform Office. Its charge is to plan, develop and implement a coordinated and comprehensive approach to VA's successful participation in national health-care reform, which will help guide the Secretary and other top management in this new endeavor. I have provided a copy of the first report produced by that office, which identifies the areas in which VA must concentrate its efforts to prepare for reform.

Under the President's proposal for health-care reform, VA would remain an independent health-care system and would give all 27 million veterans and their families the opportunity to enroll in a VA health care plan similar to private sector plans offered to other citizens. The VA, in turn, would be able to receive premiums and payments from the responsible payers, just as any other health care provider would.

This would mean that any veteran who enrolls in a VA health-care plan would receive the comprehensive benefits package described in the President's proposal. This would ensure that all VA enrollees would have available to them a full continuum of inpatient and outpatient care. That continuum of care is not available from the VA for most veterans under current law.

DRAFT

All veterans who have service-connected disabilities, low-income veterans, and veterans who are ex-POWs who choose a VA health plan would receive the comprehensive benefits package totally free; they would pay no premiums, no copayments, no deductibles. For the great majority of these veterans, this would constitute a vast expansion of VA preventive and outpatient care benefits and elimination of the current VA medication copayment requirements.

These service-connected veterans would include all veterans with a service-connected disability, more than 3 million veterans. The low-income veterans include all veterans with annual incomes below the following levels (which are annually adjusted for inflation): $19,912 for a veteran with no dependents and $23,896 for a veteran with one dependent, with $1,330 more allowed for each additional dependent. There are an estimated 6.8 million veterans who would qualify for free care on this basis, including some number of service-connected veterans having dual eligibility under these criteria. Higher income, non-service-connected veterans who have Medicare eligibility would be able to use their Medicare benefits to obtain VA care.

Under the President's proposed health care reform plan, VA would continue to receive appropriations to its medical care account. In addition, for the first time, VA would also retain payments from third parties and use those funds to provide health-care services. VA will receive premium payments provided by veterans' employers for each employed veteran and family member who chooses to enroll in a VA plan. VA will also retain the copayments and deductibles it receives from higher-income, non-service-connected veterans and for the care of dependents, the premiums VA collects from the sale of supplemental benefits, and the payments it receives from other plans for the furnishing of care to other plans' patients.

In addition, the President's proposal authorizes a $3.3 billion investment fund ($1 billion in FY 95, $0.6 billion in FY 96, and $1.7 billion in FY 97) to assist in the establishment and operation of VA health plans.

The scenario I just described is one that would ensure the viability of VA, and beyond that, would give VA the opportunity to flourish as a significant provider in the American health care marketplace for the following reasons:

- All veterans who choose VA as their provider will receive care and treatment based not on our current complex eligibility rules but, rather, based on medical need and the spectrum of services included in the comprehensive benefits package.

- As VA recognizes, in the new competitive environment, we will need to improve access to care by establishing clinics in communities where veterans

DRAFT

do not today have convenient access to VA services. In addition, long waiting times for health care services will have to be eliminated.

- In combination with Federally appropriated funds, new funding streams would give the VA system new stability and the opportunity to compete effectively.

The significant changes to the VA health care system afforded by the proposal, along with other provisions granting VA the flexibility now available to other health care providers, are all part of a formula that we believe is essential for the success of VA under national heath care reform. The President's proposal builds upon the strengths of the VA system and provides an excellent starting position to implement the major changes that health care reform will bring to the country. For example, we already function under a managed care structure that could be expanded upon under reform. In addition, our costs for providing care are comparable or lower than those in the private sector, and the quality, overall, has been notably higher, according to the findings of the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

I do not want to minimize the challenges to VA, however, which are formidable. VA has never before had to "compete" for patients. We have never had to make customer service our number one priority, above all others. And we have never had to develop and implement business plans in the strict sense. But we welcome the challenge because it affords us an opportunity to improve and grow and because it will allow us to carry out our mission of caring for our nation's veterans.

Senator, the Department of Veterans Affairs and the facilities serving Oregon veterans have set forth their visions to become successful participants in the reformed national health care delivery system that I hope this country will soon enjoy. Last Fall, in anticipation of health care reform legislation my staff and I at the Portland VA Medical Center began a strategic management process. Its purpose is to identify the changes we need to make to enhance customer service and efficiency and to ensure that our facility meets the standard that would be expected of the very best provider in the community, while retaining the high quality of care we have always given our veterans. We are well on our way to identifying and making those changes which would allow us to provide to every veterans choosing the VA plan, comprehensive care based on a primary care model. We plan to offer a full range of services, enhanced by education and research, benefiting veterans, their families, and the nation as a whole.

As Secretary Brown stated in his May 18, 1994 letter to Members of Congress, "The veterans' health-care provisions in the President's bill are critically important to the future of the VA." The Secretary also recognized that the final health-care reform package may differ from the President's proposal, and urged all members of Congress to help ensure that any health-care reform legislation finally enacted will

DRAFT

achieve for veterans the kinds of improvements that the President's plan would provide.

I would be pleased to respond to any questions you may have.

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

SPECIAL

June 1, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2856

TO: Legislative Liaison Officer -

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

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

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

SUBJECT: OPM Qs and As RE: HR 3600, Health Security Act

DEADLINE: 4:00 P.M. June 2, 1994

COMMENTS: HOUSE COMMITTEE ON WAYS AND MEANS DATA REQUEST -- The attached table provides FEHBP weighted average monthly premiums (program-wide).

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

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

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew
Lynn Margherio
Judy Feder
Judy Whang
Jennifer Klein
Bob Rideout
Al Seferian
Len Nichols
Meeghan Prunty
Janet Forsgren

LRM #I-2856

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

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

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

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

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: OPM Qs and As RE: HR 3600, Health Security Act

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

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

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

FEHB Weighted Average Monthly Premiums – Programwide

Calendar Year	1984	1985	1986	1987	1988	1989
Weighted Avg Monthly Premium	151.40	149.68	132.57	155.74	196.99	236.86
% Change	9.9%	-1.1%	-11.4%	17.5%	26.6%	20.3%
Calendar Year	1990	1991	1992	1993	1994 **	
Weighted Avg Monthly Premium	256.46	268.48	288.25	312.23	323.18	
% Change	8.7%	4.7%	7.4%	8.3%	3.5%	

Premiums represent the total programwide weighted average monthly premiums.
Populations reflect March enrollment figures for each year.

** 1994 weighted average premium is based on March, 1993 populations.

June 2, 1994

SPECIAL

NOTE TO: NANCY-ANN MIN
IRA MAGAZINER
JACK LEW
CHRIS JENNINGS
LYNN MARGHERIO
JUDY FEDER
JUDY WHANG
GREG LAWLER
MEEGHAN PRUNTY
JASON SOLOMON
BARRY CLENDENIN
DANIEL BLUME/ANDY SWIRE
SHANNAH KOSS

FROM: Bob Pellicci (x5-4871) B Pellicci

SUBJECT: REP. CARDIN REQUEST FOR INFORMATION -- The attached responds to Sean Cavanaugh's request for technical assistance on physician training/academic health center issues.

