I. COST CONTAINMENT:

A. AUTOMATIC FAIL SAFE BUDGET PROTECTION

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

B. PENALTY FOR HIGH COST HEALTH PLANS DESCRIPTION NEEDED

C. INDIVIDUAL AND SMALL EMPLOYER PURCHASING GROUPS

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

Establishment, Organization, Duties

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

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

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

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

D. ACCOUNTABLE HEALTH PLANS

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

Qualified health plans must:

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

area to family status and age;

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

- comply with administrative standards and reporting requirements;

- meet requirements for designated underserved areas;

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

E. STANDARD BENEFIT PACKAGE

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

- Inpatient and outpatient care.

- Emergency, including appropriate transport services.

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

- Mental illness and substance abuse.

- Family planning and services for pregnant women.

- Hospice care.

- Home health care.

- Outpatient laboratory, radiology and diagnostic.

- Outpatient prescription drugs and biologicals.

- Outpatient rehabilitation services.

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

- Investigational treatments.

F. REQUIREMENTS ON LARGE EMPLOYER PLANS

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

Standards for Large Employer Plans

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

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

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

- meet financial solvency requirements, consistent with Section 414 of ERISA;
- meet premium payment and collection criteria;

[provide mediation procedures for hearing and resolving malpractice claims;]

- offer both the standard and catastrophic benefit packages;
- provide an alternative plan if more than 50% of the

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

- provide for equitable enrollment criteria.

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

G. INSURANCE MARKET REFORMS

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

H. AMENDMENTS TO ERISA

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

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

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

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

I. ROLE AND STRUCTURE OF NATIONAL HEALTH BOARD

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

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

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

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

c) [illegible]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. FEDERAL RESPONSIBILITIES

Sets forth certain authorities for the HHS Secretary as follows:

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

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

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

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

II. UNIVERSAL COVERAGE

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

Voucher Phase-In

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

Expanded Access to Employer Plans

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

UNIVERSAL COVERAGE

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

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

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

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

instead of the uniform benefit plan).

ACCESS FOR THE UNDERSERVED

Community-Based Primary Care Grant Program

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

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

Enhanced Assistance for Community Health Centers and Federally Qualified Health Centers

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

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

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

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

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

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

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

the individual agrees to practice in a rural community.

Development of Networks of Care-in Rural and Frontier Areas

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

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

Rural and Frontier Emergency Care

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

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

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

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

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

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

PRIMARY CARE PROVIDER EDUCATION

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

Medicare GME Demonstration Project

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

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

Community-Based Physician Training

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

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

Expansion of National Health Service Corps

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

Increased Resources for Primary Care Health Professions Training

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

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

- creates a new scholarship program and increases Title VII

Public Health Service Act funding for physician assistants;

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

State Programs for Non-Physician Providers

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

PROGRAMS RELATING TO PRIMARY AND PREVENTIVE CARE SERVICES

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

Maternal and Child Health Coordination

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

School Health Education

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

TAX AND ENFORCEMENT PROVISIONS
GENERAL TAX PROVISIONS

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

Employer Contributions

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

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

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

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

Contributions by Individuals and the Self-Employed

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

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

PROVISIONS RELATING TO ACCELERATED DEATH BENEFITS

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

LONG-TERM CARE PROVISIONS

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

Qualified Long-Term Care Treated as Medical Care

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

Treatment of Long-Term Care Insurance or Plans

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

are deductible as a medical expense;

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

Requirements for Issuers of Long-Term Care Insurance

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

Uniform Language and Definitions

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

QUALITY ASSURANCE AND SIMPLIFICATION

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

PART I - STANDARDS AND MEASUREMENTS OF QUALITY

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

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

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

-- states and localities requiring additional cost control measures.

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

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

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

-- Director, National Center for Health Statistics;

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

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

This new agency will be authorized to:

-- set priorities for strengthening the medical research base;

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

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

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

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

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

other information for providers.

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

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

PART III - MEDICAL RESEARCH TRUST FUND

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

SUBTITLE B -- ADMINISTRATIVE SIMPLIFICATION

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

Adoption of Standards for EDI

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

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

Timetable for Adoption of Standards

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

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

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

Privacy and Confidentiality

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

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

PATIENTS' RIGHT TO SELF-DETERMINATION REGARDING HEALTH CARE

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

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

execution specified under state law;

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

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

TREATMENT OF EXISTING FEDERAL PROGRAMS

MEDICAID PROGRAM

OPTIONAL COVERAGE UNDER QUALIFIED HEALTH PLANS

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

PART II -- LIMITATION ON CERTAIN FEDERAL MEDICAID PAYMENTS

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

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

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

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

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

PART III -- STATE FLEXIBILITY CONTRACT FOR COORDINATED CARE SERVICES

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

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

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

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

PART IV -- OTHER PROVISIONS

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

SUBTITLE B - MEDICARE

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

PART I - ENROLLMENT OF MEDICARE BENEFICIARIES IN QUALIFIED HEALTH PLANS

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

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

PART II - ENHANCEMENT OF MEDICARE RISK CONTRACTS

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

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

PART III - MEDICARE SELECT

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

PART IV - OTHER PROVISIONS

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

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

****

MEDICAL LIABILITY REFORM

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

MEDIATION AND ALTERNATIVE DISPUTE RESOLUTION

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

Mandatory Alternative Dispute Resolution

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

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

PART II -- LIABILITY REFORM

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

Reform of Procedures

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

Practice Guidelines

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

Drugs and Devices

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

SUBTITLE B -- ANTI-FRAUD AND ABUSE CONTROL PROGRAM

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

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

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

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

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

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

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

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

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

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

Statutory Safe Harbors

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

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

Certificates of Review (Waivers) Awarded by the Attorney General

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

Provider Notifications for Reduction of Antitrust Penalties

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

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

New Office at HHS

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

SUBTITLE G - DEFINITIONS

Key terms are defined as follows:

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

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

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

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

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

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

5/25/94

TABLE 2
OPTION PACKAGE FOR 10% and 15% HMO REDUCTIONS (HSA BASE)

In order to get a 10% or 15% reduction all of the following would be needed:

Change	HSA	-10%	-15%
Hosptial or specialized facilities admission deductible	0	$250	$400
Emergency Room Use (includes physician charges	$10	$100	$150
Inpatient Surgery (in addition to hospital deductible)	$10	$100	$150
Delivery (in addition to hospital deductible)	$10	$100	$150
Outpatient Surgery (includes facility charge):			
Outpatient hospital	$10	$50	$75
Freestanding facility	$10	$25	$35
Office Surgery	$10	$15	$20
Physician, dental visits, Other practioners (other than prevention, ADM, and vision)	$10	$15	$20
ADM residential or outpatient	$25	$35	$45
Routine vision exams	$10	$25	$35
Home Health Care	$10	$15	$20
Ambulance	0	$50	$75
DME	0	20%	30%
Prescription Drugs	$5	$10	$15

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 2

To Ken Thorpe	From Sharman Stephens
Dept./Agency	Phone #
Fax # HMO 15% & copy of earlier FFS	Fax #

5/25/94

TABLE 1
OPTION PACKAGES FOR 15% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE*

Each option contains a set of changes all of which must be done to obtain 15%.

Option I

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $2500
Raise deductible to $400
Add a $250 per hospital admission deductible

Option II

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $3000
Cut Mental Health benefit to Blue Cross Standard
Change Prescription Drug cost sharing (.2 to .6 in higher)

Option III

Raise Out of Pocket $1500 to $2500
Eliminate Prescription Drug or Mental Health

Option IV

Raise Out of Pocket $1500 to $2,000
Raise deductible to $250
Eliminate preventive services package
Cut mental health benefit to Blue Cross Standard

*To get full 15% will need comparable reductions in HMO benefits. See Table 2 for HMO package.

CCSOl Thursday, May 26, 1994 5:17 pm

MEMORANDUM

To : Jennifer Klein

From : Jim Mays

Subject : More Cost-sharing Variations - (Fee-for-service only)

Copy : Ken Thorpe

Following up on your request for options to cut 10%, 15%, and 20% off the "HSA-5%" level, here are cost-sharing changes which should generate approximately these additional savings.

Additional 10% cut:

deductible = $500/$1,000
coinsurance = 25%
cost-sharing maximum = $2,500/$3,000

Additional 15% cut:

deductible = $700/$1,400
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

Additional 20% cut:

deductible = $1000/$2,000
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

ccsol
/a /s

Please add this to the earlier fax for Ken. Thanks

Post-it™ brand fax transmittal memo 7671 | # of pages ▸

To Ken Thorpe	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-7400
Fax # 202-401-7321	Fax #

Administrative Issues With MEDCO/MERCK Proposal

- **ENROLLMENT** - Confusion could result among beneficiaries as a result of having to make a choice among three drug processing firms in order to receive their Medicare benefits.

  + Under the proposal, beneficiaries who do not make a choice among plans would be assigned by HCFA to the plan which includes their pharmacy.

    ++ How would HCFA obtain this information? Beneficiaries who do not make a choice might also be incapable of indicating a preference among pharmacies.

    ++ What happens if the preferred pharmacy is in all three plans?

  + Beneficiaries may not understand that their choice of plan has implications as to which pharmacy they may use.

  The enrollment process could be costly and is unprecedented; there is no working model in the public or private sector for an enrollment process for drug coverage only.

  Under the proposal, beneficiaries who age-in would have to wait until the annual open enrollment period to make a choice of plan.

- **SELECTION ISSUES** - With multiple entities and beneficiaries enrolling in their plan of choice, some plans could experience adverse selection. No mechanisms to risk adjust payments are specified.

- **POTENTIAL FOR SIGNIFICANT OVERPAYMENT** - Under the proposal, plans would guarantee a 5% savings relative to what spending would be under the Chairman's mark. It is not clear whether 5% is sufficient given the use under the proposal of restrictive formularies, pharmacy networks and manufacturer discounts. If the 5% savings is too small relative to the potential savings from the restrictive benefit proposed, contractors would

receive a windfall.

- **INCENTIVES** - Payment incentives faced by plans could lead to an actual increase in the costs for other Medicare services. Payment on the basis of a fixed price per prescription or therapy day would provide an incentive to reduce the mix of drugs provided. While such an incentive is consistent with the move to increase use of generics, it could also result in an inappropriate reduction in such mix.

- **FORMULARIES**

  + Multiple DBM firms, each with their own formularies, could result in coverage that varies significantly within a geographic area.

  + Non-institutionalized beneficiaries on average purchase 15 prescriptions per year. The average for beneficiaries with functional impairment and for those with poor health is 26 and 31, respectively. Given restrictive formularies, it is doubtful that a beneficiary will be able to find a plan that covers all of the drugs that they are currently taking. As a result, the proposal will lead to beneficiaries changing their prescriptions.

  + Although a beneficiary's physician could in theory obtain coverage for a drug not on a plan's formulary, this would involve proving medical necessity to the DBM firm which could have an economic interest in opposing such an approval.

