SUMMARY

1. Overview:

No mandate

Phased-in individual based subsidies

tax on high cost health plans

Hard cap on Federal health spending

Pros	Cons
Starting small allows time to learn about how to manage insurance reforms	Won't get universal coverage
Solid fail-safe protection for the Federal budget	Very little private sector cost-containment
Subsidies are targeted very well to low income households	Premiums in the community rating pool are likely to be high due to adverse selection; subsidies might not be large enough to cover these higher premiums.
Minimizes job losses	Medicare program savings and no expansion of benefits to the elderly
Incentives are improved for insurers and patients	Low for universal

2. Coverage/Insurance Reforms:

No mandate, but firms of 100+ must offer plans.

2 kinds of groups: age adjusted community rated (limited to firms of < 100 and individuals) and experience rated (for all other groups).

Voluntary purchasing pools for individuals and small businesses with 100 or fewer employees with community rating.

Individuals and small groups could also join FEHB plans but would pay the community rate.

Groups of firms under 100, (MEWAs), are grandfathered into their right to receive experience rating.

Firms with more than 100 workers will be experience rated or self-insured.

Guaranteed renewability and limits on pre-existing condition exclusions.

If 95% not covered by 2002, National Health Commission meets to make (nonbinding) recommendations to Congress on achieving universal coverage.

3. Subsidies:

Once eligible, those below 100% of poverty receive a voucher equal to the average premium price in a geographic area.

Once eligible, those between 100-240% receive a sliding percentage of the average premium price.

Subsidy eligibility phased-in -- from 90% of poverty in 1997 to 240% in 2002, IF financing allows.

No cost-sharing subsidies.

4. Benefit package:

One standard (equal to FEHB's BCBS standard) and one basic (catastrophic).

Under 200% of poverty cannot use subsidies for basic plan

5. High cost plan assessment:

Within each group of plans (community rated and experience rated/self-insured) the highest priced 40% are taxed.

Tax rate is 25 percent of difference between the average premium in that group and the plan's premium.

6. Medicaid:

Preserved as a separate program and beneficiaries are not part of the community rating pool.

at community rating

State option to enroll limited numbers of Medicaid cash (AFDC & SSI) into private health plans.

Growth in Federal payments is capped.

Disproportionate share payments are phased out by 2000.

Medicare Managed Care

7. Medicare:

Program savings smaller than HSA, but most of same proposals.

Includes Durenberger bill proposals that push harder for greater HMO enrollment.

No Medicare drug benefit or new long term care program.

8. Other Federal Programs

FEHB remains as is, but those eligible for community rating pool are allowed to join.

Indian Health Service, Veterans' health care, and DoD apparently unaffected.

Outline refers to initiative to improved access in underserved areas through increased resources for community health centers. Specific proposals are unclear, however.

9. Tax incentives:

Phased in deduction of health insurance premium payments for individuals.

Individual

Deduction limited to average premium in each group.

10. Financing:

Cost containment/Savings

Fail-safe mechanism funds subsidies only as other Federal health savings become available

- Increase amount
- to Individuals

Medicaid and Medicare savings

Cigarette tax increased $1 per pack

Assessment on high cost plans

Postal Service savings

Medicare HI tax levied on State and local workers

Long Term Care tax advantages and inheritance taxes are made more generous

Fiscal Summary

Changes from Baselines

($ Billions)

	1995-1999	1995-2004
Outlays		
Low Income Voucher Program	217.3	613.6
Medicaid	72.4	268.9
Medicare	77.3	252.3
Other Federal Health (1)	13.0	13+
Revenues		
Tobacco tax (2)		
High Cost Plan Assessment		
Tax Expenditures		
Other Revenues		
Net Deficit Effect	54.6*	79.4*

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

(1) This includes FEHB and Postal Service Effects included in the proposal. Because of insufficient information, it does not include an estimate of the proposal's effects on the PHS or the cost of administering the vouchers. The proposal does not appear to affect VA, DOD, or the IHS, so no spending change is estimated.

(2) This assumes a $1 per pack cigarette tax starting in 1995.

Year by Year Analysis of Low Income Voucher Program ($ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline										
Medicaid	96.4	108.2	121.5	136.3	152.2	170.4	190.8	213.6	239.1	267.6
Medicare	158.1	176.0	194.0	213.1	235.5	260.8	289.1	321.1	357.0	397.9
Tax Expenditures										
Baseline Total										
Reform										
Low Income Voucher Program	0	0	30.2	49.5	62.4	75.2	87.0	96.3	103.2	109.9
Medicaid	96.4	105.6	114.0	123.0	132.0	141.6	155.2	170.0	186.0	203.4
Medicare	157.7	172.8	186.3	202.1	214.5	226.8	256.4	281.4	309.6	342.7
Tax expenditures										
Reform Total										
New revenues Tobacco High Cost Plans										
Net Expected Surplus or Shortfall	-0.4*	-5.8*	15.0*	25.2*	21.2*	12.4*	18.7*	13.0*	2.7*	-9.6*
Total Uninsured (mil.) (% insured)	40.9 (84.5%)	41.4 (84.4%)	32.9 (87.7%)	30.3 (88.8%)	29.3 (89.3%)	29.4 (89.3%)	29.9 (89.2%)	30.4 (89.1%)	31.0 (89.0%)	31.4 (88.9%)

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

ISSUES AND POSSIBLE SOLUTIONS

1. Coverage:

Issues	Possible Solutions
Many remain without coverage, perpetuating uncompensated care and cost-shifting to the privately insured.	Add a triggered ~~employer and/or~~ individual mandate. either or both on employer, mandate
Premiums will be high in the community rating pool due to adverse selection. small pool problem	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Can still preserve voluntary nature of purchasing cooperatives.
Some moderate-sized firms will be vulnerable to bad experience rating.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.

2. Subsidies:

Issues	Possible Solutions
Subsidy schedule produces very high marginal tax rates.	Smooth it out by having the poor pay something.
Pegging the vouchers to the overall average (experience rated pool plus community rated pool) in a geographic area means that very low income individuals will have difficulty affording plans in the community rating area.	Tie the subsidies for each type of pool to the average premium in that type of pool.

3. Benefit Package:

Issues	Possible Solutions
Offering a basic and a standard package will lead to adverse selection and uncompensated care.	Limit access to basic plan to those above specified income levels (250% of poverty, for example).

4. High Cost Plan Assessment

Issues	Possible Solutions
Assessment is likely to fall on plans with a sicker than average enrollment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.
Little revenue will be raised from the assessment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Also, have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.
Assessment is unlikely to lead to significant cost containment in the private sector.	Have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.

5. Medicaid:

Issues	Possible Solutions
Limitation of Federal payments while leaving Medicaid program and obligations largely as in current system, places states at risk.	Integration of Medicaid program into larger reform. For example, non-cash assistance recipients could be treated as other low income families.
Disproportionate Share Hospital payments phased out faster than uncompensated care is eliminated, which could have adverse impacts on teaching hospitals.	Tie DSH phase-out to decrease in the number of uninsured.

6. Medicare:

Issues	Possible Solutions
Proposal includes Medicare program reductions, but no benefit expansions.	Phase-in Medicare drug benefit as savings allow.
7% growth target could lead to across-the-board reductions. Unclear if included in final proposal. This could lead to increased cost-shifting to the private sector.	Develop specific policies for reduction in spending.

7. Tax Incentives:

Issues	Possible Solutions
Tax deductibility for individuals tied to the average priced plan in a geographic area penalizes those in plans with adverse selection.	Tie tax deductibility limits to average of plans in that individual's particular pool.

8. Financing:

Issues	Possible Solutions
Financing will be insufficient to fully fund subsidies on a year by year basis, limiting the expansion of subsidies to more income groups.	Broaden the measure of full financing from a year by year metric to a multi-year (3, for example) metric. Alternatively, other sources of increased revenue could be introduced.

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

	MOE 2000 (1) ($ millions)	Population 2000 (2) (thousands)	MOE Per Capita 2000	Index to US 2000
UNITED STATES	23,400	276,241	$85	1.00
Alabama	171	4,485	$38	0.45
Alaska	69	699	$99	1.17
Arizona	449	4,437	$101	1.19
Arkansas	101	2,578	$39	0.46
California	3,946	34,888	$113	1.34
Colorado	201	4,059	$49	0.58
Connecticut	537	3,271	$164	1.94
Delaware	33	759	$43	0.51
District of Colum	142	537	$264	3.11
Florida	884	15,313	$58	0.68
Georgia	408	7,637	$53	0.63
Hawaii	98	1,327	$74	0.87
Idaho	53	1,290	$41	0.48
Illinois	857	12,168	$70	0.83
Indiana	427	6,045	$71	0.83
Iowa	115	2,930	$39	0.46
Kansas	149	2,722	$55	0.64
Kentucky	186	3,989	$47	0.55
Louisiana	445	4,478	$99	1.17
Maine	118	1,240	$95	1.12
Maryland	486	5,322	$91	1.08
Massachusetts	638	5,950	$107	1.26
Michigan	629	9,759	$64	0.76
Minnesota	256	4,824	$53	0.63
Mississippi	98	2,750	$36	0.42
Missouri	618	5,437	$114	1.34
Montana	28	920	$30	0.36
Nebraska	85	1,704	$50	0.59
Nevada	146	1,691	$86	1.02
New Hampshire	54	1,165	$46	0.54
New Jersey	657	8,135	$81	0.95
New Mexico	43	1,823	$23	0.28
New York	3,656	18,237	$200	2.37
North Carolina	523	7,617	$69	0.81
North Dakota	20	643	$31	0.36
Ohio	950	11,453	$83	0.98
Oklahoma	160	3,382	$47	0.56
Oregon	124	3,404	$36	0.43
Pennsylvania	882	12,296	$72	0.85
Rhode Island	85	998	$85	1.01
South Carolina	268	3,932	$68	0.81
South Dakota	20	770	$26	0.31
Tennessee	465	5,538	$84	0.99
Texas	1,321	20,039	$66	0.78
Utah	71	2,148	$33	0.39
Vermont	30	592	$50	0.59
Virginia	427	7,048	$61	0.71
Washington	297	6,070	$49	0.58
West Virginia	110	1,840	$60	0.71
Wisconsin	148	5,381	$27	0.32
Wyoming	18	522	$34	0.41

(1) HCFA OAct; ASPE; NOTE: State estimates do not sum to U.S. total due to rounding.
(2) CPS State Population Projections (Series A).