DEADLINE: NOON FRIDAY, JUNE 3RD

JUN 2 1994

n:\wp\clear.19

NOTE TO JUDY FEDER

The attached materials respond to a request from Sean Cavanaugh, of Congressman Cardin's staff, for technical assistance on physician training/academic health center issues.

This request asks for assistance with six items.

The attached draft response includes items that recommend Mr. Cardin adopt provisions included in the HSA. Other items have been previously cleared for the staff of other committees.

Responses which are based on provisions of the HSA include:

4. Factors for payment of IME, and

5. Features of the allocation system.

Items previously cleared include:

1. Recipient of DME funds previously cleared for Senate L&HR

3. Factors for payment of DME previously cleared for House E&C and Senate L&HR

6. Study on medical education previously cleared for House E&C

The only draft response not previously cleared is:

2. Recipient of IME funds

If there are any questions regarding this draft response, please call me at 690-5824.

[redacted]

cc: Bob Pellicci

DRAFT

N:\WP\CARDIN.1

1. RECIPIENT OF DME PAYMENTS

If Mr. Cardin's goal is to:

> Specify that payments for direct medical education (DME) would be made directly to the residency program, or any other entity designated by the program, including a teaching hospital, consortium, or group practice

Then Mr. Cardin could:

1. Include Section 3031, with revisions, to provide

   A. In (a), for the Secretary to make payments to "the entity designated by the program"

   B. In (b), that a funding agreement for such payments shall provide that "the entity designated by the approved physician training program" will expend the payments only for such purpose

   C. In (c), provide that "the entity designated by an approved physician training program may be the program, a teaching hospital, medical school, multi-specialty group practice, consortium

DRAFT

3. Include Section 3032 with revisions to provide:

A. In (a)(3), add language to provide that

(1) "the application shall contain a written agreement, signed by the principal participants in the physician training program which designates the entity which shall be the formal recipient of payments and which indicates that all parties agree on a distribution of payments; and"

(2) "the entity receiving payment shall agree to submit periodic documentation to demonstrate that the funds are being distributed in the manner agreed upon by all parties.

B. In (b), provide that such payments will be made by the Secretary "to the entity designated by the approved physician training program..."

1. Add to Section 3001(e) the definition:

"A postgraduate physician training consortium is defined as a formal association between two or more training institutions in a community and affiliated physician residency training programs which

(i) collaboratively determine the allocation of individual residency training slots among local training programs

(ii) provide support, direction and coordination for participating entities engaged in training residents

(iii) includes at least 50 first-year postgraduate training positions

(iv) meets other requirements as may be provided

DRAFT

N:\wp\cardin.2

2. RECIPIENT OF IME PAYMENTS

If Mr. Cardin's goal is to:

Specify the entity to receive IME payments by providing IME funds to be distributed directly to teaching hospitals

Then Mr. Cardin could:

1. Include Subtitle B with revisions

   A. In Section 3101, 3102, and 3103, substitute references to teaching hospitals for references to academic health centers

2. Do not change definition of academic health center in Section 3101 (c) or provisions of Part 2, Sections 3131 and 3132

DRAFT

N:\WP\CARDIN.3

3. FACTORS FOR PAYMENT OF DME FUNDS

If Mr. Cardin's goal is to:

Distribute direct medical education (DME) funds under a formula based on program-specific costs and, after a 10 year transition period, based on a national average payment amount

Then Mr. Cardin could:

1. Make DME payments, after a transition period, based on a national average, geographically-adjusted per resident amount, as provided in Subpart C, Sections 3031 - 33

2. Provide a transitional payment schedule for DME that blends all-payer Medicare per resident amounts for DME with the new geographically-adjusted national average amount over a 10 year period at 90/10, 80/20, 70/30...

   A. Revise Section 3033 (b) by adding in a new (3)

      (1) For the 10 years after the state in which the program is located becomes a participating state, DME payments would be made based on the amounts determined by multiplying the number of approved post-graduate positions during the year by the per resident amount calculated as a blend of:

         (a) 90, 80, 70 ... percent of the all-payer Medicare cost per resident, and

         (b) 10, 20, 30 ... percent of the adjusted national average per resident amount

   B. The all-payer Medicare cost per resident in an approved training program would be

      (1) A weighted average, based on the number of such residents at each hospital during FY 94, times the hospitals' average Medicare per resident cost during its FY 94 cost reporting period

      (2) For residents in a location that did not receive direct graduate medical education payments from Medicare in FY 94, the adjusted national average per resident amount

DRAFT

C. The hospital's FY 94 average Medicare per resident cost is the hospital's total updated per resident amount under section 1886(h) of the Social Security Act, divided by the number of approved positions, without regard to weighting factors, paid by Medicare during that period.

3. Revise Sections 3031 (a) and 3033 (a) (2) to provide that in 1996 and 1997:

   A. Institutions in non-participating states would continue to receive Medicare payments as under current law

   B. Institutions in participating states would receive all-payer DME payments based on the payment rate as revised above

   C. Medicare would transfer funds into the workforce account only for positions in participating states in 1996 and 1997

4. Revise budget figures in Section 3033(a)(1) to reflect new policy in 1996 and 1997

   A. Payments to programs would be subject to an adjustment factor such that total payments in any year (including Medicare payments and payments from the workforce account) would not exceed the amounts specified in Section 3033(a)(1)

5. Revise Section 4051 to reflect new policy in 1996 and 1997

6. For impact of ten year phase-in, see attached table

DRAFT

n:\wp\cardin.4

4. FACTORS FOR PAYMENT OF IME FUNDS

If Mr. Cardin's goal is to:

Distribute IME funds according to Medicare policy, with consideration give to payments for residents participating in ambulatory settings

Then Mr. Cardin could:

1. Pay IME based on provisions of Section 3103 (b) without revision

   A. Section 3103 (b) provides for payments to be based on:

      (1) The ratio of hospital gross receipts from both inpatient and outpatient services in the previous year, and

      (2) The current law Medicare indirect teaching adjustment specified by in Title XVIII

2. Provide for the study of IME payments in section 3103 (c) to include analysis and recommendations concerning IME payments in ambulatory settings

DRAFT

x:\wp\cardin.5

5. FEATURES OF PHYSICIAN TRAINING ALLOCATION SYSTEM

If Mr. Cardin's goal is to:

> Structure a residency allocation plan to promote the training of more primary care physicians

Then Mr. Cardin could:

1. Include the provisions of Subtitle A, Part 1, Subparts A and B, Sections 3001, 3011, 3012, and 3013

DRAFT

N:\wp\cardin.6

6. STUDY OF THE EFFECTS OF REFORM ON MEDICAL EDUCATION

If Mr. Cardin's goal is to:

> Provide for the Secretary of HHS to study the effects of health reform on medical schools and make recommendations regarding whether a distinct funding source is warranted, what such a funding source should be, and a method for distribution of possible funds

Then Mr. Cardin could:

1. In Section 3103, insert a new (d):

"(d) The Secretary shall

(1) Analyze

(i) The impact of competitive health plans on payments for professional services delivered by physicians who are faculty at medical schools

(ii) The costs associated with the shift of medical education from hospital inpatient to ambulatory, non-hospital sites

(iii) The nature and extent of any uncompensated costs of clinical research

(iv) Other factors relevant to the cost of medical education

(2) Make recommendations regarding

(i) The need for a national program of assistance for medical education

(ii) A method to distribute funds among eligible medical schools under such a program

(iii) Possible sources of revenues to support such a program

2. The Secretary shall report on such analysis and recommendations by December 31, 1996

PAUL D. WELLSTONE
MINNESOTA

United States Senate

WASHINGTON, DC 20510-2303

456 5560
456 2604

FROM THE OFFICE OF SENATOR PAUL DAVID WELLSTONE

FAX COVER SHEET

TO: PRESIDENT CLINTON

via: CHRIS JENNINGS

STEVE RICCHETTI

FROM: ELLEN SHAFFER

DATE: 6/17

MESSAGE:

COVER SHEET + 2 PAGES = 3 TOTAL PAGES

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

TEL:

Jun 17'94 14:41 No.018 P.01

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 15, 1994

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

Dear Mr. President/Bill:

We have always agreed that universal coverage must be the cornerstone of health care reform. That stand cannot waver as we continue our progress in Congress to enact comprehensive health care reform legislation.

Just as the Senate Committee on Labor and Human Resources reinforced that commitment last week, troubling signals have appeared from the press and some Members indicating that universal coverage is not a realistic goal.

As you well know, the building blocks of meaningful reform are inextricably linked. Universal coverage is not only a humane goal, one which most industrialized countries have attained. Because it would end wasteful and inflationary cost-shifting, it is also key to making health care affordable.

Affordable, universal coverage is impossible without meaningful, employer-based financing. We have been debating this issue long enough to be clear on this point. 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. 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 us to deliver.

The legislative process involves compromise. There will certainly be major compromises on matters of importance as different views shape the final health care legislation. But there must be a firm foundation on which those compromises are built. Universal coverage, affordable for all and fairly financed, must remain the basis of that foundation.

☐ 717 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-2303
(202) 224-3244

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

☐ POST OFFICE BOX 281
105 3D AVENUE, SOUTH
VIRGINIA, MN 55792
(218) 741-1074

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

Those of us on the Labor Committee have already accepted difficult compromises and will have difficulty sacrificing further.

We look forward to assisting your efforts toward the goal of true universal coverage for health care in any way that we can.

Sincerely,

Paul David Wellstone
United States Senator

Howard Metzenbaum
United States Senator

Paul Simon
United States Senator

Carol Moseley-Braun
United States Senator

DEMONSTRATION OF CAPITATED DRUG BENEFIT OPTION

SUMMARY - The Secretary would be required to initiate a demonstration under which beneficiaries would be given the option of receiving their drug benefits through a drug benefit management (DBM) plan instead of standard Medicare. This option would structured similar to the current Medicare risk program. The demonstration would start two years after the effective date of the standard drug benefit and would be authorized in 6 states for 5 years.

ENROLLMENT

- During an annual, 30-day open enrollment period, beneficiaries in the demonstration states would have the option of enrolling to receive their drug benefits through a DBM plan with a Medicare contract or HMO/CMP with a risk contract. Beneficiaries who become entitled to Medicare between open enrollment periods would have the option of enrolling in the month preceding entitlement to Medicare. As with the risk program, no health screening would be permitted.

- The Secretary would prepare materials that would provide information that would assist beneficiaries in making a choice among the available drug benefit plans, HMO options and standard Medicare. The cost of preparing these materials would be born by the plans. As with the risk program, all marketing materials would have to be approved in advance by the Secretary. Direct marketing (e.g. door to door, telemarketing) to beneficiaries would be prohibited.

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

STANDARDS

In order to be eligible to participate in this demonstration, drug benefit management plans would have to have a contract with the Secretary. There would be no limit on the number of contractors in a demonstration state. The Secretary would develop standards similar to those under the risk contracting program and other standards that would address:

- Access to community pharmacies

- Drug utilization review requirements

- Formulary structure (definition of major indications, minimum requirements and procedures for a physician obtaining coverage of a drug not on the formulary)

- Beneficiary safeguards in regard to use of prior authorization
- Compliance programs
- Procedures for out-of-area claims
- Financial requirements
- Quality standards and 50% commercial enrollment

These standards would be developed by the Secretary one year prior to the start of the demonstration.

DBM plans would be required to provide access to a pharmacy in every community throughout the state. In addition to this statewide pharmacy network, mail-order pharmacies could be offered by plans as an option to enrollees.

BENEFICIARY COST-SHARING

Similar to the risk contract program, plans would have the option of offering a cost-sharing structure that would be different from that under standard Medicare. They could

- require a monthly premium in lieu of part or all other cost-sharing.
- offer a point-of-service option with coinsurance higher than the 20% under standard Medicare.

However, the actuarial value of the plan's premium and cost-sharing could not exceed 95% of the actuarial value of the deductible and coinsurance under standard Medicare.

In addition, plans would be prohibited from having differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that the Secretary believes would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription drugs.

PAYMENT

One year prior to the start of the demonstration, the Secretary would develop a payment methodology based on the costs of the drug benefit under standard Medicare. Payment to plans would be discounted to take into account the savings generated by restrictive formularies and pharmacy networks.

During the first three years of the demonstration, the Secretary could require plans to provide complete utilization data in order to refine the payment methodology. The Secretary would have the authority to audit this data.

SCOPE

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:

NAME: Jack Lew / Chris Jennings

OFFICE:

ROOM NO.:

PHONE NO.:

FAX NO.: 456-7431 DATE:

TOTAL PAGES (INCLUDING COVER): 5

REMARKS:

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION

ANDREA S. LEVARIO
LEGISLATIVE ANALYST

ROOM 425 G.1
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201

PHONE: (202) 690-7538
FAX: (202) 690-8425

28 June 94

NOTE TO: Melanne Verveer
Jack Lew
Chris Jennings

FROM: Andrea Levario

Attached is the letter on administrative costs that the First Lady requested Ken Thorpe to prepare for her to send to Members of Congress. Please let me know if there is anything more you would like us to do on this matter. I can be reached at 690-5508.

cc: Ken Thorpe
Karen Pollitz

Dear Member:

In recent discussions, a number of questions have been raised regarding the comparative administrative costs of operating public and private health insurance and the causes of differences. I want to share with you information which addresses these questions.

Analysis conducted by the Health Care Financing Administration's Office of the Actuary indicates that in 1991 administrative costs for all private health insurance were equivalent to nearly 17 percent of benefits paid out. For the same year, Medicare administrative costs were slightly more than two percent of paid benefits. For purposes of comparison, Medicaid's administrative costs were, on average, equal to 4.2 percent. (See Chart 1.)