  + The structure of a plan's formulary would be determined by each plan. Thus, it may be difficult for beneficiaries to compare formularies when choosing a plan.

  + Members of the "independent" Pharmacy and Therapeutic Committee would determine formulary and prior authorization policy for each plan. Although members of the committee are prohibited from having a direct financial interest in a DBM firm or in the pharmaceutical or biotech industry, there is no prohibition of a family member having a direct interest or the individual having an indirect interest (e.g. through a holding company).

- **DRUG UTILIZATION REVIEW** - Physicians are used to dealing with uniform medical review criteria for Medicare beneficiaries in a geographic area. With three DBM firms in a geographic area, physicians will have to cope with three different formularies and DUR protocols.

- **CONTRACTING ISSUES**

  + The proposal calls for state-sized service areas. This would mean that HCFA would have to administer up to 150 separate contracts. HCFA is currently pushing to consolidate the number of contractors processing other Medicare claims.

  + There is no provision for a fall-back mechanism in the event that no acceptable bids are received in a geographic area.

  + HCFA is not given specific authority to terminate a contract during the first year of operation, even if massive quality problems occur.

- **DIFFERENTIAL PREMIUMS** - Under the proposal, Medicare beneficiaries currently receiving drug benefits through a former employer could continue to do so and would not have to pay the drug portion of the Part B premium.

  + Why would employers continue to offer primary drug coverage to retirees when coverage under Medicare becomes available?

  + SSA systems are not equipped to deduct a differential Part B premium.

- **OTHER ISSUES** - Under the proposal, HMOs would be able to serve as Medicare drug contractors. HMOs could use information on the individual's drug utilization to target healthy individuals for enrollment under a risk contract.

DATE:
TIME:

Executive Office of the President
Office of Management and Budget
Health Policy

725 17th Street, NW, Room 7021
Washington, DC 20503

FAX: (202) 395-3910 **Voice: (202) 395-3844**

To: Larry Levitt / Chris Jennings

FAX #:

Voice #:

From: L Nichols

Notes: a copy for each please

Number of Pages (including cover sheet): 3

Health Care Reform model parameter/assumption checklist, 6/14/94 5:35 pm

	Default option (don't run: just for discussion/comparison purposes)	Modifications (MB6.13.94)
benefit package	HSA-5% by higher cost sharing	HSA-8% with age rating until 2000 (2:1 limit)
employer mandate	all firms; 80% in aggregate; HSA-like per worker obligations;	exemptions: no firm mandate until 1998. no payroll taxes if don't offer in interim. 1% payroll tax on 500+ whether offer or not triggers: Case I: 100+ in 1998 if 85% of currently uninsured workers and dependents not covered; 26-99 in 1999 if 80% . . .; 2-25 in 2000 if 75% . . . plus individual mandate in 2000; Case II: Case I plus 1 year (100+ in 1999, etc).

individual mandate	HSA-like; 20% plus unpaid "employer" portion;	Case I: year 2000 only Case II: year 2001 only
firm subsidies	5.5-12% individual wage caps, depending on firm size and average wage, for all firms (Retreat Model 1)	2.8%-12% individual wage caps, converted to dollars, tied to premium targets and indexed at HSA growth rates; Subsidies phased-in: Case I: assume 7/1/96 start date -- 1996 currently insuring firms get 25% and newly insuring firms get 75% until mandate, when mandated firms get 100%. Case II: assume 1/1/97 start date -- same rules.
individual subsidies	HSA	change 3.9% to 5.0% on 20% share; no special early retiree policy;

alliances/community rating pools	Medicaid non-cash, nonworkers, and workers in firms with ≤ 1000;	workers in firms with ≤ 500, nonworkers, self-employed, part-timers, non-cash Medicaid; AFDC and SSI capitated; govt. buys non-cash Medicaid comm. rate policy until 2000 (2001) when they are treated like others eligible for subsidies. We'll convey an assumption about higher take-up rates later).
premium caps	HSA-like, enforced through either mandatory alliances or voluntary alliances and state insurance offices.	tax plans above target to recapture individual subsidies and revenue losses, rate to be determined by Treasury, based in part on bidding assumptions (attachment 1).
interim premium adjustments	NA	adjustments need to be made for: adverse selection: uncompensated care: S&L + Fed DSH: smaller community rating pool????????? NET: (attachment 2)

Financing		**?** **NOTE: lose Medicaid, Medicare Worker, Other Federal Program, and Cafeteria plan savings until 2000;**

Attachment 1, 6/15/94

The purpose of this attachment is to clarify assumptions about the time path of premiums under the proposed assessment rules. It is not possible to construct a premium forecast in the absence of hard caps without making heroic assumptions. Below are three scenarios which (hopefully) bound the range of reasonable possibilities.

Global Assumptions:

The average unconstrained bid in the absence of any tax would be 7.5% higher than the adjusted HSA target (H^* = CBO's HSA premium adjusted for adverse selection, uncompensated care, and S&L+Fed DSH). This average is the result of (1-x%) of plans that bid above the target, on average P_a, and x% of plans that bid at (H^*) or below (P_b) the target, i.e.,

average pre-tax bid = $1.075H^* = (1-x)P_a + x^*H^* + x_bP_b$, where $x = x^* + x_b$.

Now,

IF $x = .4$ (default assumption in year 1, see table below),
$x_b = .05$,
$P_b = .95H^*$,

then $P_a = 1.13H^*$. This says that the average bid above the target would be 13% higher than the target in year 1 (1996). It seems reasonable to assume that P_a/H^* does not increase over time, as competition works its magic.