	UI Model 139: HSA (Note: Marginal rates for House-Hold Subsidies are smoother than specified in HSA) (assumes MOE)	UI Model 138: 12% Ind. Wage Cap with 5.5%-12% for firms < 75; CBO Premiums [Retreat Model 1] (assumes MOE)	UI Model 150 2.8-12% i.w. cap; No employer requirement for the <=20 firms. Kennedy sliding cap; c.a.=1% on 1-10; 2% on 11-20. 5% lower premium (assumes MOE)
Total Employer Payments 1 Year (1994) ($m)	225,245	226,847	207,655
Average Employer Payments per Family	2,176	2,192	2,006
Total Family Payments 1 Year (1994) ($m)	58,357	60,398	63,320
Average Family Direct Premium Payments	564	584	612
Government Subsidies: 1 Year (1994) ($m)	88,170	82,096	82,728
employer	40,082	34,489	25,130
household	48,088	47,607	57,598
Government Subsidies: 5 Years ($m)	396,000	359,906	365,564
employer	179,000	145,199	105,797
household	217,000	214,708	259,767
Government Subsidies: 10 Years ($m)	1,082,000	962,004	965,560
employer	521,000	412,144	300,304
household	561,000	549,861	665,257
Select Revenue Estimates: *			
Corporate Assessment	7,600	40,600	45,200
Other Revenue	19,300	24,600	34,060
Total (5 Years)	26,900	65,200	79,260
Select Revenue Estimates: *			
Corporate Assessment	15,200	81,200	90,400
Other Revenue	38,600	49,200	62,060
Total (10 Years)	53,800	130,400	152,460
Net Effect on Deficit * (5 Years)	74,000	(394)	(8,796)
Net Effect on Deficit * (10 Years)	126,000	(70,596)	(89,100)

* Revenue estimates are for those components that differ from HSA. Deficit effects are relative to current system.
Revenue estimates for the non-HSA packages are preliminary; they are not official Treasury estimates.
** Non-HSA estimates assume outsourcing is 25% of HSA outsourcing. This is preliminary and may understate outsourcing effects.

	UI Model 139: HSA (Note: Marginal rates for House-Hold Subsidies are smoother than specified in HSA) (assumes MOE)	UI Model 138: 12% Ind. Wage Cap with 5.5%-12% for firms < 75; CBO Premiums [Retreat Model 1] (assumes MOE)	UI Model 150 2.8-12% i.w. cap; No employer requirement for the <=20 firms. Kennedy sliding cap; c.a.=1% on 1-10; 2% on 11-20. 5% lower premium (assumes MOE)
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Net Effect on Deficit * (5 Years)	74,000	(394)	(8,796)
Net Effect on Deficit * (10 Years)	126,000	(70,596)	(89,100)

Trilogy: Pulled '99.

* Revenue estimates are for those components that differ from HSA. Deficit effects are relative to current system.
Revenue estimates for the non-HSA packages are preliminary; they are not official Treasury estimates.
** Non-HSA estimates assume outsourcing is 25% of HSA outsourcing. This is preliminary and may understate outsourcing effects.

RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

1. There are no premium caps. Health plans may charge whatever price results from a more competitive market.

2. To protect the federal budget from the risk of higher premiums, excess federal costs are recaptured through an assessment on high cost health plans.

   The assessment serves two purposes: To maintain budget neutrality, and to exert downward pressure on premiums.

   (The federal budget is at risk for subsidy payments and tax revenue loss resulting from higher premiums. Higher premiums could be caused by windfall payments resulting from universal coverage -- particularly in the short term -- or by a failure of competition to bring down premium increases over time.)

3. The assessment on high cost plans could work as follows:

   a. It could be applied only in states (or substate areas) where competition is ineffective. It is triggered automatically in a state if the average premium exceeds the "target premium" in that state.

      The target premium for a state (or substate area) is based initially on current health care costs, but with added funding for the uninsured and assuming no windfall for providers or insurers. The target premium grows from year to year at pre-established rates based on reasonable expectations for a more competitive health care marketplace.

   b. It could be structured in a variety of ways. Two options are:

      i. The assessment for a health plan is X% of the difference between the plan's premium and the target premium.

      ii. The assessment is applied to a plan's entire premium, but the percentage assessment rises by Y percentage points for each dollar the plan's premium is above the target premium.

      (Note: After the first year, the assessment could be applied based on a health plan's rate of growth instead of its premium relative to the target premium.)

   c. The assessment could be applied after the fact (i.e. lagged a year) or set prospectively based on bids from health plans.

   d. The assessment could be administered as a tax, or as an offset to payments to health plans (assuming there is a premium clearinghouse or reinsurance pool of

some kind).

If administered as an offset to payments to health plans, the assessment would in turn be used to offset federal subsidy payments to the state (or substate area).

e. The percentage assessment is set nationally each year, and is calculated in order to recoup excess federal costs. While the same assessment percentage applies everywhere, it is triggered only in areas where competition is ineffective. If the assessment raises too much or too little revenue to recapture excess federal costs, the percentage is adjusted accordingly in the following year.

4. The assessment would apply to community rated plans, but could be broadened to experience rated and self-insured plans as well (with some modifications).

Language (how to sell)

Model Assumptions:

500 ✓

250 ✓

- perhaps alternative baseline assumption or one tied to current experience.

7/26/94

FAX TO CHRIS JENNINGS

RE: RESPONSE TO YOUR REQUEST

I have attached a paper which describes the payment methodology for the PBMs and the measures we suggest be included in the Mitchell proposal which would reduce the possibility of skimming by the PBMs. On a separate track, we are working with Kathy King on modifications to the Durenberger proposal for paying risk HMOs using a bidding process. The payment to the PBMs would parallel this process.

I spoke with Theresa and confirmed with her that the Mitchell proposal includes the additional (CPI) rebate on single source drugs (same as in HSA). I conveyed this to Scott at CBO.

Peter Hickman

Payment Methodology for PBMs

- Payment to PBMs would be parallel to the bidding process envisioned under the Mitchell bill for risk HMOs. Plans would submit bids both for the Medicare benefit and for the standard mandatory "Medigap" benefit which would fill in the deductible and coinsurance. The bid for the "medigap" benefit could not exceed 95% of the actuarial value of the deductible and coinsurance under the fee-for-service benefit.

Measures to Reduce Possibility of Skimming By PBMs

- Enrollment only through Secretary - 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.

  Rationale - Prohibiting enrollment through the plan, as is allowed in the current risk program, would eliminate opportunities for plans to selectively enroll healthy individuals.

- Marketing Restrictions - Direct marketing (e.g. door to door, telemarketing) to beneficiaries would be prohibited. As with the risk program, all marketing materials would have to be approved in advance by the Secretary.

  Rationale - Similar to enrollment issue.

- Disenrollment Surveys - Plans would be required to pay for surveys of individuals who disenroll from the plan during the open enrollment period. Such surveys would attempt to determine whether individuals with medical conditions that require extensive use of prescription drugs are over-represented among disenrollees and what practices of the plan led to the decision of these individuals to disenroll. Plans would face a termination of their contract and/or civil money penalties and intermediate sanctions if they were found to engage in practices that encouraged the disenrollment of such individuals.

  Rationale - Would discourage plans from engaging in practices that would lead to the disenrollment of individuals with medical conditions that require extensive use of prescription drugs.

- Review of Cost-sharing structure - Both HMOs and pharmacy benefit 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.

Rationale - Prevents cost-sharing structure from being used to discourage enrollment of individuals with high drug needs.

- State-wide Service Areas - Contracts would require state-wide service areas. Pharmacy benefit plans would be required to provide access to a pharmacy in every community throughout the state.

  Rationale - Plans could not "red-line" low-income areas or other areas determined to be less desirable.

- Review of Prior Authorization Programs - The Secretary would have to approve prior authorization programs to ensure both fair procedures and that such programs are not guise for discouraging enrollment of individuals with medical conditions that require extensive use of prescription drugs.

  Rationale - Prevents prior authorization programs from being used to discourage enrollment of individuals with high drug needs.

- Beneficiary Compliance Program - Pharmacy benefit plans would be required to have programs to work with enrollees to improve compliance with prescribed drug regimens.

  Rationale - Such a program would ensure that beneficiaries with significant drug needs are monitored.

- Beneficiary Cost-Sharing - Beneficiaries would be guaranteed 5% savings on average cost sharing relative to fee-for-service benefit.

  Rationale - This guarantee would attract individuals with high drug costs to the PBMs.

7/22/94

5pm

Hilley

FAX

DATE: _____ **TIME:** _____

TO:

RECIPIENT: Bob Reischauer

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: John Hilley

ORGANIZATION: _____

NUMBER OF PAGES: 5
(including this one)

COMMENTS: Attached are draft specifications for a subsidy structure we're looking at. It is subject to change, and obviously needs to be fleshed out substantially. However, we thought that it may provide enough info. for you to begin working on it. Thanks for your help. Please call with any questions.

HEALTH CARE REFORM -- POSSIBLE COMPROMISE

- No Mandates. Under this plan, neither employers nor employees would be required to purchase health care insurance.

- Targeted Subsidies. Subsidies would be available to encourage certain low income individuals and firms to purchase insurance. These subsidies would be targeted to groups that tend not to have health insurance.

- Subsidies Capped at Premium Targets. To the extent premiums exceed the statutory premium targets outlined below, individual and business subsidies only will be available up to the value of the premium target. Assume, for example, a low income individual eligible for subsidies equal to 100 percent of his premium cost. If he chooses a health plan with a premium above the statutory target, only that portion of the premium below the target would be 100 percent subsidized.

- Targeted Individual Subsidies. The following subsidies would be available to individuals:

  - Low-income families. Beginning in 1997, low income individuals and families would receive a subsidy worth a fixed percentage of the average premium. For those below 75 percent of the Federal poverty level, these subsidies would equal 100 percent of the premium. For persons with income between 75 and 200 percent of poverty, the subsidy would range on a sliding scale from 100 to 0 percent.

    To maximize participation, individuals determined to be presumptively eligible for 100 percent subsidies automatically would be enrolled at point-of-service.

  - Cash assistance recipients. Beginning with the January 1, 1997 abolishment of Medicaid, cash assistance recipients would receive subsidies equal to 100 percent of the premium.

  - Former non-cash Medicaid eligibles. Beginning in 1997, individuals who would be medically needy or other non-cash recipients under the current Medicaid program (except pregnant women, infants and children) would receive subsidies covering 100 percent of the premium for six months, then would be treated the same as others based on income.

  - Individuals leaving welfare for work. Beginning in 1997, individuals leaving welfare for work would receive subsidies equal to 100 percent of the premium for two years (not one year limit under current law).

- Low income pregnant women and children. Beginning in 1997, pregnant women and children under 19 with incomes up to 185 percent of poverty would be eligible to receive subsidies equal to 100 percent of the premium. For those with incomes between 185 percent and 240 percent of poverty, the subsidies will range on a sliding scale from 100 to 0 percent. As above, individuals determined to be presumptively eligible for 100 percent subsidies would be automatically enrolled at point-of-service.