Two factors are especially relevant to explaining the difference in administrative costs between public and private health insurance. First, Medicare is a universal system without marketing or sales expenses and it bears no administrative costs for determining the acceptability of or avoiding potential risks ("underwriting") posed by applicants.

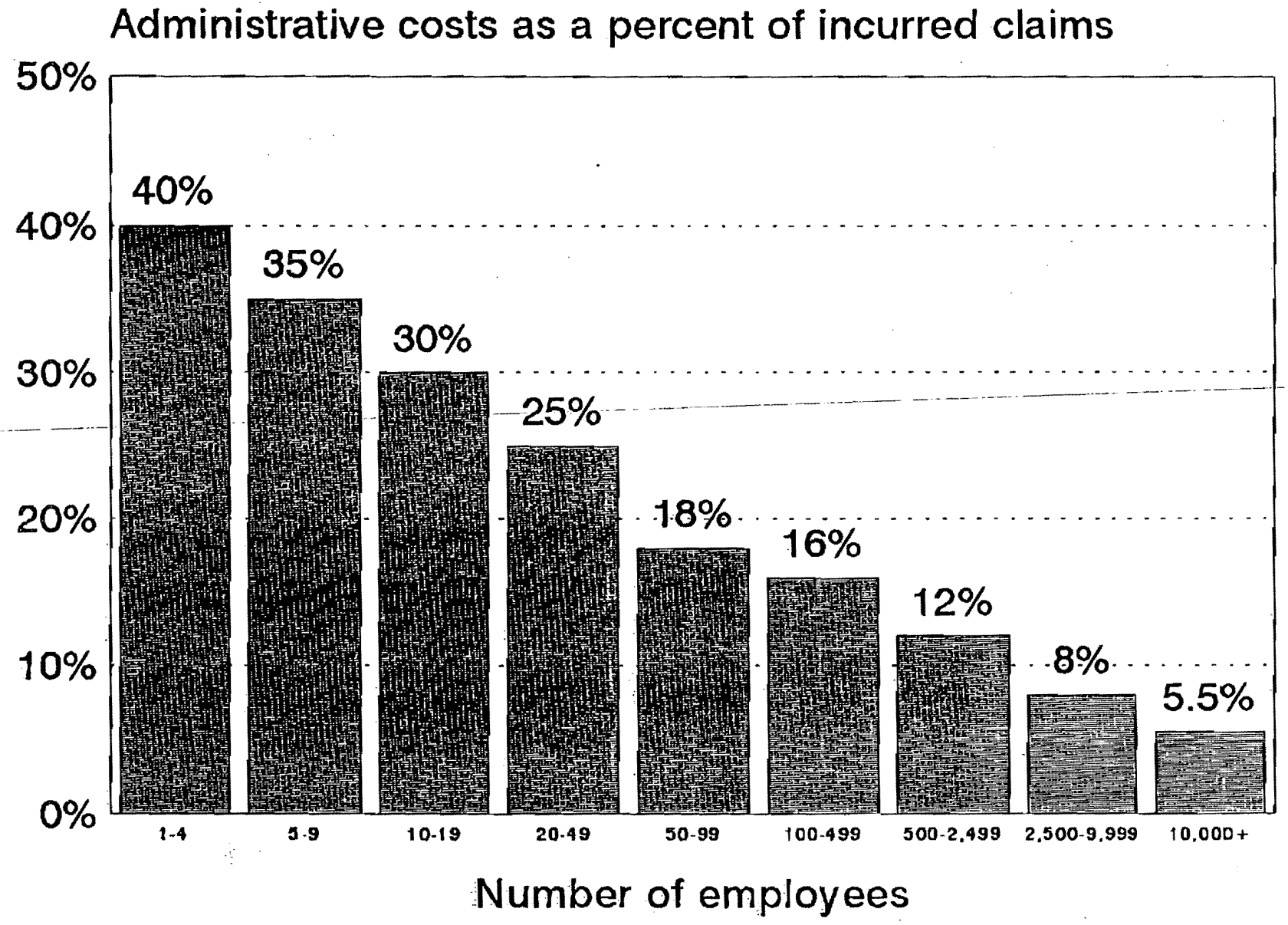
Second, as Chart 2 indicates, administrative cost as a percentage of benefits is closely related to the size of the group covered; small groups face relatively much higher administrative expenses than do large groups. Because of its size, Medicare enjoys substantial administrative economies of scale; with an enrollment of nearly 35 million persons, the pool over which its administrative expenses are spread is very large.

The Health Security Act addresses both of these factors which account for the high administrative costs too many small groups are now experiencing. Together, universal coverage, insuring large groups, and prohibiting underwriting assure low administrative costs.