- Default schedules for x:

	1996	1997	1998	1999	2000	2000+
No tax	30%	27.5%	25%	22.5%	20%	20%
tax, inelastic demand	30%	27.5%	25%	22.5%	20%	20%
tax, inelastic supply	30%	32.5%	35%	37.5%	40%	40%
tax, equal supply and demand elasticities	30%	30%	30%	30%	30%	30%

Now, enter taxes/assessments on high cost plans.

The tax is to be set on the *total* premium of all those plans which bid above the target.

Let τ = the tax rate on the deviation from the target, and t = the tax rate on the total premium. The relation between the tax rates would then appear to be:

$\tau(P_a - H^*) = tP_a$, for they both must raise the same amount of money.

Now, since $P_a = kH^*$ in general, $(k > 1)$,

$t = \tau(k-1)/k$. Treasury informed us on Friday that $\tau \approx .45$-$.8$, depending on the elements of the "hole" one needs to make up. The proposal then evolved to protect employer subsidies from premiums higher than our targets, and to make household subsidies slightly less generous, so our initial guess is that $\tau \approx .5$. With $k = 1.13$, as we assumed above, $t = .057$. We rounded this to $t = .06$ in all that follows.

Scenario 1: perfectly inelastic demand.

Plans know they can pass the full tax increase onto their enrollees. In this case there is no reason to bid other than the pre-tax bid. Then the post-tax weighted average is:

$(1+y)H^* = (1-x)(1+t)P_a + x^*H^* + x_b P_b$.

y is the percentage over the target the post-tax premium turns out to be.

IF: $x_b = .05$, $P_b = .95H^*$, $P_a = 1.13H^*$, then

	y (t=.2)	y (t=.1)	y (t=.06)
1996	24.7%	16.7%	13.6%
1997	25.6%	17.4%	14.1%
1998	26.5%	18.0%	14.6%
1999	27.3%	18.6%	15.1%
2000	28.3%	19.2%	15.6%

The driving force behind the trajectory is the assumption of market share at or below the target (x). To derive the appropriate premium in year z, multiply 1 + y times the appropriate H^*. Since we believe t = .06 is the best a priori guess, we recommend using the third column for now for Scenario 1.

Scenario 2: perfectly inelastic supply

Plans know they can pass the full tax increase backward onto their providers, or alternatively, alter the mix of services that lowers costs. In this case plans that bid above the target before would bid $P_a/(1+t)$ after the tax, yielding a post-tax average premium of:

$$(1+y)H^* = (1-x)P_a + (x-x_b)H^* + x_bP_b.$$

This scenario embodies more favorable assumptions for competition, so we assume higher market shares for plans at or below the target and growth in their market shares through time.

Note this average premium is independent of t.

IF: $x_b = .10$, $P_b = .90H^*$, $P_a = 1.13H^*$, then

	y
1996	8.6%
1997	8.3%
1998	8.0%
1999	7.6%
2000	7.3%

The driving force behind the trajectory is still the assumption of market share at or below the target (x). To derive the appropriate premium in year z, multiply 1 + y times the appropriate H^*.

Scenario 3: **equal, nonzero and finite demand and supply elasticities**

Plans know that the incidence of the tax will be shared among providers and enrollees. α is the fraction of the tax that can be pushed back to providers. This is the real world, and the average post-tax premium is:

$$(1+y)H^* = (1-x)[1+(1-\alpha)t]P_a + (x-x_b)H^* + x_bP_b.$$

$0 \le \alpha \le 1$. Note that $\alpha = 0$ and this reduces to Scenario 1, $\alpha = 1$ and this reduces to Scenario 2.

IF: $\alpha = .5$, $x_b = .075$, $P_b = .95H^*$, $P_a = 1.13H^*$, **then**

	y (t=.2)	y (t=.1)	y (t=.06)
1996	16.6%	12.7%	11.1%
1997	16.6%	12.7%	11.1%
1998	16.6%	12.7%	11.1%
1999	16.6%	12.7%	11.1%
2000	16.6%	12.7%	11.1%

Again, we recommend the third column as a best first guess.

Summarizing our recommended post-tax adjustment, (1+y):

Post-tax Premium Adjustment Factors (multiply by net adjusted CBO HSA in each year to get premium) (real 1994 $)				
Year	base case: no taxes, no premium caps	Scenario 1 perfectly inelastic demand	Scenario 2 perfectly inelastic supply	Scenario 3 equal and finite demand and supply elasticities
1996	1.089	1.136	1.086	1.11
1997	1.091	1.141	1.083	1.11
1998	1.095	1.146	1.080	1.11
1999	1.098	1.151	1.076	1.11
2000 and beyond	1.102	1.156	1.073	1.11

There are still two issues.

Issue one: What premium we are subsidizing?

For firms, we are mandating the 80% of the actual but subsidizing up to the target/capped premium. This means firms pay the post-tax premium but firm subsidies are calculated on target premiums.

For households, we subsidize post-tax premium.

The "hole" that t has to make up is the household subsidies plus revenue effects.

Issue two: What growth rates should be applied to these factors?

