(e). 44

Summary: Lewin seems to be way too high on revenue gain from corporate assessment.

Lewin's estimate that the deficit doesn't change with an alliance at 100 compared to an alliance at 5,000 assumes that firms above the threshold can assume to come in -- he does not have a firewall. This should (and does) produce very different results than from assuming a firewall.

With a firewall, Lewin shows that the number of people in the regional alliance declines by 37 million as the threshold shifts from 1000 to 100, and that the premium in the alliance increases by 6%. This is similar to our results.

Without a firewall, Lewin estimates that the regional alliance declines by 18 million. Although he does not provide an estimate, it is likely that the premium change would be approximately 3%.

We have estimated that subsidy costs would increase by at least $45 billion over the five year time frame with a firewall. Lewin estimates a change of $20 billion with no firewall. The difference between $20 and $45 is largely explained by the existence of the firewall in the $45 billion estimate.

The mystery is why Lewin's corporate assessments increase so much. Lewin has the five year corporate assessment increasing by $33 billion, when we are estimating approximately $20 billion. Given the 'no firewall' feature of Lewin's estimate, his corporate assessment change, other things equal, should be approximately one-half of ours.

Don't know the details, but Lewin #s seem suspicious. With 18 million more people in corporate alliances, this is probably 9 million workers. If average wage in corporate alliance is $25,000, then 1% assessment per person is $250, and one year additional assessment revenue should be $2.25 billion. Then 5 year number might be around $10 billion.

1000 → 100

$45 subsidy

$20 [illegible] against

Wilkens revenue

224 5406

Steve

606 1300

301 654 2000

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

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: THORPE To: CHRIS JENNINGS

Phone: (202) 690- _____ Phone: _____
(202) 690-6870
FAX: (202) 401-7321 Fax: _____

Number of Pages (Including Cover): _____

Comments: MORE FOR NEXON —

SENT TO OMB —

Subsidies Relative to Kennedy Mark Under Alternative Growth Rates
(Billions of Dollars)

Scenario	1996-2000	1996-2004
1	$422	$1085
2	$410	$1045
3	$391	$1020
4	$389	$1015
5	$383	$1006
Mark	$376	$1000

NOTE THAT THESE NUMBERS DO NOT INCLUDE ANY UPGRADE IN BENEFITS IN THE YEAR 2001. ALL NUMBERS PRELIMINARY AND NOT OFFICIAL

To Kim

PER CAPITA GROWTH RATE/: (DOES NOT INCLUDE POP. GRTH)

TRIGGER SCENARIOS

CLINTON

Premium increases gradually lowered to CPI by 1999

In 2001, increase is GDP growth + an amount to cover benefit improvements (GDP = 4.4%, benefit improvements = 3.6%)

After 2001, increases equal GDP growth (4.4%)

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	4.5	4.0	3.5	3.0	3.0	8.0	4.4	4.4	4.4
1.00	1.05	1.09	1.12	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 1

Increases in 1996 and 1997 equal CBO estimates of premium increases under Cooper (slightly below baseline)

Trigger would limit increases in to CPI beginning in 1998 until costs equal Clinton, except that the increase in 2001 equals CPI (3.0%) + cost of new benefits (3.6%)

Costs equal Clinton by about 2004

Subsequent increases equal growth in GDP (same as Clinton)

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	3.0	3.0	3.0	6.6	3.0	3.0	3.0
1.00	1.08	1.16	1.20	1.23	1.27	1.35	1.39	1.43	1.48

SCENARIO 2

Assumes Cooper increases in 1996 and 1997

Increases are limited to CPI minus 1 (2%) per year from 1996-2000

Increase in 2001 is CPI - 1 (2%) plus the cost of benefit improvements (3.6%)

In 2002, increase is slightly below Clinton growth rate (GDP) to bring costs in line with Clinton beginning in that year. After 2002, increases equal GDP growth.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	2.0	2.0	2.0	5.6	4.0	4.4	4.4
1.00	1.08	1.16	1.18	1.21	1.23	1.30	1.35	1.41	1.47

SCENARIO 3

Increases equal Cooper in 1996 and 1997

Trigger brings costs back to Clinton level by 1999 by allowing zero nominal growth in 1998 and 1999. Subsequent increases equal Clinton.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	0.0	0.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.16	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 4

Increases equal Cooper in 1996 and 1997

Trigger would reduce the rate of growth or premiums to bring costs down to the Clinton level as quickly as possible. However, the growth rate could not be reduced below negative one percent per year.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	-1.0	1.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.15	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 5

Increases equal Cooper in 1996 and 1997

Trigger would reduce premiums in 1998 to the level they would have been under Clinton.