Sincerely,

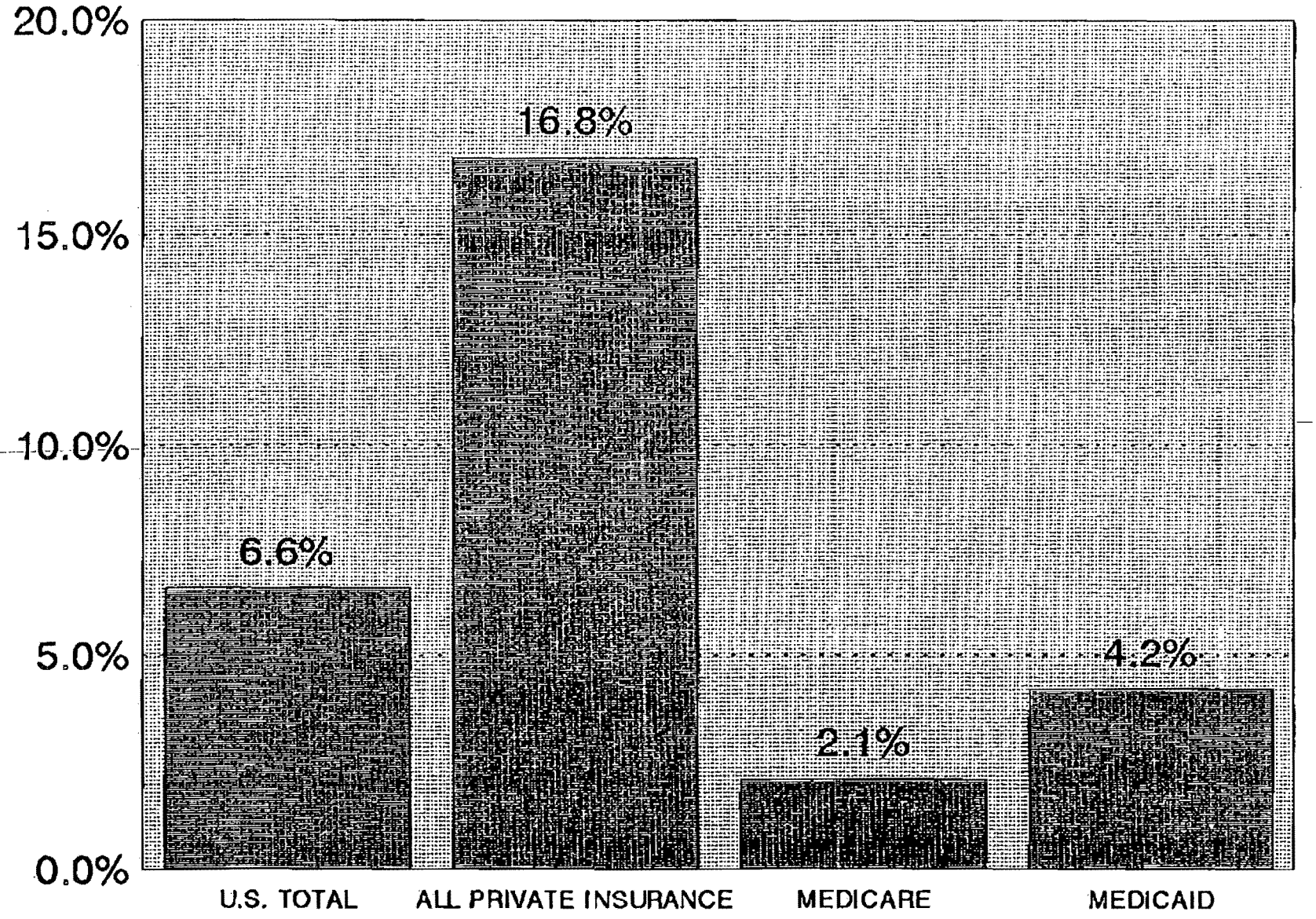
HRC

Administrative costs of health insurance are much higher for small firms.



Source: Hay/Huggins Company, Inc.

ADMINISTRATIVE COST AS PERCENT OF BENEFITS, 1991



Source: HCFA Office of the Actuary

To Chris

Date 6/27 Time

WHILE YOU WERE OUT

M Fred Griefe

of

Phone 861-1725

Area Code Number Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	

RETURNED YOUR CALL

Message

Operator

INTERNATIONAL
BROTHERHOOD OF TEAMSTERS
AFL-CIO

OFFICE OF
RON CAREY
GENERAL PRESIDENT

FAX TRANSMITTAL COVER SHEET

SENDING FAX NUMBER IS (202) 624-6925

TO: Stacey Rubin

FROM: Fredda Vladeck

2 PAGES FOLLOW THIS PAGE

PLEASE CALL (202) 624-6986 IF THERE IS A PROBLEM WITH THIS TRANSMITTAL

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

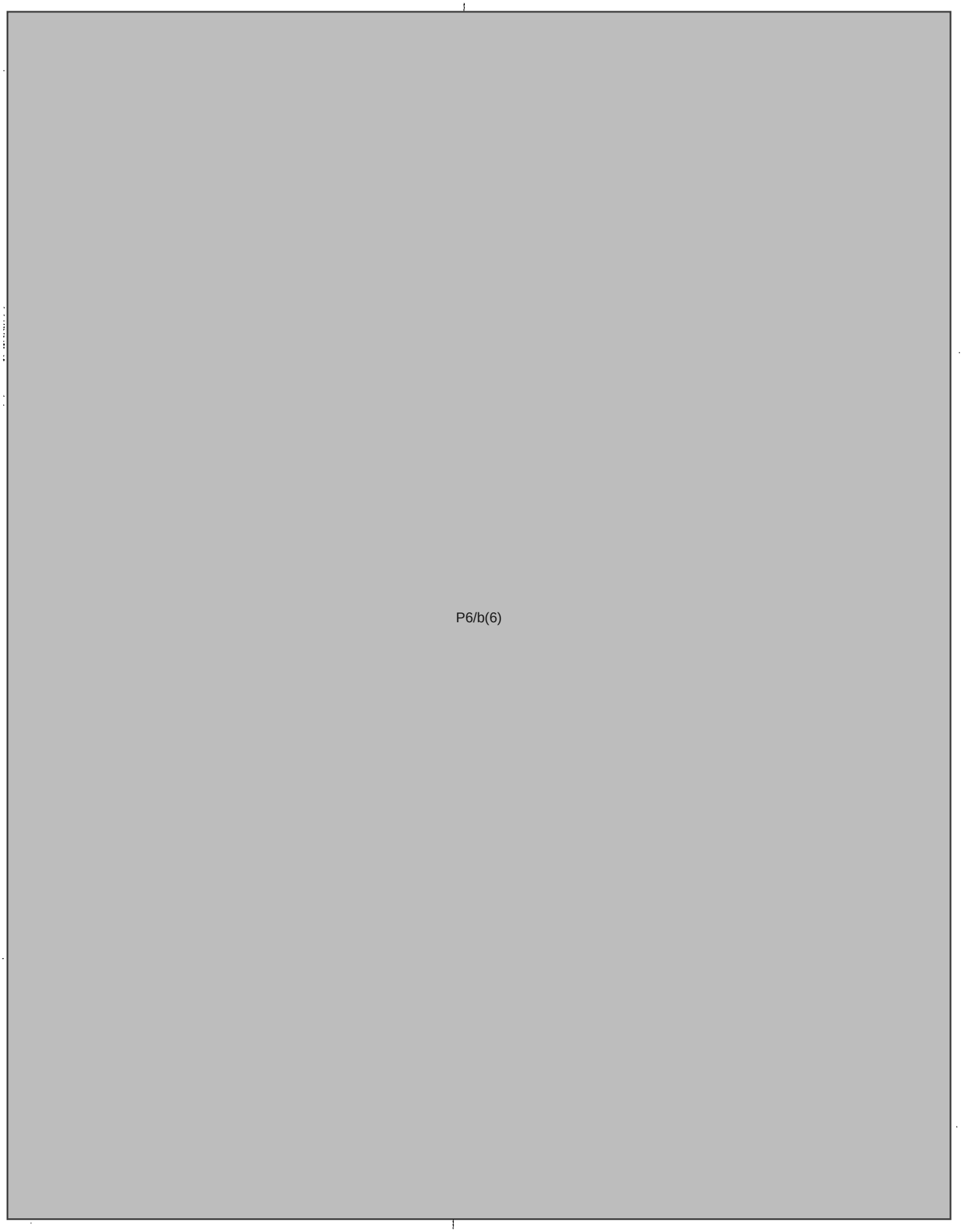
AFL-CIO

TO: Chris Jennings

FROM: Fredda Vladeck Fredda Vladeck

DATE: May 31, 1994

P6/b(6)


P6/b(6)

U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210

DATE: 6/21

TO: Chris Jennings

AGENCY: WH

456-5560 456-7431

TELEPHONE NUMBER: 219/35206 ***FAX:*** ~~219-5861~~

FROM: ***MEREDITH A. MILLER***
Deputy Assistant Secretary for Policy
Pension and Welfare Benefits Administration
U. S. Department of Labor
200 Constitution Avenue, NW, Room S-2524
Washington, DC 20210

COMMENTS:

Chris - the numbers you sent me are one of the data source that we used to develop the #'s we sent over for clearance. We need clearance on our estimates of self-insurance which are based on these #'s. These #'s won't do the trick w/ Finance. Sorry for the back & forth. Linda & Len have our #'s please feel them to look at our chart ASAP. TY - I've attached our request.