It seems reasonable that the default premium growth rate is the managed competition growth rate, baseline minus 1%, or about 7% per capita. The year to year changes in our real 1994 adjustment factors should be thought of as marginal to this trend. Therefore, the factors that should be multiplied by 1994 HSA premiums are:

Net Premium Adjustment Factors (taking into account managed competition trend, pre-trigger adjustments, and deflated back to 1994 $)				
Year	base case: no taxes, no premium caps	Scenario 1 perfectly inelastic demand	Scenario 2 perfectly inelastic supply	Scenario 3 equal and finite demand and supply elasticities
1996	1.152	1.201	1.149	1.174
1997	1.211	1.266	1.202	1.232
1998	1.282	1.341	1.264	1.299
1999	1.328	1.393	1.302	1.343
2000 and beyond	1.288	1.351	1.252	1.297

These numbers, multiplied by CBO's HSA premium, yield real 1994 premiums for this model.

Attachment 2

capped premium adjustments during transition to final trigger

	1996	1997	1998	1999	2000
base premium adj. vs. HSA	-8%	-8%	-8%	-8%	-8%
% reduction in uninsured	7.5%	15%	33%	49%	100%
% reduction in uncompensated care	15%	30%	48%	64%	100%
adverse selection add-on	6%	7%	7%	6%	0
uncompensated care add-on	4%	3%	2.5%	2%	0
S&L + Fed. DSH subtraction	-5%	-4%	-2%	-1%	0
Academic Health Center extra 1%	+1	+1	+1	+1	+1
NET capped premium adjustment vs. HSA	-2%	-1%	+0.5%	0%	-7%

DRAFT

Trigger Model 6.1.94

	1996	1997	1998	1999	2000	1996-2000	1996-2004
Subsidy cost:							
HSA	11	37	98	122	128	396	1082
Trigger	58	64	72	74	114	382	948
Assessment Revenues:							
HSA	1	2	2	2	1	8	12
Trigger	12	13	14	14	15	68	128
Number uninsured							
HSA	33	23	0	0	0		
Trigger	34	31	25	20	0		

Subsidy cost of Trigger assumes: No benefit package expansion in 2001, 8% growth in subsidies after 2000, 25% of the HSA level of outsourcing after 2000, no subsidies for state and local governments

Assessments: 2% of payroll on firms with 26-999 workers that don't offer health insurance, 1.5% for firms with 1000+ workers that do offer, 3% for firms with 1000+ workers that don't offer.

6/6/94
leader\trigger.out

MEDICAID
MEDICARE WORKER.

PROJECT FOR THE

REPUBLICAN FUTURE

June 7, 1994

MEMORANDUM TO: REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: Reading the President's Lips on Universal Coverage

"If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen [and] veto the legislation." (President Clinton, January 25, 1994)

"[W]e're certainly going to be prepared to discuss any matter, but there's been nothing forthcoming from the White House. The President is the cause of the deadlock, and it isn't going to be broken until he's prepared to act." (Senator George Mitchell, April 2, 1990, demanding that President Bush abandon his "no new taxes" pledge)

Congress stands in recess and Dan Rostenkowski stands indicted as a 17-count felon. But the scramble to create passable legislation from what remains of the Clinton health care plan continues unabated. The June 2 *Los Angeles Times* reports that Republican and Democratic staff of the Senate Finance committee have been "working together," during the recess, to present that committee with a set of options when it returns today. In other words, some Hill Republicans are working overtime to pull Democratic chestnuts out of the fire. Will we ever learn?

Not if we believe that we can at this point forge a bipartisan health bill with the Democratic leadership that serves the national interest (and Republican principle). The problem is this: the Democratic leadership still has no interest in a sound, sensible health care bill. Speaking before the New York State Democratic Convention in Buffalo last week, Senator Moynihan himself brashly declared: "In this Congress my mission is clear -- get the President his bill."

There you have the openly and stubbornly expressed goal of the president and the Democratic leadership: *his* bill. Of course, as Pat Moynihan knows better than anyone else in Washington, the president has no chance of getting "his bill" as originally written. But backroom dealings could still produce a bill different

enough from the White House package to be viable in the legislative process, but sufficiently similar ("Clinton-lite") to protect the president's "read my lips" pledge on health care. And that bill would be a bad one for the country. That's why Republicans should hold off on health care negotiations until Mr. Clinton eats his words.

Once again: we are *for* a sound bipartisan bill. And such a bill will require negotiations. But if we are to negotiate with Democrats over health care reform, it must be on *our* terms, not theirs. The current atmosphere of Democratic anxiety -- signalled most recently by Senator Dianne Feinstein removing her name as a cosponsor of the president's bill -- is an opportunity for Republicans finally to force a decisive change in the terms of debate. George Mitchell, Jay Rockefeller, and others in Congress have so far demanded that federally enforced universal coverage be the minimum requirement of an acceptable health care bill. And universal health care coverage, as defined by the president and his allies, cannot exist without a system of federal mandates on employers or individuals or both. Democrats are no longer in any political position to make such haughty demands. Why do we still accord them any deference? And why should Republicans be party to an effort to "get the president his bill?" We shouldn't.

We think Republicans should condition their cooperation in passing health care legislation on explicit Democratic abandonment of a universal system based on mandates of any sort: immediate, phased in, triggered, or linked to soft or hard targets. Just as George Mitchell forced President Bush to break his no new taxes pledge as a precondition to budget negotiations in 1990, President Clinton should now be forced to buckle under and give up on federally mandated universal health insurance coverage. Absent such a concession by the president, we must convince the public that his obstinacy is the real obstacle to health care reform. And we must continue to advance true, targeted health care reform that has bipartisan and public support.

This strategy can only work if Republicans resist current entreaties to join the Democrat leadership in crafting a watered-down Clinton bill. But if Democrats continue to insist on universal coverage achieved through Clinton-lite means, then we should take this battle to the country, make it a centerpiece of the fall campaigns, and explain why no bill is better than a bad one.