- Temporarily unemployed, uninsured. Beginning in 1997, individuals working for six months in a job with insurance would be eligible for the low income subsidy for up to six months after losing their jobs. In calculating these persons' eligibility for such subsidies, AGI will be adjusted to exclude (1) unemployment compensation and (2) 75 percent of income earned while employed. To maximize participation, individuals would be encouraged to enroll when applying for unemployment insurance benefits (we're still checking with DoL on feasibility of this last item).

possibly "or uninsured"

- Employer Subsidies. The following subsidies would be available to employers:

  - Employers who expand coverage to additional workers. Beginning in 1997, employers who expand coverage to all their employees in a specific class (i.e., full time, part time) would receive subsidies to make their employees' premiums more affordable. Employers would pay the lesser of 50 percent of the premium or 8 percent of each newly insured employee's wages. The employee would pay 50 percent of the premium, with workers with incomes under 200 percent of poverty eligible for the individual subsidies described above.

  - Employers who do not currently offer insurance. In addition to the employer subsidies outlined above, employers with fewer than 25 workers who have not offered insurance before January 1 1997 and begin offering it to an entire class of workers would be eligible for the same low income subsidies available to individuals and families. (An employer would receive subsidies equal to 100 percent of the premium for their 50 percent share for workers at or below 75 percent of poverty, and subsidies offsetting part of the premium for workers up to 200 percent of poverty. Employees would be similarly eligible for subsidies for their family share.) Insurance companies and cooperatives would be able to promote this benefit within the community rated pool.

- Individuals up to age 25. To further maximize coverage, individuals could be covered under parents' policies until they turn 25.

- Premium Assessment. As provided for in HSA, a national per capita baseline premium target would be established and adjusted for each health care coverage area. To the extent community rated plans exceed that target, they would pay an assessment on the excess at a rate of 35 percent. As in HSA, the initial target for community rated plans would be established based on current expenditures. The per capita target for both community rated and experienced rated plans would increase at the following rates, except that the target for experienced rated plans would be measured on a three year rolling average basis:

1996:	CPI + 3.0%
1997:	CPI + 2.5%
1998 & beyond:	CPI + 2.0%

- Risk Adjustment. Risk adjustment between community-rated health plans to account for differences in health status among enrollees.

In addition, experienced rated plans would be required to make transfers to the community rated plan pools to adjust for the increased morbidity rates in the community rated pools due to the coverage of the nonworking population, including the former Medicaid population, retirees, and other individual purchasers. The Secretary of HHS would estimate the above average costs incurred by community rated plans that provide services to individual purchasers and that total amount of costs would be assessed on a per capita basis from all insurance plans, including those in the community rated pool and in the experience rated market. The receipts would then be redistributed to community rated plans based on the portion of above average cost individuals they enroll.

- Insurance Market Reforms. As follows:

  - Market segments and boundaries. Firms with fewer than 500 workers and individual purchasers (self-employed, nonworkers, Medicaid-eligibles) would be in the community rated pool. Firms with 500 or more workers, existing Taft-Hartley plans, and rural cooperatives with 500 or more members would be permitted to self-insure or purchase experience-rated coverage.

  - Community rating requirements. Community rated plans could modify their rates based on coverage category (e.g., single, family, etc.), geography, and age (with 2:1 band for population under 65 years of age). Each health plans would be required to establish a single set of rates for the standard benefits package applicable to all individuals and groups within the community-rated segment of a community rating area. Rates for HIPCs could be discounted to reflect administrative savings.

  - Health plan requirements. Health supplemental benefits must be priced and sold separately from the comprehensive benefits package. Plans would be subject to the following market reforms: guarantee issue, guarantee renewal, open enrollment, limit pre-ex exclusions to 6 months; and exit from market rules.

- Guaranty fund. States would be required to establish guaranty funds for all community-rated health plans.

- HIPCs. The plan includes multiple, competing, voluntary HIPCs. If a HIPC is not available in every community rating area, states would be required to establish or sponsor HIPC in unserved area. HIPCs would be responsible for entering into agreements with plans and employers; enrolling individuals in plans; collecting and distributing premium payments; coordinating out-of-coverage with other HIPCs; and providing consumer information on plans' quality and cost.

  HIPCs must accept all eligible individuals and firms; provide enrollees a choice of at least 3 plans, including 1 FFS. Requirement of 3 plans could be waived by Governor in rural areas. The National Health Board would establish fiduciary standards for HIPCs. HIPCs would be permitted to negotiate discounts with plans reflecting economies of scale in administration and marketing.

  Eligible employers (firms with less than 500 workers) must offer at least three plans, including a FFS to their employees. Firms could satisfy this requirement by offering a HIPC to their employees. These firms could choose from among the HIPCs in their community rating area. In order to qualify for employer premium contribution, employees would be required to purchase health insurance through the HIPC chosen by their employer. Employees could choose from the plans offered by the HIPC.

- Self-insured plans. In general, self-insured plans must comply with the above responsibilities and reforms, including employer and individual premium contribution requirements, coverage of a comprehensive package of benefits, guaranteed issue and renewal, and pre-existing condition limits.

- Long Term Care. This plan includes a federal entitlement capped at $48 billion over the 1995-2004 period.

- Medicare Drug. This initiative gives Medicare beneficiaries three options: fee-for-service, a Drug Benefit Carriers option, and an HMO option – all effective 1/1/98. Beneficiaries would have a $500 annual deductible; a 20 percent copay; and an annual out-of-pocket limit of $1,200 in 1998. Medicare Part B premium would be increased by 25 percent of drug benefit costs, with Medicare paying the remaining 75 percent. Drug manufacturers would sign rebate agreements with HHS in exchange for no formulary. Drugs used as part of HMOs or capitated drug plans and the working aged would not be subject to rebates. Rebates for single source and innovator multiple source drugs would be 15 percent; multiple source drug rebate would be 6 percent.

07/19/94 18:21 ☎

FAX

DATE: _____ **TIME:** _____

TO:

RECIPIENT: Bob Reischauer

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: John Hilley

ORGANIZATION: _____

NUMBER OF PAGES: 5
(including this one)

COMMENTS: Attached are (1) Modifications to our earlier transitional employer subsidy proposal designed to address concerns raised by your office, and (2) an update on the specifications for that proposal which includes these modifications.

I will forward more specs on our new proposal shortly.

Additional Modifications to Transitional Employer Subsidy Proposal

- To avoid employer gaming of the subsidy structure, only employers who pay at least 50 percent of an employee's premium would be eligible for federal subsidies.

- Presumably, firms could use the transitional employer subsidies to gradually pass back onto employees health care premium costs, thereby allowing employers to continue to "pay" for such insurance after the more generous transition subsidies expire. However, some employees may assume that temporary transition subsidies will translate into temporary insurance, and try to get all their health problems addressed in the first year. To avoid this perception (and the behavioral consequences), firms which accept transitional subsidies must agree to offer insurance that year and in the two subsequent years.

- This proposal could potentially create some perverse incentives for two earner families. For example, families already covered under one spouse's plan may attempt to switch all children to the second spouse's plan if the second spouse's plan is highly subsidized. Such behavior would be somewhat limited by the fact that the first spouse's plan often may be more generous (extra benefits) or desirable (lower deductibles) than the second spouse's subsidized plan. To minimize these incentives, however, we would require that all family members purchase insurance as a unit through one employer (unless one employer offers insurance only to the actual employee). We would also require that two earner families purchase insurance through the higher earner.

- One key definitional issue is who qualifies for generous transitional subsidies as a previously non-insured worker. Because some firms may employ a mix of insured and uninsured workers, the "non-insured" determination would be made on a per worker basis. A related issue is what level of employer contribution should qualify as "providing insurance." Under this plan, workers who had been offered an employer contribution worth at least $500 would not qualify for transitional employer subsidies. New workers would not qualify for transitional employer subsidies if all other workers at a firm previously had been insured; nor would new workers at partially insured firms if their salary exceeded the mean salary of the firm's insured workers.

- Transitional subsidies would not be available to new firms after the transition period. Generous transitional subsidies are designed to give non-insuring firms a longer and more realistic time period over which they can pass back the cost of health insurance to their workers in the form of lower wages. After the transition period, wages throughout the job market will have adjusted downward to reflect the passback of health care costs onto workers. In this new market, firms starting up can provide insurance, pay the prevailing wage rate, and not suffer any competitive disadvantage.

7/19/94

HEALTH CARE REFORM: POSSIBLE COMPROMISE

- No Mandates. Under this option, there would be no mandate on either employers or individuals to purchase health insurance.

- Subsidies Encourage Participation. Subsidies would be available to encourage both employers and employees to purchase insurance voluntarily. The subsidy system would not go into effect until 1997, allowing offsetting Medicare cuts and tobacco taxes to accrue in a trust fund.

- Employer Subsidies. All firms would ultimately be eligible for the same subsidies. But to encourage firms to provide coverage to non-insured workers, firms would initially be eligible for more generous subsidies for uninsured workers (earning up to $18,000) than would be available to firms for already insured workers. Offering such generous subsidies upfront will ease the transition for firms which provide coverage to uninsured low and moderate wage employees. Specifically:

  - For currently uninsured workers earning up to $18,000, firms would initially have their share of insurance costs *wholly offset* if they chose to pick up their employees' health costs.

  - These transitional subsidies would eventually be phased down to a permanent maintenance level. In the second year, the employer's total payment would be capped at 2 percent of the worker's wage; growing each year thereafter by 2 percentage point increments up to the permanent subsidy level for that worker. Transitional subsidies would not be available to new firms forming after the end of the transition period. (See attached Table 1.) NOTE: We would like CBO's advice on how to modify the phase down structure so that it would maximize the amount that employers can reasonably pass back to their employees annually.

  - Firms which accept transitional subsidies in any year must agree to offer insurance that year and in the two subsequent years.

  - Because some firms employ a mix of insured and uninsured workers, the "non-insured" determination would be made on a per worker basis.

  - An employer who has offered to contribute at least $500 towards a worker's premium payment would not qualify for transitional subsidies for that worker. In terms of new workers, employers currently insuring all their workers would not receive transitional subsidies for new workers. Employers who insure some of their workers would not receive transitional subsidies for new workers whose salaries exceeded the mean salary of the firm's insured workers.

  - The permanent subsidies would cap employer premium payments between 12 percent and 6 percent of each worker's individual wage, based on the employee's wage, for employees earning up to $18,000. The subsidy would be phased out for workers earning between $18,000 and $28,000.

- During the transition, employer subsidies for currently insured workers would be somewhat below the maintenance level. In the first year, currently insuring firms would calculate the federal subsidy to which they would be entitled under the permanent subsidy regime, and they would receive 20 percent of that total. That percent would grow to 30 percent in the second year, 40 percent in the third year, 50 percent in the fourth year, 60 percent in the fifth year, 70 percent in the sixth year, and 100 percent in the eighth year. (See attached Table 2.)

- Only employers who pay at least 50 percent of an employee's premium would be eligible for federal subsidies.

- Assume provisions to minimize gaming by both employers and employees. For example, require that all family members purchase insurance as a unit through one employer (unless one employer offers insurance only to the actual employee). Also require that two earner families purchase insurance through the higher earner.