NUMBER OF PAGES INCLUDING COVER SHEET 3

Should you experience any problems receiving this transmission, please call (202) 219-8233.

06/21/94 16:16 ☎ 002
06/21/94 16:24 ☎202 401 7321 HHS ASPE/HP 001/001

United States

Th[illegible]r of Firms, Establishments, Employment and Annual Payroll by Legal Form of Organization and Firm Size for 1991

Employment Size of Firm

	Total	0-24	25-49	50-74	75-99
FIRMS	5,051,025	4,642,171	223,104	70,313	33,122
ESTABS	6,200,859	4,734,562	282,767	113,238	66,204
EMPLOY.	92,387,359	21,184,366	7,486,640	4,229,557	2,838,660
ANN'L PAYROLL ($1,000)	2,165,015,851	431,546,741	155,580,925	87,549,039	58,900,709

100-249	250-499	500-999	1000-2499	2500-4999	5000 +
53,468	14,870	6,842	4,342	1,366	1,407
164,150	96,445	81,748	110,405	82,319	669,029
8,027,967	5,115,423	4,715,151	6,701,359	4,709,394	27,179,042
169,428,799	110,016,099	107,065,336	161,582,063	120,210,338	743,143,809

Source: Census, Dept Commerce

31.2%

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL
# of pages ▶
To Dunns
Dept./Agency
Fax #
From
Phone #
Fax #
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

SIZE	# FIRMS (millions)	% FIRMS	# WORKERS (millions)	% WORKERS	% FIRMS HLTH BEN	% WORKERS HLTH BEN	% FIRMS SELF INS	%WORKERS SELF INS
1-50	4.27	95.8%	29.0	31.2%	32.8%	50.4%	3.6%	5.1%
1-100	4.37	98.1%	36.1	38.8%	34.1%	57.4%	3.7%	5.8%
1-250	4.43	99.3%	44.2	47.5%	34.8%	64.0%	4.0%	9.1%
1-500	4.44	99.7%	49.3	53.1%	35.0%	67.2%	4.1%	12.7%
1-1000	4.45	99.8%	54.1	58.2%	35.1%	69.8%	4.2%	16.1%

DOL Submission for clearance

Contact R Hinz 219-4505

P Miller 219-8233

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: June 21, 1994

Re: Tomorrow's Senate D.P.C. Luncheon

cc: Melanne

I. PURPOSE

To re-institute and further cultivate your positive relationship with the DPC message group membership and to help focus members on an agreed upon message and communication strategy for the upcoming weeks.

II. BACKGROUND

Tomorrow you are scheduled to meet with the Senate DPC Message group. As per your conversation with Senator Daschle today, the attendance is expected to be relatively light but participants should include our strongest supporters. One other special guest will be Governor Lawton Chiles.

Notwithstanding their desire to be supportive, the Members are becoming increasingly nervous about the prospects of health reform. They have been targeted with relentless anti-Clinton-plan lobbying efforts. Some are becoming worried that their support for the Clinton plan might become something of an albatross to them. This is largely based on their perceptions of the success of the negative campaigns against the plan and their assessment of developments (or lack thereof) from the Finance Committee. That's the bad news.

The good news is that they all still want to get a comprehensive reform bill enacted this year. They want to do whatever they can to help facilitate this end.

The latest news emerging from the Senate Finance Committee relates to the work of six Members of the Committee: Boren, Breaux, Bradley, Chafee, Danforth, and Durenberger. Yesterday, Senator Bradley outlined the proposal he is working on with this bi-partisan

group. The proposal provides for universal coverage that is assured by a hard trigger mechanism into an individual mandate. If 96% of the population is not insured by a specified date, the individual mandate requirement is implemented. (It is important to note that it is one rather than three triggers under this proposal.) In addition to this hard trigger, there is a soft trigger which provides for a commission to make a recommendation to Congress in a manner similar to a fast track procedure that would outline its suggestions as to the best way to achieve universal coverage. An employer requirement could be one of their recommendations. Senator Bradley's proposal also substitutes a tax-cap-like cost-containment mechanism in place of our premium caps. Lastly, of particular note, Senator Bradley provides for some type of payroll assessment for those firms that are not providing insurance at the time the trigger is set to be pulled. This mechanism along with anti-discrimination provision is being utilized in an effort to guard against firms dropping coverage all together.

So far, it is unclear where all the other members of the bi-partisan group stands in regard to the specific proposal. It is clear however, that they are working on a proposal extremely similar. It is also clear that the threat of pulling this bill out of Senate Finance without a vote has provided for added incentive for the Republicans to cut a deal with these conservative Democrats .

Governor Chiles is expected to give a presentation about how the Republicans (through the RNC) have been attempted to kill his attempt at passing the next round of necessary provisions to get his comprehensive reform bill implemented in Florida. His discussion should help point out how many Republicans are going to be -- or are going to be pressured into being -- very partisan on this issue. Although he will share this information, he does not wish to (himself) go to the media with this. Lieutenant Governor McKay has already been quoted by the press on this issue.

According to John Hart, Governor Chiles is in town to lobby for his Medicaid waiver from HHS; the Department is in intense discussions with Florida. It is important to note that there are 5 outstanding controversial issues that are of grave concern to the Administration (. To break the logjam, Governor Chiles is attempting to meet with the President to make his case. The President has decided to meet with Governor Chiles and arrangements are now being made to set up this meeting.

SUGGESTED TALKING POINTS

- I would suggest that you reiterate the middle class theme that you have utilized in recent weeks related to who is left out in a 91% coverage world.

- I would spend some time providing encouraging words that illustrate a continued

optimism that we can work something out. In this context, I would suggest however, that you acknowledge the enormous pressures working against this end.

- Avoid mentioning any comment that indicates a desire that the Finance Committee be bypassed. Instead focus on the desire and hope that the Committee can produce a bill that can be legitimately defined as providing coverage to all Americans.

- Solicit advice and suggestions as to ways in which we can better communicate a more useful message out of the White House and how we can help Members do the same.

- If asked, I'd characterize the Bradley/bi-partisan discussions as too early to tell, but express that you are encouraged that under whatever options they are considering, it is clear that they want to guarantee universal coverage.

- If you decide to make yourself available to the media following the meeting develop, a common set of talking points that you would like all participants to use following the meeting.

Chris –

Lynn told me he has given this to Susan Foot Mixon

Congressman Andrews & will probably give it to Bradley

All is

Critical Issues

a. cost. con

b. Mandate

Uniqueness of the Debate

a. nothing to endorse

What you need to do

2. Say correct flaws

4. but support reform

Your Issues

Nexus
Durenberger
Andrews

Strengthening Market Forces To Stay Within Spending Targets

add-need controls of some kind - even in voluntary options

Proposal: Allow HPPCs/Health Alliances to require high-bid plans to increase deductibles as one way to stay within spending targets

Description:

If health plan premium bids exceed budget targets, some plans, e.g. President Clinton's proposal, would require immediate imposition of across-the-board price controls & mandatory price-rollbacks. But there are also market-oriented alternatives that can create stronger market incentives for higher-cost plans to moderate their premium increases and better control costs. Such market-oriented actions may prove quite effective and avoid the need for mandatory price controls.