The next few months provide us the chance not only to block Clinton's legislation, but to deliver an unqualified defeat of Clinton's principles generally. The best way to seize health care from the Democrats is to fight for a bill that explicitly rejects the central tenets of Clintonism: federal mandates, politically determined benefit packages, price controls, state-run "alliances," and the like. The result will be a better health care bill and a triumph for our principles of limited government and measured, targeted reform.

Lien #

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: WEDNESDAY, JUNE 22, 1994
FINAL

Scheduling Desk:	**Julie Hopper**	
	202-456-7561	**work**
	202-456-2317	**fax**
	P6/b(6)	**home**
	1-800-528-7528	**WHCA#4096**

PREV RON **The White House**

10:00 am- 10:15 am **PVT MTG** w/Maggie Williams and Patti Solis

10:15 am- 10:30 am **PVT MTG** w/Maggie Williams

10:30 am- 11:00 am **PRIVATE MEETING**
Map Room
CLOSED PRESS

11:20 am **ARRIVAL** OF Queen Noor
South Portico

11:25 am **PROCEED** to Yellow Oval Room

NOTE: The President and King Hussein will join HRC and Queen Noor at approx. 11:30 am

11:30 am- 12:30 pm **BRUNCH**
Yellow Oval Room
CLOSED PRESS

PARTICIPANTS:
- The President
- HRC
- King Hussein
- Queen Noor

Staff Contact: Tony Lake

12:30 pm The President and HRC bid farewell to King Hussein and Queen Noor
SOUTH PORTICO
OPEN PHOTO

12:40 pm **DEPART** The South Portico
EN ROUTE Capitol Hill
[Drive Time: 10 minutes]
Travelling w/HRC:

- Neel Lattimore or Karen Finney
- Melanne Verveer
- WH Photographer

12:50 pm **ARRIVE Capitol Bldg**
OPEN PRESS ARRIVAL

Greeters: Senate Sergeant at Arms

12:50 pm **PROCEED to** [S-221]

12:55 pm **PROCEED** to S-211

1:00 pm-
2:00 pm **MESSAGE GROUP MEETING**
S-211, Capitol Bldg.
HRC's Holding Room: Sec. of the Senates Office
CLOSED PRESS

PARTICIPANTS: Approx. 45-50 to attend

FORMAT:
- Sen. Tom Daschle gives opening remarks and intros HRC
- HRC gives remarks
- Open discussion
- Sen. Tom Daschle intros Gov. Lawton Chiles
- Gov. Lawton Chiles gives brief remarks
- Open discussion

Hill Contact: Debra Silimeo 224-3986
Staff Contact: Chris Jennings 456-5560

2:05 pm **DEPART** Capitol Hill
OPEN PRESS DEPARTURE
EN ROUTE The White House

2:15 pm **ARRIVE** The White House South Portico

2:20 pm-
2:25 pm **DROP BY**
Diplomatic Reception Room
CLOSED PRESS

NOTE: WH Photographer will be present.

Staff Contact: Carolyn Huber

2:30 pm-
5:00 pm — **OFFICE/PHONE TIME**

7:15 pm — **DEPART** The White House South Portico
[w/The President]
EN ROUTE The Washington Hilton
[Drive Time: 10 minutes]

7:25 pm — **ARRIVE** Washington Hilton

7:30 pm-
7:45 pm — **MEET AND GREET** w/Co-Chairs
Cabinet Room
CLOSED PRESS

PARTICIPANTS: Approx. 20 to attend

FORMAT: Mix and mingle

Staff Contact: Joan Baggett

7:50 pm-
8:15 pm — **MEET AND GREET** w/Vice Chairs and Benefactors
Jefferson Room
CLOSED PRESS

PARTICIPANTS: Approx. 120 to attend

FORMAT: Receiving line

Staff Contact: Joan Baggett

8:15 pm — The President and HRC proceed to the International Ballroom

8:15 pm-
9:15 pm — **DNC GALA**
International Ballroom
Attire: Business
POOL PRESS

PARTICIPANTS: Approx. 2,000 to attend

FORMAT:
- The President and HRC are announced into the room and proceed to tables
- Entertainment [Kenny Loggins]
- Terry McAuliffee intros Vernon Jordan
- Vernon Jordan gives remarks and intros

Chm. David Wilhelm
- Chairman Wilhelm gives remarks and intros The President
- The President gives remarks, works ropeline on departure [NOTE: The President will work one side and HRC will work the other]

9:15 pm — **DEPART** Washington Hilton Hotel
EN ROUTE Omni Shoreham
[Drive Time: 5 minutes]

9:20 pm — **ARRIVE** Omni Shoreham

9:30 pm-
10:00 pm — **SAXOPHONE CLUB RECEPTION**
Omni Shoreham
POOL PRESS

PARTICIPANTS: Approx. 1200 to attend

FORMAT:
- Offstage announcement
- Paula Poundstone intros Chm. Wilhelm
- Chm. Wilhelm intros The President
- The President gives remarks
- Work ropeline on departure

Staff Contact: Joan Baggett

10:10 pm — **DEPART** The Omni Shoreham
EN ROUTE The White House
[Drive Time: 5 minutes]