- Anti-Discrimination Clause. A firm's coverage policy must be consistent across its entire workforce. That is, a firm that contributes to the insurance costs of any of its full-time workers must offer the same contribution to all of its full time workers. Similarly, a firm offering insurance to any of its part-time workers must offer it to all part-time workers. (Senate Finance Committee Chairman's mark.)

- Individual Subsidies. For those individuals receiving coverage through an employer, their individual share would be capped at 3.9 percent of income, based on a sliding scale up to 150 percent of poverty. The 3.9 percent cap would apply to any shared employee/employer contribution scheme in which the employer pays at least 50 percent of the premium cost. Individuals without employer coverage who pay the full premium themselves would pay both the employer and individual share, subject to the same caps. For example, an individual whose wage would have capped his employer's payment at 10 percent of the worker's wage would pay up to 13.9 percent of his income on his own insurance (10 percent + 3.9 percent).

- Premium Assessment. As provided for in HSA, a national per capita baseline premium target would be established and adjusted for each health care coverage area. To the extent community rated plans exceed that target, they would pay an assessment on the excess at a rate of 35 percent. As in HSA, the initial target for community rated plans would be established based on current expenditures. The per capita target for both community rated and experienced rated plans would increase at the following rates, except that the target for experienced rated plans would be measured on a three year rolling average basis:

1996:	CPI + 3.0%
1997:	CPI + 2.5%
1998 & beyond:	CPI + 2.0%

- Minimizing Federal Risk. After the transition period, subsidies would be based on target growth rates, not actual growth. This would ensure that premium cost increases above the target rate would be borne by individuals and businesses, not by the federal government.

- PAYGO Offsets. This proposal includes the HSA cigarette tax and the approximately $70 billion in five year Medicare cuts included in the Senate Mainstream proposal.

- Insurance Market Reforms. Insurance market reforms must be modified to avoid adverse selection. Modifications include allowing both age adjustments for community rating (2 to 1 age band) and 6 month pre-existing condition exclusions for the currently uninsured.

- Community Rating Threshold/Assessment. Firm size threshold for community rating would be reduced from 5,000 to 500. Firms with more than 500 employees would be assessed 1 percent of payroll. All firms, regardless of size, would be eligible for employer subsidies.

- Benefits Package. Actuarial equivalent of the Blue Cross/Blue Shield standard option. Assume no outyear expansion.

- Medicaid Population. Integrate Medicaid population into the health system in a manner similar to HSA. Assume a reimbursement growth rate consistent with the premium targets outlined above.

- Other Provisions. For non-delineated provisions, assume Labor Committee approach.

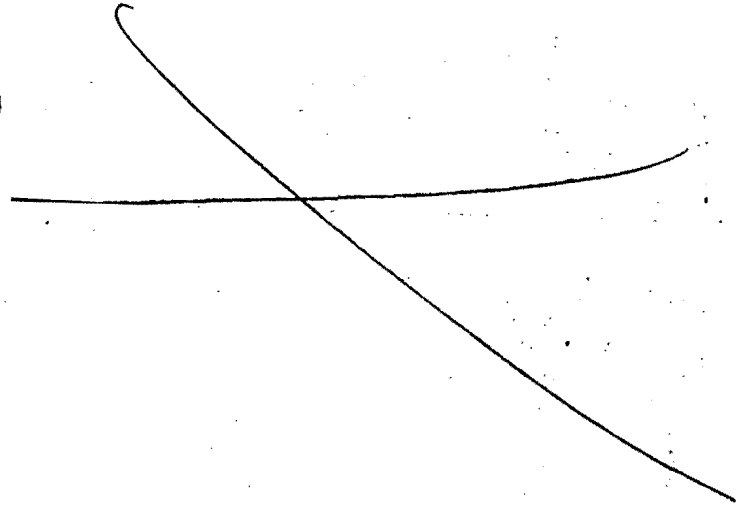
TRANSITION EMPLOYER SUBSIDIES FOR NON-INSURED WORKERS: TOTAL EMPLOYER PREMIUM PAYMENTS AS A PERCENT OF EMPLOYEE WAGE

Worker Wage:	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
$12,000 & Under.....	1/	1/	0%	2%	4%	6%	6%	6%	6%	6%
$12,001-$13,000.....	1/	1/	0%	2%	4%	6%	7%	7%	7%	7%
$13,001-$14,000.....	1/	1/	0%	2%	4%	6%	8%	8%	8%	8%
$14,001-$15,000.....	1/	1/	0%	2%	4%	6%	8%	9%	9%	9%
$15,001-$16,000.....	1/	1/	0%	2%	4%	6%	8%	10%	10%	10%
$16,001-$17,000.....	1/	1/	0%	2%	4%	6%	8%	10%	11%	11%
$17,001-$18,000.....	1/	1/	0%	2%	4%	6%	8%	10%	12%	12%

1/ No subsidies available in 1995 and 1996.
NOTE: Employer subsidies phase out for workers with wages between $18,000-$28,000.

TABLE 2: PHASE IN OF EMPLOYER SUBSIDIES FOR CURRENTLY INSURED WORKERS

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Percent of Maintenance Subsidy Available to Employer	0%	0%	20%	30%	40%	50%	60%	70%	100%	100%



FAX

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PERSON SENDING: John Hilley

ORGANIZATION: _____

NUMBER OF PAGES: 11 – GME/Benefits
(including this one)

COMMENTS: Attached are specs for several provisions in our new targeted subsidy proposal. Given the number of pages, I'll send it in several batches. We will also try to get additional Medicare info. to you tonight (beyond what is in these specs), but that may slip 'til tomorrow.

WORKFORCE/GME/GNE/AHC/MEDICAL SCHOOLS/HEALTH RESEARCH

Title III, Subtitle A - Workforce Priorities under Federal Payments

A. National Council regarding Workforce Priorities.

National Council on Graduate Medical Education. L Sec 3001

o Appointed by the HHS Secretary
* o Composition: size 12-18 members
- one quarter: consumers, at least one rural
- one quarter: specialty physicians who are faculty of medical schools; specialty physicians not faculty; CEOs of teaching hospitals
- one quarter: primary care physicians who are faculty of medical schools; primary care physicians who are practicing, but not faculty of medical schools; at least one rural physician.
- one quarter: officers and employees of health plans; officers or employees of purchasing cooperatives.
- Ex officio members: other federal officers or employees
o Definitions: medical school includes a school of osteopathic medicine.

B. Authorized Positions in Specialty Training

Approved physician training programs. L Sec 3011

o definitions
- approved physician training program
* - qualified applicant: entity that trains individuals in an approved physician training program and receives payments under Part C

Annual Authorization of Number of Specialty Positions; Requirements regarding primary health care. L. Sec 3012

o annual authorization of number of positions
* o primary health care. "the National Council shall ensure that, of the class of training participant entering eligible programs for the first time for academic year 2000-2001 or any subsequent academic year or any subsequent year, the percentage of such class that completes eligible programs in primary health care and does not subsequently (within 10 years) enter a nonprimary care training program is not less than 55 percent (without regard to the academic year in which the members of the class complete the programs) and the percetnage of such class that completes eligible programs in nonprimary care specialities is not more than 45 percent (without regard to the academic year in which the members of the class complete the programs."
o percentage applies to aggregate, not individual programs.
o designations regarding three year periods

- o considerations in designating annual numbers
  - factors to consider
  - recommendations of private organizations
  - total # "bears a relationship to the # of graduates"
- o interim voluntary targets
- o study by IOM, not later than 2005, of effect this program.

* o definitions
- primary health care: family medicine, general internal medicine, general pediatrics, geriatric medicine and obstetrics and gynecology.

* - medical shortage specialties or protected medical specialties, as designated by the Council, should have special treatment among those nonprimary care specialties, such that their number shall not be reduced and may even increase, as directed by the Council.
- only those participants in programs with a significant primary care training emphasis will have completed training in primary care.

Allocations among specialties and programs. L Sec 3013
- o advance notice
- o initial period
- o certain considerations
  - geographic
  - underrepresented minorities and women
  - underserved rural and inner-city communities
  - recommendations of private organizations

C. Costs of GME

Federal formula payments to qualified entities. L Sec 3031.
- o in general

* o payments for operation of approved physician training programs: "The purpose of payments is to assist a qualified applicant with the costs of operation of an approved physician training program." (Do we want to specify more?)
- o qualified applicant definition
  - in general

* - includes: resident training program, "teaching hospital, medical school, group practice, an entity representing two or more parties engaged in a formal association, a community health center or another entity operating an approved physician training program."

Application for Payments. L. Sec 3032
- o in general
- o certain entities: written agreement among all participants, as to payment allocation

* o add section that stipulates that "residency training program directors will be notified by the institution in which they reside of the amounts of GME and IME funding received by the institution in association with the number of postgraduate trainees in their program."

* o definition of residency training program director.

Transitional Payments to Institutions. L. Sec 3061
- o payments as grant, contract, cooperative agreement.
- o eligible entities
  - reduces number of specialty positions with respect to number in 1993-94.
- * o application for payments: These payments should be based on the historical amount GME payments, rather than the national average per resident amount.
- o amount of payments
  - annual phase out over four years; one quarter less each year.
- * - in urban or rural underserved communities, where the Secretary has determined that there would be harm in terms of access to care for the community, if residents were not providing services, eliminating the phase out or reducing its pace should be considered.

Part 2 Institutional Costs of Graduate Nursing Education

Authorized Graduate Nurse Training Positions L Sec 3071
- o definitions
- * - graduate nurse training programs include: nurse practitioners; nurse anesthetists; midwives; clinical nurse specialists.

Applicability of Part 1 Provisions. L Sec 3072
- o National Council composition by PHS Act sec 851.
- * o allocation method needs to be worked out.
- o funding: $200 mill each year.

Part 3 Related Programs

A. Workforce Development

Programs of Secretary HHS. L Sec 3081
- o Funding: 1995-6 - $100 mill/yr; 1997-2000 - $150 mill/yr
- o primary care physician and PA training
- o underrepresented racial and ethnic minorities
- o expanding rural health careers
- o nurse training
- o inappropriate practice barriers
- o advisory board on health care workforce
- o other programs
- o relationship to existing programs
- o mental retardation and other developmental disabilities

Programs of Secretary of Labor L Sec 3082
- o funding: $200 mill/yr
- o retraining programs; advanced career positions; workforce adjustment programs

Redeployment of Health Care Workers. L Sec 3083

B. Transitional Provisions for Workforce Stability

Application L Sec 3091

Definitions L Sec 3092

Obligations of Displacing Employer L Sec 3093

Employment with successors L Sec 3094

Collective bargaining obligations L Sec 3095

Subtitle B - Academic Health Centers

Discretionary Grants regarding Access to Centers L Sec 3131
- o rural info and referral centers
- o urban and rural areas
- o authorization: 1995 - $3 mill; 1996 $4 million; 1997-2000 - $5 million

Subtitle C - Health Research Initiatives

Part 1 - Programs for Certain Agencies

Biomedical and Behavioral Research L Sec 3201
- o findings
- * o availability of funds
  - 0.50 percent of premiums, 20% for AHCPR

Expenditures for Health Research L Sec 404F
- * o 20% for AHCPR.