Here's how it would work. If a HPPC/HA received premium bids that exceeded the spending target for its area, one of the tools in its arsenal would be to notify high-bid plans of a premium limit. The limit would be determined by the HPPC/HA as the maximum that could be allowed and still keep total health insurance premiums within its budget. The plans would be allowed to meet this target premium through their own internal price negotiations with providers, improved management - and/or by increasing their deductibles. Plans would not be allowed, however, to change either the standard benefits covered or the maximum cost-sharing limits.

Pro-Competitive Effects

This approach puts higher-cost plans at a competitive disadvantage. They will be offering the same benefit package as their competitors - but with both higher premiums and higher deductibles. Research shows that individuals key off of both figures when making comparisons among similar benefit plans. Thus a high-cost plan would still be allowed to market its product, but with potential stiff market penalties of lower enrollment, which should cause it to work harder toward economies before the next year's bid. To the extent that the traditional fee-for-service plans are more expensive, this approach strengthens new competitive pressures on them to match HMO economies. The HPPC/HA would be able to keep its spending within budget targets without eliminating plans, regulating plans that are well-managed, or provider price controls.

Economic research, e.g. RAND health insurance experiment, also indicates that higher deductibles, in themselves, help to reduce utilization and health costs. Also, economic theorists, such as Harvard's Martin Feldstein, argue that higher deductibles are the best way to create a more effective healthcare market. A number of legislative proposals, particularly Republican-sponsored, endorse making available higher deductible (catastrophic) options to strengthen market incentives.

Consumer Effects

A deductible penalty can become a significant pro-competitive factor. At fairly low expense levels, there is about a $1/$1 tradeoff between premiums and deductibles, i.e. to reduce a

premium by $100/year may involve almost a $100/year deductible increase. At higher deductible levels, because fewer individuals incur such costs, the tradeoffs are greater, e.g. a $100/year premium reduction for an already higher-deductible plan may require a $125, $150 or more further increase in deductibles. Thus, the farther a health plan's premiums are from the HPPC/HA target, the (disproportionately) greater its deductible increase penalty is likely to be.

To the extent that these deductible adjustments are for higher-cost plans, selected by higher-income persons, they would not lessen affordability of health insurance plans more likely to be chosen by moderate income individuals. And they preserve some consumer ability, at least during a transitional period, for individuals to have freedom-of-choice to stay with existing providers and traditional plans while the plans work to bring their costs under control.

Revenue Effects

This approach produces similar revenue savings to a tax cap or other premium limit, i.e. there will be restraint on premium levels and thus on tax-favored employer contributions, so there will be reduced Federal tax expenditures. Individuals will be paying the higher deductibles out-of-pocket from their own after-tax incomes.

Relation To Other Cost Control Strategies

This approach adds another, powerful weapon to a HPPC/HA's arsenal for making strong healthcare markets work for consumers in its area, particularly during the short-term transition period. In the longer-run, if market-oriented measures do not prove effective, relying heavily on deductible increases could be faulted for shifting too many costs to consumers and require higher government subsidies. Other national strategies could thus be required, depending on the reasons markets are not working as well as hoped, e.g. anti-trust, benefit package reductions, price controls.

FAX MESSAGE

TO: Mr Chris Jennings, The White House
FAX No.: 202-456-7431
From: Uwe E. Reinhardt, 270 Brooks Bend, Princeton, N. J. 08540
Tel. 609-924-7625/-5394
Fax 609-924-6083
Date: June 23, 1994
Pages (cover included): 4

Dear Chris:

I have just unburdened my soul, once more, in the attached op-ed piece, which I hope to publish somewhere. I've sent it to the NYT. Whatever happens, I would like to share it with you.

Keep on trucking! Best regards,

Sincerely,

Uwe E. Reinhardt 6/23/94

In survey after survey, the American public has expressed overwhelming support for universal health insurance. To the respondents, that term probably means that every American should have unfettered access to needed health care, and that no family should suffer financial distress as a result of ill health. Practically, this means that the nation's haves should subsidize the health insurance of the have-nots.

Every industrialized nation has achieved universal coverage decades ago. By contrast, some 40 million Americans (17% of the population) remain uninsured. They are haunted by the prospect of going without appropriate health care when it is needed or of going broke over medical bills. Uniquely in the United States, medical bills are one of the major reasons for personal bankruptcy. Even the currently insured should worry about that fate, if their health insurance is tied to a particular job. In the emerging global economy, any particular job can be easily lost, and with it the family's health insurance. One serious illness can rob such a family of its entire savings. As one pundit has aptly put it, private health *insurance* in America is really health *unsurance*.

Many politicians favor a policy to control first the health-care costs for insured Americans, before insuring the uninsured. They look to charity care by the hospital sector as a safety net for the uninsured. But that safety net is now financed by relatively lax cost control, which allows doctors and hospitals to recoup the cost of their charity care from insured patients. More effective cost control for insured patients will destroy this financial cushion and, with it, the safety net. Consequently, a strategy of *cost-control-first, universal-coverage-later* will visit very harsh rationing on the uninsured.

Not only the uninsured will bear the cost of that rationing. It will spill over onto the rest of us. First, the often costly, last-minute charity care rendered the uninsured in hospitals may actually cost society more than would the more cost-effective, earlier interventions the insured

take for granted. Second, sustained neglect of proper health care for millions of low-income Americans may yet unleash in this country a major public health hazard--in the form of communicable diseases--that is apt to spill over onto the well-to-do, whose children may end up paying a stiff price for their parents' current myopia.

Finally, unless universal coverage is made compulsory and is strictly supervised, the insurance reforms now advocated by some centrist reformers--mandatory community rated premiums and immediate coverage of pre-existing medical conditions--will unleash a veritable festival of adverse risk selection on the part of both consumers and insurers. Consumers will self-insure as long as they are young and healthy, and throw themselves upon the mercy of community-rated insurance when they are older or sick. Similarly, at community rated premiums insurers can reap huge profits by avoiding potential customers with health problems. One should never underestimate the industry's genius in this game of "cherry picking."

In short, one need not be a card-carrying socialist to support the principle of universal coverage for very pragmatic reasons, which is probably why ordinary Americans support it in such overwhelming numbers. But if universal coverage be their wish, now would be the ideal time to communicate that to the Congress in forceful language. We have, at long last, a President who is passionately committed to that goal; but he faces a deeply divided Congress. That Congress is buffeted by powerful interest groups, whose financial fortunes rest in the *status quo*, and by a business elite that opposes universal coverage on purely ideological grounds. The "people" may well be drowned out in the fracas, especially if they remain diffident.