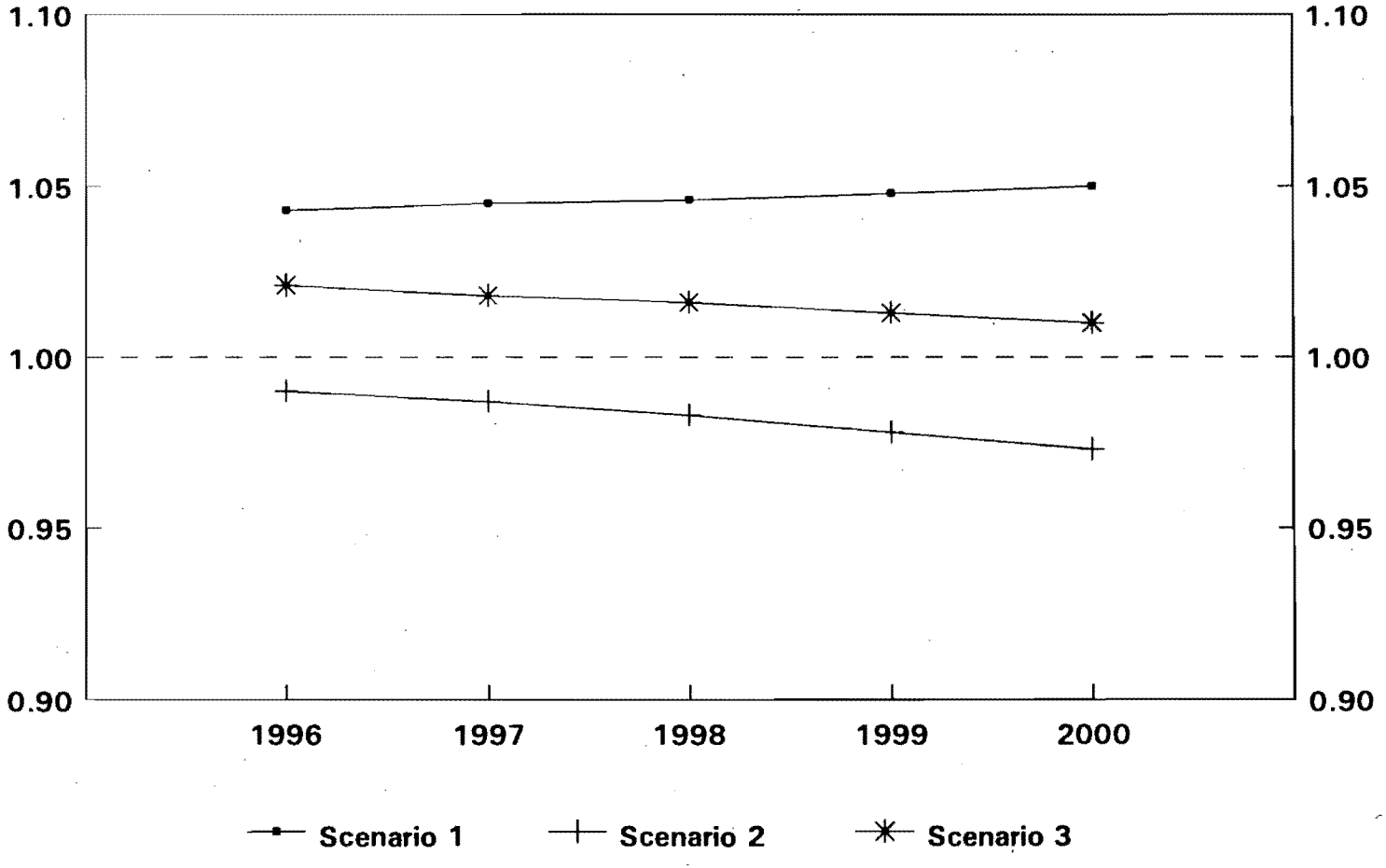
10:15 pm — **ARRIVE** The White House South Portico