Health Services Research L Sec 3202
- * o section 902. (Why not change language of Agency for Health Policy and Research here).

Part 2 Funding for Program
- o Health Services Research: 1995 - $150 mill; 1996 - $ 400 mill; 1997 $500 mill; 1998-2000 $600 mill.

Annual Amount of Payments L Sec 3033
- o 1996 - $3.2 billion...2000 - $5.8 billion.
- o Per resident amount: five year transition to 50/50.
- o Inflation and wage/wage-related costs adjustment.

Medical School Fund Account

Federal Payments to the Medical School Fund L Sec 3041
- o in general
- * o trust fund payments to individual medical schools will be based on enrollment as of 1993-94 for 75% of the fund; research for 25% of the fund. Each medical school will have to demonstrate that that portion of the fund allocated on basis of full-time equivalent students will be (has been) divided 50% for primary care ambulatory training; 25% other ambulatory care training; 25% for the general support of primary care departments and divisions.
- o Of the 50% of funds for primary care ambulatory training, per capita payments should be made by medical schools for off-school education (see Sec 3083 of Ed and Labor bill).

Application for payments. L Sec 3042

Annual Amount of Payments. L Sec 3043
- o 1996 - $200 mill...2000 - $600 million
- * o Amount for Individual Programs
  - formula: three-fourths on enrollment
    one-fourth on research

Academic Health Centers

Federal Formula Payments to AHCs. L Sec 3051
- * o in general: needs to be adjusted to include Schools of Dentistry and Schools of Public Health
- o distribution of funds to high intensity non-teaching rural hospitals would be according to a formula based on the case mix index and would result in an increase in payments of approximately five percent.
- o payments for costs attributable to academic nature of the institutions.

Requests for Payments L Sec 3053
- o 1996 - $6.28 billion...2000 - $10.64 billion.
- o formula for individual institutions
- o modifications in formula: report to Congress in year 2000

D. General Provisions

Definitions L Sec 3055

E. Transitional Provisions

BENEFITS

Title I: Subtitle B

A. Value and Structure of the Benefits Package

The value of the standard benefit package would be equal to the actuarial value of the Blue Cross/Blue Shield standard option under the Federal Employees Health Benefits Program, adjusted for an average population.

Cost sharing arrangements would be specified by the National Board consistent within the following statutory requirements.

- o Cost sharing may include co-payments, co-insurance and/or deductible amounts.

- o Clinical preventive services must be covered without cost sharing.

- o There would be at least two cost-sharing options for certified standard health plans.

- o In addition. there should be a very high deductible "alternative standard" health plan designed with in the following guidelines: it must cover all 16 benefit categories; it should not be offered through employers; insurers offering this plan in a community rating area must also offer a community-rated standard plan in that area; enrollees selecting this plan should be included in the community rating pool for standard plans and should not be able to add supplemental policies.

- o At least one health plan with a point-of-service option should be offered by all self-insured employers and all health insurance purchasing cooperatives.

- o All plans must have an out of pocket limit of no more than $2,500 per individual and $3,000 per family, except the very high deductible, alternative standard plan.

- o Low income individuals and families would be eligible for reduced cost sharing at percentages specified in statute to assure affordable access to care. Individuals/families with incomes below poverty would pay 20 percent of the required cost sharing; individuals/families with incomes between 100-200 percent of poverty would pay 40 percent of the required cost sharing.

B. Covered Services

Health plans would be required to offer the same set of covered services. Categories of covered services and equipment would be defined in statute as follows:

1. Hospital services, including inpatient, outpatient, 24-hour a day hospital emergency, and hospital services provided for the treatment of a mental or substance abuse disorder. The definition of the term "hospital" would be the same as in Medicare, with additional reference to facilities of the uniformed services, Department of Veterans Affairs and Indian Health Service.

2. Health professional services, including inpatient and outpatient services and supplies (including drugs and biologicals which cannot be self-administered. Health professional services means professional services that are lawfully provided by a physician or another person who is legally authorized to provide such services in the State in which the services are provided.

3.Emergency and ambulatory medical and surgical services, including 24-hour a day emergency services, or ambulatory medical or surgical services.

4. Clinical preventive services, including services for high risk populations, age-appropriate immunizations, tests or clinician visits consistent with any periodicity schedule specified by the National Health Board. The National Health Board would be directed to consult with appropriate government agencies, task forces and professional groups (for example, using recommendations of the advisory committee on Immunization Practices, the US preventive Services Task Force, and for children, the American Academy of Pediatrics). Special consideration should be given to services for women, children and vulnerable populations.

5. Mental illness and substance abuse services. Mental illness and substance abuse disorders would be defined, respectively, as those listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or revised version of such manual.

o The National Health Board would be directed to define mental illness and substance abuse services so as to achieve parity with services for other medical conditions and to develop standards for the appropriate management of these benefits. The term parity means provision of medically necessary or appropriate comprehensive mental illness and substance abuse inpatient, outpatient, residential and intensive non-residential services, so as to ensure that arbitrary day or visit limits or cost sharing requirements would not be applied to mental illness and substance abuse services that are not applied to medical health services. Such services should encourage use of outpatient treatments to the greatest extent possible.

o If the National Health Board determines that immediate parity cannot be achieved within cost constraints, it may limit coverage for hospital care, provided that:

1. The limit is not set below 30 days;

2. The Board ensure that public and/or philanthropic funds are available to pay for medically necessary hospital care beyond the limit; and

3. The limits are lifted no later than January 1, 2001, consistent with the procedures in section 3510.

6. Family planning services and services for pregnant women, including contraceptive drugs and devices dispensed by prescription and subject to approval by the Secretary of HHS under the Federal Food, Drug and Cosmetic Act.

7. Hospice care services, as defined in Medicare.

8. Home health care services, as defined in Medicare with limitations such that these services would be alternative of inpatient treatment in a hospital, skilled nursing facility or rehabilitation facility and would be reevaluated after each 60 day period. Covered services to include treatment as a result of illness, injury, disorder or other health condition.

9. Extended care services, as defined in Medicare when provided in inpatient skilled nursing facility or a rehabilitation facility as an alternative top inpatient hospital services. Covered services to include treatment as a result of illness, injury, disorder or other health condition.

10. Ambulance services provided by ground, air or water transportation using equipment for transporting injured or sick individuals, only if indicated by the medical condition of the individual or in cases in which there is no other method of transportation or where use of other methods is contraindicated by the medical condition.

11. Outpatient laboratory, radiology and diagnostic services, provided upon prescription to individuals who are not inpatients of a hospital, hospice, skilled nursing facility, or rehabilitation facility.

12. Outpatient prescription drugs, home infusion drug therapy and biologicals, including accessories and suppliers used directly with drugs and biologicals, including any use approved by the Food and Drug Administration or if cited in the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information and other authoritative compendia as identified by the Secretary. Blood clotting factors would be defined as in Medicare. The Secretary of HHS may revise the list of compendia.

13. Outpatient rehabilitation services, including outpatient occupational therapy; outpatient physical therapy; outpatient respiratory therapy; and outpatient speech-language pathology services and audiology services as a result of an illness, injury, disorder or other health condition. Services shall include a range of services designed to restore or maintain functional capacity or prevent or minimize limitations on physical and cognitive functions, including attaining new functional abilities at an age-appropriate rate. The need for continued services would be reevaluated at the end of each 60 day period by the person primarily responsible for providing the services.

14. Durable medical equipment, prosthetics and orthotics, and prosthetic devices, including accessories and supplies used directly with such equipment or devices. Coverage includes: 1) repair and maintenance of such equipment or devices; 2) replacement when required due to loss, irreparable damage, wear, or because of a change in the patient's condition; and 3) fitting and training for use of these items. Prosthetic devices are devices that replace all or part of the function of a body organ; orthotic devices are those accessories or supplies used directly with prosthetic devices to achieve therapeutic benefits and proper functioning; orthotics include leg, arm, back and neck braces; prosthetics include artificial legs, arms, and eyes. DME would be defined consistent with current Medicare coverage policies.

15. Vision care, hearing aids and dental care for individuals under 22 years of age, including eyeglasses, contact lenses, emergency dental treatment for acute infections, bleeding and injuries to prevent risks to life or significant medical complications, prevention and diagnosis of dental disease, including routine fillings, prosthetics for congenital defects, periodontal maintenance and endodontic services; space maintenance procedures to prevent orthodontic complications and interceptive orthodontic treatment to prevent severe malocclusion.

16. Investigational treatments, including routine care provided in research trials approved by the Secretary of HHS, the Directors of the National Institutes of Health, the Commissioner of the Food and Drub Administration, the Secretary of Veterans Affairs, the Secretary of Defense, or a qualified nongovernmental research entity as defined in guidelines of the National Institutes of Health, including guidelines for National Caner Institute-designated cancer center support grants; or a peer-reviewed and approved research program as defined by the Secretary.

In addition to the above services, health plans must provide coverage for all medically necessary or appropriate services within these categories of services. Medically necessary or appropriate treatments would be defined as those intended to maintain or improve the biological or psychological condition of the enrollee or prevent or mitigate an adverse health outcome to an enrollee. For individuals under 22 years of age, health plans would be directed to give consideration to age and health status to prevent or ameliorate the effects of a condition, illness, injury or disorder, to aid in the individual's overall physical and mental growth and development, or assist the individual in achieving or maintaining maximum functional capacity.

Initial determinations of medical necessity or appropriateness should be made between patients and providers. Health plans may make determinations of medical necessity and appropriateness and shall consider: 1) any relevant determinations by the Food and Drug Administration with respect to safety and effectiveness; 2) any practice guidelines that have been developed under section 912 of the Public Health Service Act; 3) published peer-reviewed medical literature; 4) opinions of medical specialty groups; and 5) evidence of general acceptance in the medical community. The National Health Board may promulgate such regulations or establish such guidelines as may be necessary to establish additional criteria for the determination of medical necessity or appropriateness. Any such regulations or guidelines shall be consistent with this Act and shall permit a health plan to use the providers and methods that the plan determines to be appropriate and consistent with standards of quality care provided that the plan complies with all other provisions of this Act. In the absence of sufficient evidence to make coverage determinations, the National Health Board shall recommend to the Secretary specific areas for which priorities should be given to undertake clinical trails or practice guidelines.

C. The National Health Board

The National Health Board, in consultation with expert groups, would be authorized to promulgate regulations to: clarify covered services and cost-sharing; refine the statutory definition of medical necessity or appropriateness; develop appropriate schedules for covered services; and refine policies regarding coverage of investigational treatments, within the guidelines above. The board would also be authorized to issue regulations to modify the categories of covered services and cost sharing that would go into effect unless Congress overturns the regulations by joint resolution considered under fast-track procedures.