Subsequent increases equal Clinton

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	-3.2	3.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.12	1.16	1.19	1.29	1.35	1.40	1.47

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:
APPROPRIATIONS
SELECT COMMITTEE ON ETHICS
LABOR AND HUMAN RESOURCES

United States Senate

WASHINGTON, DC 20510-2003

SUITE 709
HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-2003
(202) 224-4654
TTY: (202) 224-5223

FAX TRANSMITTAL FORM

DATE: 6/7/94

THE FOLLOWING 6 PAGE(S) (INCLUDING THIS FORM)
IS/ARE FOR: Rick Kronis

FROM: Mary Hinrichs Richards

OFFICE OF SENATOR BARBARA A. MIKULSKI
U.S. SENATE
709 HART SENATE OFFICE BUILDING
WASHINGTON, D.C. 20510

IF THIS TRANSMITTAL IS INCOMPLETE, PLEASE CALL (202) 224-4654.

THANK YOU!

WORLD TRADE CENTER, SUITE 253
401 E. PRATT STREET
BALTIMORE, MD 21202-3041
(410) 962-4510

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ANNAPOLIS, MD 21401-1933
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CITY CENTER ON THE PLAZA
213-219 WEST MAIN STREET
SALISBURY, MD 21801
(410) 546-7711

(1) Senator Mikulski's amendment is contained in subsections (a)(1) and (a)(2) of section 1524.

(2) Subsection (c) of section 1524 reflects necessary definitions from section 8203 of the President's bill.

(3) Subsection (b) of section 1524 reflects the language of 1523(f) currently in the bill and is more properly relocated in this one section dealing with FEHBP supplemental plans.

Rick -

We are advised by Leg Counsel that if we only add a new paragraph 1523(f)(5), it will deal only with cost-sharing policies. In order for supplemental policies to be covered a new §1524 is needed.

Note the language we talked about now in §1524(a)(1) in this draft.

Thanx, MAR

O:\MAT\MAT94.204 S.L.C.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To require the FEHBP to offer supplemental plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Ms. MIKULSKI

Viz:

In section 1523(a), strike "subsection (f)" and insert "section 1524(c)".

Strike section 1523(f).

Insert after section 1523 the following new section:

SEC. 1524. SPECIAL RULES FOR FEHBP SUPPLEMENTAL PLANS.

(a) FEHBP SUPPLEMENTAL PLANS.—

(1) DEVELOPMENT.—The Office of Personnel Management shall develop FEHBP supplemental plans, including at least one supplemental health benefit policy and at least one cost sharing policy. Each such FEHBP supplemental plan shall be developed in consultation with representatives of Federal employees, including consideration of a Federal Government contribution with respect to such plan.

(2) OFFERING.—The Federal Government shall offer FEHBP supplemental plans developed in accordance with paragraph (1) to Federal employees, annuitants, and any other community rate eligible individual (as defined in section 1902(9)).

(b) FEHBP EXEMPTION FROM RULES FOR OFFERING OF COST SHARING POLICIES.—Subsection (a) of section 1523 shall not apply to an FEHBP supplemental plan if the plan meets the following requirements:

(1) The plan must offer each Federal employee and eligible individual a choice of a policy that provides standard coverage and a policy that provides maximum coverage (in accordance with standards established by the Board under section 1523(a)(3)).

(2) The plan is offered only during the annual open enrollment period for community-rated health plans (described in section 1232(d)(1)).

(3) Subject to subsection (b)—

(A) the price of the plan shall include an amount, established in accordance with rules established by the Board in consultation with the Office of Personnel Management, that takes into account any expected increase in utilization of the items and services in the comprehensive benefit package resulting from the purchase of the plan by individuals enrolled in a community-rated health plan; and

(B) the plan provides for payment, in a manner specified by the Board in the case of an individual enrolled in the plan and in a community-rated health plan, to the community-rated health plan of an amount equivalent to the additional amount described in subparagraph (A).

(c) DEFINITIONS.—For purposes of this section:

(1) ANNUITANT.—The term "annuitant" means an "annuitant" as defined by section 8901 of title 5, United States Code.

(2) FEHBP.—The term "FEHBP" means the health insurance program under chapter 89 of title 5, United States Code.

(3) FEDERAL EMPLOYEE.—The term "Federal employee" means an "employee" as defined by section 8901 of title 5, United States Code.

MEMORANDUM

TO: DISTRIBUTION
FR: JOHN HART
DT: JUNE 14, 1994
RE: NEW HAMPSHIRE NEWS RELEASE

FYI, Here is a press release from Dr. Stephen Gorin, Chair of the New Hampshire Health Care Coalition. In this press release, he strongly criticizes Senator Gregg's opposition to health care reform.