RON — The White House

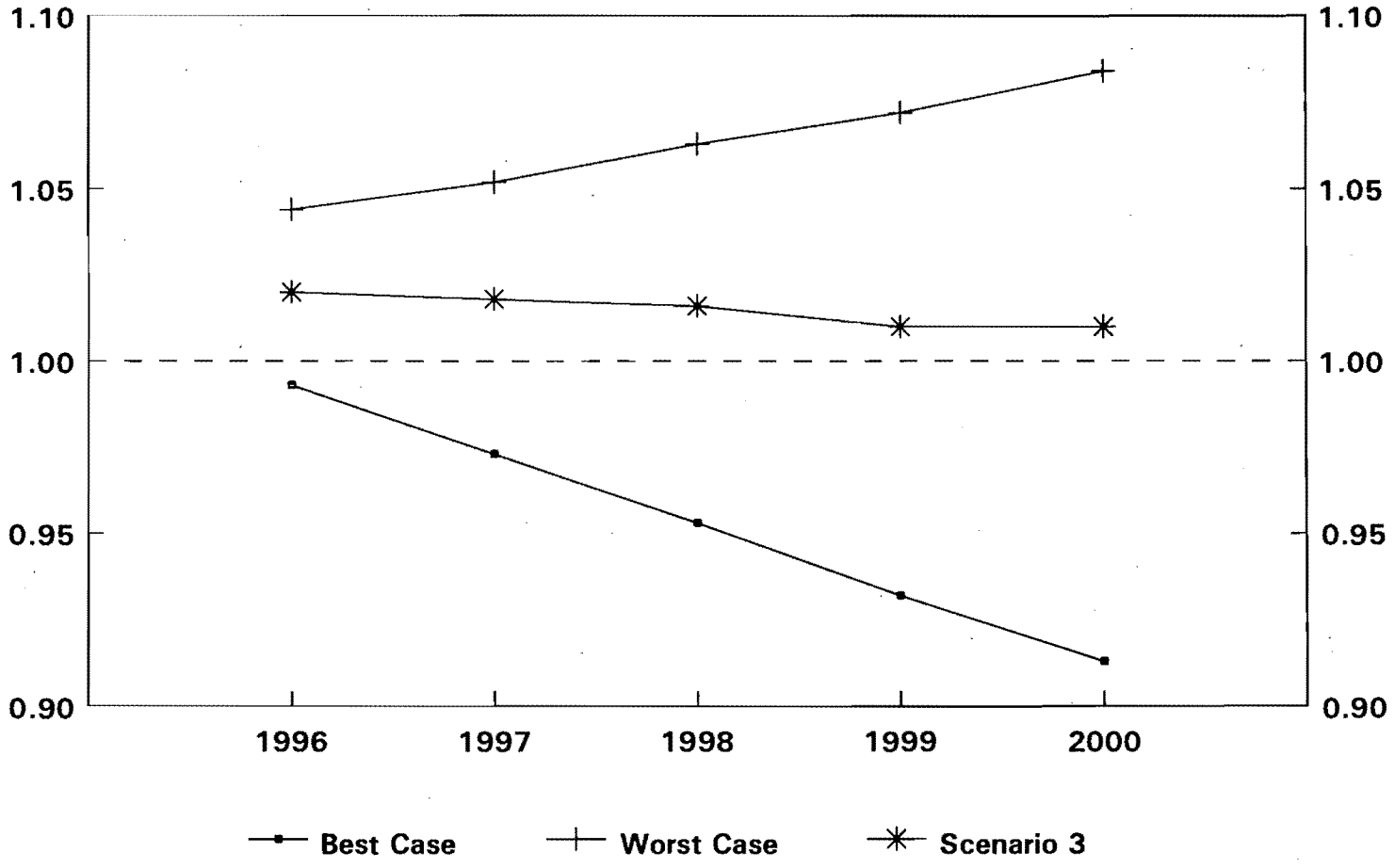
HAPPY BIRTHDAY!! To: Julia Sanders - Housekeeping

WEATHER FORECAST FOR WASHINGTON, DC:
-- Partly cloudy. Wind northwest at 5 to 10 knots, becoming south at 5 knots. Low 67 to 72. High 89 to 94.

Net Premium Adjustments
Relative to No Assessment
(Graph 1)



Net Premium Adjustments
Relative to No Assessment
(Graph 2)



June 22, 1994

TO: Chris Jennings

FROM: Marilyn Yager

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1). Thank you for helping out today with a health care briefing for the 1994 Fellows at the U.S. Public Health Service. The audience will be 32 primary care practitioners and academicians. They spend the summer at the Public Health Service learning about the development and implementation of primary care policy, programs, and legislation.

From 10:00 am - 10:30 am Walter Zelman will provide a health care reform policy overview. In your timeframe, 10:30 am to 11:00 am, please provide an overivew of politics of health care reform and the likely legislative timetable. Please allow for some questions.

The briefing is in room 474, the Indian Treaty Room.

2). In addition, last week you and I discussed the problem the American College of Emergency Physicians are having with confusion with the Finance Committee over our original language on pre-admission review for emergency services. The Emergency Physicians lobbyist Stephanie Kennan was told by Moynihan staff that the Finance version would use the Clinton language requiring preauthorization for the provision of urgent and emergency services. I have attached a summary of our original language and the proposed ACEP recommendation.

On two different occasions, Ira has told this group that we intended to change the language last Fall before completing the final version of HSA, and we just never got to it. However, he assured them that we would let Committee staffs know that did not think our original language made sense.

You suggested last week that you could talk with Moynihan staff, and possibly help to arrange a clarification meeting. Please advise.

3). Just a reminder -- you and I have a meeting tomorrow with the Hoffman-LaRoche CEO at 9:00 am in Room 476.

American College of Emergency Physicians

WASHINGTON OFFICE
900 17th Street, N.W., Suite 1250
Washington, D.C. 20006
(202) 728-0610 FAX # (202) 728-0617

ISSUE: PRE-AUTHORIZATION OF SERVICES

Background: The Administration's "Health Security Act" would require pre-authorization for the provision of urgent and emergency services. (Title V, Subtitle C, Sec. 5201(c)). This provision would require that the request for pre-authorization be accompanied by information attesting to the fact that the patient has an emergency medical condition and that the health plan has 24 hours to review the claim and notify the provider of approval or disapproval.

ACEP Position: The College opposes this provision. The success of emergency medical treatment depends upon the timely application of necessary emergency care. A provision requiring 24 hour pre-authorization for emergency care is not compatible with the purpose of emergency care.

The College believes that in the instance of an emergency, no pre-authorization should be necessary. In the instance of other treatment a patient may require in the emergency department, the College supports a provision allowing pre-authorization for treatment and payment, but that the health plan must respond within 30 minutes of the request. Failure to respond within 30 minutes should be deemed authorization for both treatment and payment for services provided.

NATIONAL OFFICE - P.O. Box 619911 Dallas, Texas 75261-9911 - (214) 550-0911

4:30 or 5:30
Morley atlernoon

Moynihan - 8 hours [illegible]
[illegible] [illegible] [illegible] [illegible]
what is wrong with it?

2 Federal workers

- Dole passed out
Brokaw interview

- DNC - Dole/Nickles

- Leaders [illegible] [illegible] - not
2 - Moynihan

- 7/6/88

- FEHBP. within the concepts
what's wrong with this?