FAX

DATE: _____ **TIME:** _____

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QUALITY

Without the Finance legislative language, I have borrowed much from the Labor bill. This section may need to be modified.

Title V, Subtitle A

L Sec 5001 National Quality Council
- o 15 members appointed by the President, not FT
  one-third: health providers/quality researchers
  one-third: consumers
  one-third: health plans, purchasers, States

- o Duties, to develop
  - national goals and performance measures
  - uniform quality goals
  - surveys of plans and consumers
  - consumer report cards
  - establish consumer info/advocate (not in L)
  - establish quality improvement foundations
  - evaluate implementation of this Act.

- o Staff

L Sec 5002 National Goals and Performance Measures
- o Outcomes of health services and procedures
- o Health promotion
- o Prevention of diseases and other conditions
- o Access to care and appropriateness of care

L Sec 5003 Performance Measures for Health Plans
- o Access to services: provider to patient ratios; waiting times for appts; travel distances; community involvement and outreach.
- o Appropriateness of care
- o Consumer satisfaction
- o Quality improvement
- o Documenting provider credentials & competency
- o Management of clinical, admin, financial info
- o Utilization and underutilization monitoring

L Sec 5004 Health Plan Data Analysis and Consumer Surveys
- o National sample

L Sec 5005 Evaluation and Reporting of Quality Performance
- o Annual reports on plans by States
- o Consumer Report Cards
- o Public availability of National Practitioner Data Bank data.

L Sec 5006 Development and Dissemination of Practice Guidelines
- o Advise AHCPR
- o Standards for evaluating guidelines

L Sec 5007 Research on Health Quality
- o Recommendations to AHCPR

L Sec 5008 Quality Improvement Foundations
- * o Secretary shall select through a competitive grant making process one QIF per State or if States agree per region.
- * o Eligible applicants: add based in State.
- o Duties described:
- * modify last duty, notice to the State only if it is determined that patients lives are in danger.

L Sec 5009 Authorization of Appropriations
- * o Use finance committee proposal and present cost of PROs: 1996, $100 mill; 1997 $200 mill; 1998 $300 mill; 1999 $300 mill; 2000 $300 mill.
- * National Quality Council budget. TBA.

L Sec 5010 Role of the States in Quality Assurance
- o disseminate to consumers information on quality and access to aid in selection of health plans.
- o disseminate information on the quality of health plans and health care providers contained in reports by National Quality Council.
- * o support the creation of a non-governmental, State-based office of consumer advocacy through competitive grant making process as described in Sec 1207 with the responsibilities described therein.
- o ensure collaboration with QIFs.

L Sec 5011 Role of Health Plans in Quality Management
- o measure and disclose performance measures.
- o furnish info
- o maintain quality management systems

L Sec 5012 Information on Health Care Providers

L Sec 5013 Conforming Amendments to PHS Act.

Costs of these efforts in each bill are:

	FINANCE	LABOR
	billions of $ over 5 years	
National Quality Council	none	$ 0.02*
Centers for Consumer Information/Advocacy	$ 1.025	$ 0.55**
State Accreditation, Certification, Enforcement and Information Programs	$ 1.3	?

and may change

Quality Improvement Foundations	$ 0.8	$ 1.5*
ACHPR	$ 1.0	$ 2.25

* estimates, not included in bill,
** includes advocate and survey programs; advocate program funded by a 0.02% assessment on community-rated premiums.

Source of funds for the Finance estimates was the Health Security Trust Fund, which was the repository for most of the Finance Committee new revenue streams (e.g., tobacco taxes, premium taxes, etc.) The Labor Committee made "authorized to be appropriated such sums as may be necessary".

HEALTH SERVICES FOR THE MEDICALLY UNDERSERVED
ESSENTIAL COMMUNITY PROVIDERS

Title III, Subtitle E (Labor) vs. Title XII (Finance)

o Creation of infrastructure development account within the Health Security Trust Fund. HHS Secretary required to deposit $1.3 billion annually, adjusted for inflation, to fund these programs.

o Purpose of infrastructure development account

- to support certified community health plans and essential community providers with operating and capital funds;

- to support development of community health networks;

- to attract and retain more providers to underserved areas;

- to stimulate telemedicine demonstration projects for rural underserved areas;

- to foster enabling services (transportation, translation, outreach, health education, case management, home visiting, etc.) and supplemental services (dental, mental health and substance abuse services) in underserved areas;

- to provide a new emphasis on urban and rural health.

o Eligible Entities.

1. covered entities as defined in section 340B(a)(4) of the Public Health Service Act (? except that subsection (a)(4)(iii) and (a)(7) shall not apply. FQHCs, qualified migrant and community health centers, etc.;

2. rural health centers;

3. qualified homeless programs;

4. family planning providers and maternal and child health block grant recipients;

5. nonprofit hospitals and public hospitals;

6. public and private nonprofit community mental health centers;

7. runaway homeless youth centers;

8. rural referral centers;

9. State or local public health agencies;

10. Isolated rural facilities;

11. providers of services in urban areas under Title V of the Indian Self-determination Act;

12. public or nonprofit entities in nonmetropolitan areas in consortium of community-based providers including at least three of (A-F in Labor 3411 (c)(7).

13. school health services sites

14. other institutions, physicians, and other providers servicing a HPSA or MUA.

o Grants and contracts for development of plans and networks and the expansion and development of health care sites and services. L Sec 3421.

o Grants and contracts for operating assistance to certified community health plans and community health networks;

o Provide loans, loan guarantees and grants for capital assistance to these entities. L Sec 3441.

o Provide grants and contracts for enabling services and supplemental services. L Sec 3461.

o Expand funding for the National Health Service Corps. L Sec 3461.

o Provide funding for telemedicine demonstration projects. Use language from Conrad bill on telemedicine.

o Create the position of the Assistant Secretary for Rural Health.

o Certification of essential community providers. L Sec 1682.

o Health plan requirements relating to essential community providers. L Sec 1531.

- Health plans should be required to contract with more than one ECP in each HPSA or MUA, if there is more than one.

- Health plan payments to FQHCs on reasonable cost rates.

o The vulnerable poluation adjustment payments program should be in a separate section and will depend on the fate of the disproportionate share (DSH) program.

MEDICARE

I. Individual Election to Remain in Private Health Plan

- Managed care plans that have, or would be eligible for Medicare risk contracts, must offer continued membership in the health plan (with the same benefits) to enrollees who become eligible for Medicare, and their spouse and dependents.

- Payments would be made to health plans on the same basis as Medicare payments to risk contracting organizations.

- Individuals electing this option would be charged a premium by the health plan equal to the difference between the health plan's premium (adjusted to reflect the actuarial difference between the Medicare beneficiaries and other plan enrollees) and the Medicare payment amount.

- Payments under this section would be the sole Medicare payment to which the beneficiary is entitled.

II. Improvements in Medicare Risk Contracts

- Health plans entering into Medicare risk contracts would be required to meet the standards for integrated health plans specified in the Chairman's mark.

- The current "50/50" requirement under the Medicare risk contract program could be waived if the plan provides for adequate quality of care to meet quality standards for Medicare risk contracts and other rules.

- Reform the AAPCC payment methodology with a formula based on the weighted average of fee-for-service per capita costs in the community rating areas and the premiums submitted by Medicare health plans to the Secretary to provide Medicare benefits; the Secretary would be permitted to risk adjust payments for health disease, cancer or stroke.

  Finance Committee staff is working on details of provisions in Finance mark regarding Medicare risk contract improvements including reformed calculation of AAPCC.

III. Medicare Outpatient Prescription Drug Benefit

- Medicare beneficiaries would have three options to obtain prescription drug coverage: fee-for-service, a Drug Benefit Carriers (DCB) option, and an HMO option; effective January 1, 1998.

- $500 annual deductible; 20% beneficiary copay Annual out-of-pocket limit $1,200 in 1998.

- Part B premium would be increased by 25% of new drug benefit costs. Medicare would assume remaining 75%.

- Office of Technology Assessment would establish a Prescription Drug Payment Review Commission (RxPAC) which would report to Congress annually on the operation of the Medicare prescription drug program.

- Drug manufacturers would sign rebate agreements with the Secretary in exchange for no formulary. Drugs used as part of HMOs or capitated drug plans and the working aged would not be subject to rebates. Rebates for single source and innovator multiple source drugs would be 15%; multiple source (generic) drug rebate would be 6%.

MEDICARE SAVINGS

Specific cuts to be determined.

NOTE: Phase down of low income subsidies (from 75% - 200% of poverty) is linear.

FAX

DATE: _____ **TIME:** _____

TO:

RECIPIENT: Bob Reischauer

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: John Holley

ORGANIZATION: _____

NUMBER OF PAGES: 8 *(including this one)*

COMMENTS: Attached are specs for several provisions in our new targeted subsidy proposal. Given the number of pages, I'll send it in several batches. We will also try to get additional Medicare info. to you tonight (beyond what is in these specs), but that may slip 'til tomorrow.

Home and Community Based Long-Term Care Program

I. Home and Community-Based Long Term Care Program

- A new program for individuals with 3 or more deficiencies in Activities of Daily Living (ADL), severe mental retardation or severe cognitive impairment.
- Eligibility open to persons of all ages and incomes.
- Services under this program are considered a capped entitlement to the States, not an individual entitlement.
- Federal government will make grants to the States to carry out this program, at a matching rate of approximately 15 points higher than the FMAP (Medicaid rate). The allotment for states must take into account the percentage of State residents below the poverty line.
- Cost-sharing and deductibles based on income of beneficiaries. Increase top income bracket to 400% of poverty, instead of 325%, and impose 40% copay with $600 deductible. Supplemental insurance policies that cover the deductibles and copayments could be sold.
- State plans must also provide assurance to the Federal government that existing medicaid beneficiaries will not be "dumped" into the program. States may enhance Medicaid services of beneficiaries who are eligible for the new program.
- State plans must include protections for long-term care workers whose jobs may be displaced by the need to offer consumer-directed, non-institutional services.
- The benefit will be phased in over seven years beginning in 1998, with full funding in 2004.
- States are not required to maintain spending for Medicaid personal care and home and community based waivers.
- Medicaid will no longer be the primary payer for dual-eligible individuals.
- Limit the percentage of SSI clients in the new program to some percentage of the total number.

II. Long Term Care Insurance Standards

- Private long term care insurance policies would be subject to Federal model standards to be developed by the Secretary of HHS in consultation with the National Association of Insurance Commissioners within one year of enactment.

- The Secretary has authority, in consultation with NAIC, to develop alternative requirements. Pending regulation, enact interim statutory requirements similar to the Senate Labor provisions.

- Participating states would be required to certify policies as meeting new Federal standards.