Ironically, the opponents of universal coverage have in common that they typically luxuriate in very comprehensive health insurance coverage, purchased for them by some private employer or, in the case of federal legislators, by the government. In a table headed "What Business Execs say about Health Care Reform", for example, *Fortune* (May 30, 1994, p. 26) reported that 49% of the executives polled in its spring survey opposed "giving coverage to the

uninsured," 13% had no opinion, and only 38% favored it. About 75% of them favored "access [to health care] through personal insurance."

Yet, few of these executives are likely ever to have purchased "personal health insurance" themselves. Most of them enjoy generous, life-long coverage purchased for them by their company's benefit manager, at group premiums totally divorced from the executive's health status and treated as tax-deductible expenses for the company, but not as taxable compensation for the executive. Even if the company took the full premium out of the executive's take-home pay, this tax-preference effectively buys him or her a dollar's worth of health insurance at a cost of only about 50 cents in forgone take-home pay. Is it not bizarre to hear people so well protected by their group policies, and so coddled by the tax code, preach to America's uninsured (most of whom are low-paid working stiffs) the virtue of "individual responsibility" in health care?

Congress' see-saw over health reform suggests that we may not see a health reform bill at all this year, or that it will follow Scarlett O'Hara's famous dictum to "think about it tomorrow." In the present case, the Scarlett O'Hara technique would take the form of so-called "soft triggers" designed to nudge some future Congress to consider this or that action, if by some distant point in the future X% or more of the population remain uninsured. Practically, that approach is likely to leave between 20 to 30 million middle-class Americans uninsured by the end of the decade. By then the cost of ordinary spells of illness will quickly break the bank of an uninsured middle class family. If American voters are content to let this game of Russian Roulette in health care go on, then let them note that it may hit their own household hard one day, and let them then be "individually responsible" for their plight, as they intended to be, when they were well-off, and healthy.

Uwe E.Reinhardt
Princeton University

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?

6/23
5:10 PM

Chris -
from Nancy-Ann

Scott

TO: Chris Jennings 456-7431
From: Jeff Farrow Please rite.

Consumers' Guide Rates Best, Worst of Nation's Hospitals

WASHINGTON (AP) A New Jersey hospital has the lowest death rate among America's acute care hospitals while Puerto Rican hospitals have seven of the 10 highest, according to a federal guide.

The Consumers' Guide to Hospitals issued Monday lists about 5,500 acute care hospitals and analyzes 18 million federal Medicare cases for the period 1989 to 1991 to establish the death rate for each institution. Data for the guide come from the Health Care Financing Administration, a part of the Department of Health and Human Services.

Among hospitals with at least 1,500 Medicare cases, and at least five 1991 cases each of heart attack, pneumonia and congestive heart failure, the book lists the Deborah Heart & Lung Center, in Browns Mills, N.J., as having the lowest death rate. Of 3,905 cases at Deborah Heart, the actual death rate was 3 percent and the adjusted death rate was 4.3 percent.

In the same category, the San Juan Municipal Hospital in Rio Piedras, Puerto Rico, was listed with the nation's highest death rate. Of 3,412 cases, the Rio Piedras hospital had a death rate of 20.6 per cent and an adjusted death rate of 18.8.

The next six hospitals on the highest death rate list also are in Puerto Rico. The adjusted death rate allows for the fact that some hospitals treat patients who are sicker than those of other hospitals.

Ten highest death rates:

1. San Juan Municipal, Rio Piedras, Puerto Rico, 3,412 cases

20.6 percent 18.8 percent.

2. Arecibo District Hospital, Arecibo, Puerto Rico, 3,415 20.8 18.0

3. Ponce District Hospital, Ponce, Puerto Rico, 3,428 17.3 15.1

4. Mayaguez Medical Center, Mayaguez, Puerto Rico, 4,267 20.6 14.9

5. Dr. Eduardo Garrido Morales Hospital, Caguas, Puerto Rico 3,422 20.0 14.8

6. Aguadilla Regional Hospital, Aguadilla, Puerto Rico, 2,359 18.5 14.6

7. Hospital Universitario Dr. Ruiz Arnau, Bayamon, Puerto Rico, 4,045 19.3 14.5

8. Baptist Memorial Hospital, Forrest City, Ark., 2,043 :15.7 14.3

9. Redlands Community Hospital, Redlands, Calif., 5,492 13.3 13.8

10. Campbell Memorial Hospital, Weatherford, Texas, 2,140 13.0 ;13.6

Optional Language Re Universal Coverage Triggers

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

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

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

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

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

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

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

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

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

Chafee allows MEWAs to continue

Employer Group Purchasers

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

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

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

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

Employer Requirements

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

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

Association Health Plans

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

Individuals

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

COBRA

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

BENEFITS PACKAGE

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

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

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

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

c) Preventive Care

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

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

Def of Med Necessary

Covered Services

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

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

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

FLORIDA

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

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

Total is on page 5.

PMPM = Per member Per month

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

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

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

* Includes the component price for all covered mental health services

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

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

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

* Includes Provider Services

MEDICARE

A. Maintain Medicare as a separate program.

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

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

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

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

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

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

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

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

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

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

D. Medicare risk contracts would be improved.

MEDICARE SYSTEM REFORM:

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

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

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

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

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

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

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

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

PAYMENTS TO MEDICARE HEALTH PLANS:

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

Federal Contribution to Health Plans:

option 1: (pure price competition)

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

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

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

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

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

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

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

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

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

E. Administrative Simplification.

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

Provides for coordination of Medicare and supplemental insurance claims processing.

Permits standardized, paperless process.

F. Improvements in hospital payment methodologies would include:

1. Medicare Dependent Hospitals:

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

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

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

o Expands the EACH/RPCH program to all states.

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

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

o Designation of EACH hospitals

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

o Skilled Nursing Facility Services in RPCHs

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

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

o Payment for outpatient rural primary care hospital services

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

o Clarification of physician staffing requirement for RPCHs

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

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

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

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

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

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

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

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

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

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

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

4. Extension of the Rural Health Transition Grant Program:

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

MEDICARE REFORM

I. SYSTEM REFORM:

Medicare Health Plans:

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

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

Standard Benefit Packages:

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

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

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

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

The standardized medigap plans would be made

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

Medicare Market Areas:

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

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

Enrollment Process:

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

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

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

Uniform Information:

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

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

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

II. PAYMENTS TO MEDICARE HEALTH PLANS:

Federal Contribution to Health Plans:

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

Proposal:

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

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

-- 95% of AAPCC, or

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

Beneficiary Premiums/Rebates:

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

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

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

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

Refinements to the AAPCC Calculation:

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

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

Risk Adjustment:

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

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

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

Low Cost Market Areas:

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

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

Assessment of Medicare Risk Contracting:

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

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

III. MEDICARE SIMPLIFICATION:

Medicare simplification:

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

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

Provides for coordination of Medicare and supplemental insurance claims processing.

Permits standardized, paperless process.

IV. MEDICARE COST CONTAINMENT

Cost containment:

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

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

Also, we would like to propose the following:

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