- Participating states are also required to develop a long term care insurance standard regulatory and enforcement program, which includes adoption of the NAIC model standards and consumer protections, and a premium review and approval process. Standards include mandatory offer of inflation protection and mandatory nonforfeiture protection.

- Certain marketing, coverage, and reporting requirements for insurers and agents would be established to protect consumers.

III. Tax Clarifications for Long Term Care Insurance

- Per-diem payments under a long term care insurance contract generally would not be included in gross income, subject to a cap of $150 per day. Expenses for long term care services and insurance premiums would be treated as medical expenses. Employer contributions for long term care insurance would not be excludable from gross income. Long term care insurance could not be offered through a cafeteria plan.

- A long term care insurance contract generally would be treated as an accident and health insurance contract, and a long term care insurance rider to a life insurance contract generally would not disqualify the life insurance contract. Effective date: January 1, 1996.

- Tax credit for working aged included in the Finance Committee provisions.

IV. Life Care Program

To be determined.

V. State Programs for Extended Services for Children with Special Health Care Needs

- Medicaid rules governing covered services, recipient eligibility, and federal/state match rate, would be retained to cover services not otherwise provided through certified health plans. Finance Committee provision.

- The current flexibility provided to States to determine the optional services and groups they cover would be retained.

VI. Miscellaneous Long Term Care

- Extend PACE demonstration sites to 40. Finance Committee provision.

- Note: Limited changes in the existing Medicaid long term care program are discussed in the Medicaid section.

FAX

DATE: _____ TIME: _____

TO:

RECIPIENT: Bob Reischauer

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: John Holley

ORGANIZATION: _____

NUMBER OF PAGES: 8
(including this one)

COMMENTS: Some additional specs on Medicare & risk adjustment.

7/20/94—D

Medicare Savings Proposals

Part A

- Reduce the Annual Hospital Update: Reduce the update for inpatient hospital services by an additional 0.5 percentage points in FY 1997 (for a total of 1.0 percentage points) and by 1.0 percentage points in FY 1998 through FY 2000.

- Reduce Payments for Hospital Capital: For PPS hospitals, reduce the base capital rate by 7.31 percent; reduce hospital-specific capital rates by 10.41 percent; and reduce the update to the capital rates by 4.9 percent per year between FY 1996 and FY 2003. Pay 85 percent of capital costs for hospitals and hospital units excluded from PPS for fiscal years 1996 through 2003.

- Revise the Disproportionate Share Hospital Adjustment: Reduce the current Medicare disproportionate share adjustment for PPS hospitals when the State in which they are located comes onto the new system by 20 percent.

- Graduate Medical Education (Cash Lag): Beginning with FY 1996, Medicare will cease to make GME payments to hospitals directly and instead will make a contribution into a national pool. Medicare will contribute $1.5 billion in FY 1996 and $1.6 billion in FY 1997 and FY 1998. Beginning with FY 1999, the Medicare contribution in the prior year would be increased by the change in the Consumer Price Index.

- Extend OBRA93 SNF Update Freeze: Eliminate catch-up that would result after SNF two year temporary freeze expires (i.e., cost reporting periods beginning on or after 10/1/95) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy.

- Long-Term Care Hospital Moratorium: Prohibit new long-term care hospitals from being excluded from PPS, effective upon enactment.

- Extend HI Tax to All State/Local Employees: Extend the health insurance (HI) tax to State and local workers hired before 4/1/86, and currently exempt from the HI tax, effective 10/1/95.

Part B

- Use Real GDP in MVPS for Physician Services: Beginning with FY 1995, replace the current historical five-year volume/intensity factor and performance standard factor used in calculating the Medicare Volume Performance Standard (MVPS) with the five historical growth in real gross domestic product.

2-D

Page 2:

(GDP) per capita for the surgery and other categories and real GDP per capita plus 1.5 percentage points for primary care. Eliminate the current 5 percentage point floor on maximum reductions in updates due to physicians' performance relative to the MVPS.

- Set Cumulative Targets for Physician Services: Establish cumulative MVPS rates of increase for each of the three separate categories of service: primary care, surgery and all other services. Cumulative targets would be based on the prior year's MVPS rate of increase for a fixed year (FY 1994). This is in contrast to the current way the MVPS operates where the MVPS for a year is based on the prior year's actual rate of increase in expenditures, without regard to the prior year's target rate of increase. The statutory formula to determine the specific MVPS amount would be used.

- Eliminate Formula Driven Overpayment: Eliminate formula driven overpayments (FDO) from calculation of blended payment amounts for radiology, diagnostic tests and ambulatory surgery services, effective 7/1/94.

- Competitively Bid for Other Part B Items and Services: The Secretary would be required to contract competitively for Medicare services and supplies in a geographic area effective beginning on 1/1/95. Contracts would be established with entities or individuals that meet quality standards and are able to furnish a sufficient of the item or service. The items for competitive procurement are MRIs, CT scans, oxygen and oxygen equipment and enteral and parenteral nutrients and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for these selected services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

- Competitively Bid for Laboratory Services: The Secretary would be required to establish the same kind of competitive acquisition system for Medicare lab services as for other selected Part B items and services, beginning on 1/1/95. If the competitive system does not result in a reduction of at least 10 percent in the price of all lab services from the price that would occur in 1996, then the Secretary would reduce Medicare fees for all lab services by the difference needed to result in a 10 percent savings for 1996, effective 7/1/95.

Page 3:

- Income Related Part B Premium: Beneficiaries with adjusted gross income of $105,000 or more for a single person or $130,000 for married taxpayers filing joint returns would pay a Part B premium equal to 75 percent of Part B costs, effective 1/1/96. There would be a phase-in of the income related premium for singles between $90,000 and $105,000 and married taxpayers filing joint returns between $115,000 and $130,000 if only one spouse was covered by Medicare Part B. (It would be between $115,000 and $145,000 if both spouses were covered by Medicare Part B).

- Incentives for Physicians for Primary Care: Create incentives for primary care by: (a) establishing a resource-based method to pay for the physician overhead component of the physician fee schedule, increasing primary care practice expense RVUs by 10 percent and decreasing RVUs for all non-primary care services as an offset; (b) increasing the work component of RVUs by 10 percent and reducing relative values for all non-primary care services as an offset; (c) reducing rates for office consultations to equal office visits and using savings to increase fees for all office visits; (d) reducing the work component of services with "outlier intensity" values and applying the savings to increase the work component of the relative value for primary care services; and (e) increasing the bonus payment for primary care services in rural and urban Health Professional Shortage Areas (HPSAs) to 30 percent and eliminating the 10 percent bonus payment for non-primary are services in urban HPSAs.

- Prohibition of Balance Billing: Effective 1/1/96, no extra-billing would be permitted in Medicare (i.e., payment may only be made on an assignment-related basis).

- Laboratory Coinsurance: Re-establish 20 percent coinsurance on laboratory services furnished in physician offices and hospital OPDs (but not independent labs), effective 1/1/95.

- Reduce 1995 Physician Update: Reduce the Medicare fee schedule conversion factor by 3 percent in 1995, except for primary care services.

- Extend Part B Premium at 25% of Costs: Extend the Part B premium at 25 percent of program costs for 1999 and thereafter.

Parts A & B

- Establish a Home Health Copayment: Establish a copayment for home health visits at 10 percent of the average cost per visit, effective 7/1/95 for all visits.

4-D

Page 4:

- Extend OBRA93 Medicare Secondary Payer: Extend permanently the provisions (which OBRA-93 extended through FY 1998): (a) regarding a data match between HCFA, IRS and SSA to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare; (b) making Medicare the secondary payor for disabled employees with employer-based health insurance; and (c) requiring non-Medicare insurers to be the primary payor for ESRD patients for 18 months before Medicare becomes the primary payor.

- HMO Payment Improvements: Beginning in 1995, establish separate national maximum and minimum standards for the Part A and Part B portions of the AAPCC rates. The standards would be phased-in over five years (e.g., 20 percent in the first year, 40 percent in the second year, etc.) and be based on 95 percent of the USPCC.

  Counties whose Part A AAPCC is above 170 percent of 95 percent of the Part A USPCC would be limited to that amount unless the Part B portion of their rate was below 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same except the standard would be set at 150 percent of 95 percent of the Part B USPCC.

  The minimum standard would not be phased in. Counties whose Part A AAPCC is below 80 percent of 95 percent of the Part A USPCC would be increased to that amount unless the Part B portion of their rate was above 95 percent of the Part B USPCC. The standard for the Part B portion of the rate would be the same.

- Reduce Routine Cost Limits for HHAs: Eliminate catch-up that would result after HH two year temporary freeze expires (i.e., for cost reporting periods beginning on or after 7/1/96) by recalculating the percent of the mean that would result in the same savings as a continuation of the freeze. It is currently estimated that a limit at 100 percent of the mean of the most recent cost data would accomplish this policy. Reduce cost limits on home health services to 100 percent of the median for cost reporting periods beginning on or after 7/1/97.

- Expand Centers of Excellence: Expand centers of excellence to all urban areas by contracting with individual centers using a flat payment rate for all services (Part A and Part B) associated with cataract or CABG surgery. The Secretary would be granted authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would encouraged to do so by Medicare providing a rebate to the beneficiary equal to 10 percent of the government's savings from the center.

FT July 20, 1994 (12:08)

RISK ADJUSTMENT

...v _____. the Secretary would develop at least one risk adjustment and ...ice methodology ("risk adjustment methodology") as provided in this ____.

The risk adjustment methodologies would be implemented to adjust premiums ealth plans to:

(1) reflect the expected relative utilization and expenditures for services in the standard benefit package by the plan's enrollees as compared to the average utilization and expenditures for community-rated health plans;

(2) protect health plans that enroll a disproportionate share of enrollees whose expected or actual utilization of health care services (included in the standard benefit package) are greater than the average levels of utilization and expenditures of enrollees in the health care coverage area; and

(3) spread across all health plans (on a per-enrollee basis) the expected expenditures related to specified high-cost individual purchasers (as specified by the Secretary and including nonworking individuals and individuals that would be eligible for Medicaid under current law) that exceed the expected expenditures for the average community-rated health plan enrollee (without regard to the individuals specified by the Secretary under this paragraph) in an area.

All health plans would participate in a risk adjustment system. Community-ated health plans would be required to participate in adjustments made under ...aragraphs (1) and (2). All health plans, including experience-rated plans, would be ...equired to participate in adjustments made under paragraph (3).

In developing a methodology, the Secretary would take into account the following factors of health plan enrollees:

(1) Demographic characteristics.
(2) Health status.
(3) Geographic area of residence.
(4) Socioeconomic status.
(5) Receipt of AFDC (or SSI if appropriate).
(6) Status as a nonworking individual or individual that would be eligible for Medicaid under current law.
(7) Other factors as determined by the Secretary to be material to the purposes of paragraphs 1-3.

States would implement a risk adjustment methodologies developed by the Secretary, in accordance with applicable rules developed by the Secretary.

Each State would establish a risk adjustment organization or agency to carry out the adjustments provided for in the methodology implemented by the State. The organization or agency would be required to meet standards established by the Secretary relating to organizational structure, operations, fiduciary standards and cash management.

For the adjustments related to paragraph (3) above, the Secretary each year would estimate the amount by which the expected expenditures related to specified high-cost individual purchasers (as specified by the Secretary pursuant to paragraph (3)) exceed the expenditures for average community-rated health plan enrollees. The Secretary would compute a per capita adjustment amount for each health care coverage area.

Community-rated and experience-rated plans would make payments to the State risk adjustment organizations in the areas where they provide coverage. Multistate experience-rated plans could make their payments to a single State risk adjustment organization (along with information about their geographic distribution of enrollees), which would distribute the appropriate amounts to other organizations. Health plans enrolling individual purchasers would receive additional payments for these enrollees through the State risk adjustment system.

In general to pick up from HSA:

In developing a methodology, the Secretary would give special consideration to the unique problems of adjusting payments to health plans with respect to individuals with mental illness.

A methodology developed by the Secretary may include a system of mandatory reinsurance (voluntary reinsurance should not be permitted because it is not risk adjustment).

A methodology including mandatory reinsurance should—

-provide for health plans to make payments to state-established reinsurance programs for the purpose of reinsuring part or all of the health care expenses for items and services included in the comprehensive benefit package for specified classes of high-cost enrollee or specified high cost treatments or diagnoses,

-specify the manner (which may be prospective or retrospective) in which health plans make payments to the system, and

–the type and level of reinsurance coverage provided by the system.

A methodology should be developed in a manner that is consistent with privacy and confidentiality standards.

The Secretary should work with an advisory committee to develop the methodology.

GEORGE J. MITCHELL
MAINE

7-22-94
2:00

United States Senate
Office of the Majority Leader
Washington, DC 20510-7010

FAX COVER SHEET

TO: Bob Beischer

FR: John Hilley, Office of Senator Mitchell

Number of Pages, including cover 5

If there are problems, please call 202-224-5344

MEDICAID

I. Integration of Medicaid Recipients

- In general, AFDC and non-cash population integrated into the general health care reform program and treated like other low-income people eligible for federal subsidies and enrollment in certified health plans. Medicaid recipients are integrated as low-income subsidies become available.

- States required to make premium payments and general maintenance of effort (MOE) payments for services covered under the standard benefit package.

- The Federal Government would provide subsidies similar to those provided to other low-income persons.

AFDC (Cash):

- As in the Finance bill, cash Medicaid recipients (i.e., those on AFDC) eligible for full premium subsidies as would other families with incomes less than 100% poverty.

Non-cash:

- Full premium subsidies be available to all pregnant women and infants (up to age 1) up to 185% of poverty and children up to the age of 19 years up to 185% of poverty. (*Decisions on the subsidy structure interacts with the overall subsidy structure for low-income people, yet to be determined.*)

II. Cost sharing for Integrated Medicaid recipients

- Use the cost sharing schedule in HSA: AFDC recipients in HMOs would pay only 20% of the cost sharing amount otherwise required. If no HMO is available, AFDC recipients would pay the cost sharing amount that would apply in an HMO, but not reduced to 20%. Noncash recipients receive cost sharing subsidies as all other low-income individuals -- up to 150% of poverty.

III. State and Federal Premium Payments for Integrated Recipients

- The federal government pays for all of the premium subsidies for integrated Medicaid recipients.

- States expected to pay the federal government maintenance of effort payments for these integrated recipients.

Cash:

- States required to pay an amount equal to: (1) the adjusted, per capita cost of services covered (based upon the state's current Medicaid payment rates), in fiscal year 1994, under the standard benefits package for AFDC recipients times (2) the number of AFDC recipients receiving a subsidy in a given year.

- DSH payments attributed to Cash recipients are not included in calculation of state's per capital cost of covered services.

- The per capita cost of services in October 1994 is adjusted by the current baseline growth in per capita national health expenditures.

Non-cash:

- States be required to make general maintenance of effort payment for services (based upon the state's current Medicaid payment rates), in fiscal year 1994, covered under the standard benefits package for non-cash recipients.

- State DSH payments included in the calculation of general maintenance of effort payment.

- Such MOE payments would grow no faster than the current baseline growth in national health expenditures.

VI. SSI/Disabled Medicaid Recipients

- SSI/Medicaid recipients would not be included in the community rated market. Medicaid would be retained as a separate program, with current rules, for SSI and long-term recipients.

- States have the option to pay a per capita amount for each SSI/Medicaid recipient (who is not enrolled in Medicare) that chooses to enroll in a certified health plan. States would negotiate with certified health plans for rates for the SSI population that are separate from the community rate. No certified plan could have more than 50% of its enrollment composed of SSI/Medicaid recipients.

V. Dual Eligible Recipients

- Dual eligibles - persons eligible for Medicare and Medicaid would remain under Medicaid and not be enrolled in health plans.

VI. Non-SSI, Non-Dual Eligible Recipients aged 18-64 years

- Remain under Medicaid, but as the low-income subsidies phase-in (e.g., 100% to 125%), these recipients (currently about 240,000) would be integrated and treated like other low-income individuals.

VII. Supplemental Services

- Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided through certified health plans.

- The current flexibility provided to States to determine the optional services and groups it will cover would be retained. *Note that this provision addresses issues related to children with special needs -- discussed in the Long-term Care section.*

VIII. DSH Payments

- DSH rebased in the first year based upon the reduction of Medicaid payments for mainstreamed Medicaid recipients.

- During transition, DSH payments would be phased down as the rate of coverage increased.

- DSH program changed into a more targeted program to compensate hospitals for uncompensated care.

IX. Miscellaneous Medicaid

- Allow States to expand eligibility for home-based Medicaid long term care services for single persons by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option.

- Expand the Program of All-inclusive Care for the Elderly. Increase authorized demonstration sites from 15 to 40. Require the Secretary to develop provider and service protocols.
- Eliminate the institutionalization requirement as a condition of eligibility for habilitation services under a home and community based waiver.

- Eliminate the "cold bed" rule for home and community based waiver programs.

- State Medicaid programs required to reimburse directly for services by CRNAs or clinical nurse specialists that are authorized to practice under State law, whether

	Model 1
Total Employer Payments 1 Year (1994) ($m)	226,847
Average Employer Payments per Family	2,192
Total Family Payments 1 Year (1994) ($m)	60,398
Average Family Direct Premium Payments	584
Government Subsidies: 1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies: 5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies: 10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit * (5 Years)	(394)
Net Effect on Deficit * (10 Years)	(70,596)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

	Model 2
Total Employer Payments 1 Year (1994) ($m)	218,242
Average Employer Payments per Family	2,108
Total Family Payments 1 Year (1994) ($m)	57,430
Average Family Direct Premium Payments	555
Government Subsidies: 1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies: 5 Years ($m)	331,567
employer	129,668
household	201,899
Government Subsidies: 10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit * (5 Years)	(31,533)
Net Effect on Deficit * (10 Years)	(153,081)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

1999 2004

Net Effect on Level of Average Private Health Insurance Premium

	Baseli	HSA	Senate
Medicaid Cost Shift			
Payment rates	2.5%	0.0%	0.0%
Demographics	0.0%	3.0%	3.0%
Growth rates	0.0%	0.0%	0.4%
Risk Adjustment Across Pools			
Pre-Mandate community rate	0.0%	0.0%	-2.2%
Pre-Mandate experience rate	0.0%	0.0%	2.2%
Post-Mandate community rate	0.0%	0.0%	-1.5%
Post-Mandate experience rate	0.0%	1% of p	1.5%
High Cost Plan Assessment			
community rate plans, by 2004	0.0%	0.0%	4.0%
experience rated plans, by 2004	0.0%	0.0%	2.0%
Uncompensated Care	8.0%	-8.0%	
Pre-Mandate			-5.0%
Post-Mandate			-8.0%
Small Firm Exemption	0.0%	0.0%	0.0%
Medicare Savings (shifted?)	0	346B	250B
Retiree community rating		?	?
Administrative load			
Experience rated	11.0%	8.0%	8.0%
Community rated	na	13.5%	13.5%
Academic Health Center Assessm	0.0%	1.5%	1.8%

Cafeteria plan

Net Effect on Level of Average Private Health Insuranc

	Baseli	HSA	Senate
Medicaid Cost Shift			
Payment rates	2.5%	0.0%	0.0%
Demographics	0.0%	3.0%	3.0%
Growth rates	0.0%	0.0%	0.4%
Risk Adjustment Across Pools			
Pre-Mandate community rate	0.0%	0.0%	-2.2%
Pre-Mandate experience rate	0.0%	0.0%	2.2%
Post-Mandate community rate	0.0%	0.0%	-1.5%
Post-Mandate experience rate	0.0%	1% of p	1.5%
High Cost Plan Assessment			
community rate plans, by 2004	0.0%	0.0%	4.0%
experience rated plans, by 2004	0.0%	0.0%	2.0%
Uncompensated Care	8.0%	-8.0%	
Pre-Mandate			-5.0%
Post-Mandate			-8.0%
Small Firm Exemption	0.0%	0.0%	0.0%
Medicare Savings (shifted?)	0	346B	250B
Retiree community rating		?	?
Administrative load			
Experience rated	11.0%	8.0%	8.0%
Community rated	na	13.5%	13.5%
Academic Health Center Assessm	0.0%	1.5%	1.8%

Two Parent Family
Income = 75% of Poverty

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	47.0%	47.0%	54.4%	54.4%	63.0%	63.0%	76.5%	76.5%
HSA:								
7.9% Cap	2.9%	24.5%	2.9%	25.2%	2.9%	25.8%	2.9%	26.8%
Uncapped	2.9%	30.3%	2.9%	32.2%	2.9%	32.3%	2.9%	35.0%
Senate 7.18.94:								
CR - No mandate	0.0%	0.0%	0.1%	0.1%	2.0%	2.0%	4.7%	4.7%
CR - Mandate	0.0%	0.0%	0.1%	0.1%	7.3%	15.3%	12.6%	20.6%

Two Parent Family
Income = 75% of Poverty

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	47.0%	47.0%	54.4%	54.4%	63.0%	63.0%	76.5%	76.5%
HSA:								
7.9% Cap	2.9%	24.5%	2.9%	25.2%	2.9%	25.8%	2.9%	26.8%
Uncapped	2.9%	30.3%	2.9%	32.2%	2.9%	32.3%	2.9%	35.0%
Senate 7.18.94:								
CR - No mandate	0.0%	0.0%	0.1%	0.1%	2.0%	2.0%	4.7%	4.7%
CR - Mandate	0.0%	0.0%	0.1%	0.1%	7.3%	15.3%	12.6%	20.6%