THE NEW HAMPSHIRE HEALTH CARE COALITION

Contact: Stephen Gorin, Ph.D.
603-783-9523

For Immediate Release

CONCORD, June 10. Stephen Gorin, Chair of the New Hampshire Health Care Coalition, today expressed disappointment over Senator Judd Gregg's opposition to health care reform. Gregg, a member of the Senate Committee on Labor and Human Resources, voted against Senator Kennedy's modified version of President Clinton's Health Security Act. Kennedy's plan requires employers to insure their workers, with an exemption for businesses with ten or fewer employees.

"We think it is unfortunate that, at this crucial time in the reform process, Senator Gregg has joined the minority in opposing a serious effort to bring health security to all Americans," said Gorin.

"In addition to opposing serious reform, Senator Gregg supports S. 1743, the 'Consumer Choice Health Security Act of 1993,' which represents a radical departure from our current system," said Gorin. "S. 1743 would shift the burden of coverage from employers to workers and families," Gorin said.

S. 1743 would require individuals to buy their own health insurance. It would create new taxes for employers, workers, and families and impose financial penalties on individuals who fail to buy insurance.

The Journal of the American Medical Association (JAMA) recently ranked S. 1743 among the worst plans, below our current system. The President's Health Security Act ranked near the top, second only to the Stark plan, which builds on the President's approach.

"Senator Gregg's plan also lacks community rating, prescription drug benefits, and long term care coverage," said Gorin. "Interestingly, it would also allow a federal takeover of state health insurance plans," Gorin said.

"We urge Senator Gregg to reconsider his opposition to meaningful reform. In the meantime, we hope the public and media will ask him why he voted against Senator Kennedy's bill and supports a plan that JAMA believes is worse than our current system," Gorin said.

91% coverage could be achieved through a voluntary approach like the Cooper plan, but the following trade-offs would be required:

CUTTING BENEFITS TO REDUCE COST

- CBO says the Cooper plan could be made approximately deficit neutral by dramatically reducing the benefits package (e.g. eliminating coverage for mental health, prescription drugs, preventive care, and dental, and limiting hospital coverage).

- However, providing a bare bones benefits package presents significant trade-offs:

  - Significant cost shifting remains. 97% of health care costs would no longer be covered under the plan.

  - State demonstrations show that few businesses and families would voluntarily purchase bare bones insurance, even if it is offered at very low rates. The only way to increase coverage with a bare bones package is to pay all or nearly all of the premium for the poor.

  - We would be spending a great deal of money for a benefits package that few people really want.

REMAINING COST PROBLEM

- Even with a dramatic reduction in the benefits package, the plan would still increase the deficit without a tax cap.

- Options to fill this gap include:

  - More Medicare cuts. But aging groups would oppose additional cuts unless they were offset by benefit expansions (which would eliminate any savings).

  - A tobacco tax, which may be difficult to achieve without universal coverage.

ADDITIONAL POLICY/COST TO ACHIEVE UNIVERSAL COVERAGE

- Achieving universal coverage would require at least an individual mandate.

- With an individual mandate, providing subsidies for the remaining uninsured would require substantial additional spending.

- The risk of relying solely on an individual mandate is that loss of your left base will not be offset by gains from the right.

BREAUX-COOPER COST/TAX CAP TABLE

	Comprehensive Benefits	Basic Benefits
Program Cost Without Tax Cap	350	150
Tax Cap	-50	-150
Total	300	0

PROBLEMS WITH THE 91% APPROACH

- **LEAVES MILLIONS OF AMERICANS UNINSURED.** 25 MILLION AMERICANS WOULD BE UNINSURED. AS MANY AS 40 MILLION AMERICANS WOULD BE WITHOUT HEALTH INSURANCE FOR SOME PERIOD OF TIME EACH YEAR. ALMOST ALL OF THE NEWLY INSURED WOULD BE UNDER THE POVERTY LEVEL.

- **INCREASES THE DEFICIT** FROM 1996-2004. THE FEDERAL DEFICIT INCREASES BY OVER $300 BILLION TO FUND SUBSIDIES AND TAX INCENTIVES. WITHOUT A TAX CAP, THE DEFICIT INCREASE IS $350 BILLION.

- **PLACES HEAVY BURDEN ON MIDDLE INCOME INDIVIDUALS.** MANY PEOPLE WILL PAY OVER 10% OF THEIR GROSS INCOME FOR HEALTH INSURANCE. A WORKER EARNING $30,400 COULD HAVE TO SPEND OVER $6,000 TO BUY A FAMILY POLICY AND WOULD NOT BE ELIGIBLE FOR GOVERNMENT SUBSIDIES.

- **MAY ENCOURAGE EMPLOYERS TO DROP COVERAGE.** THE EXISTENCE OF LOW-INCOME SUBSIDIES MAY ENCOURAGE FIRMS THAT CURRENTLY PROVIDE HEALTH INSURANCE TO DROP COVERAGE FOR LOW-WAGE WORKERS. THE LEWIN ANALYSIS ASSUMES THAT FIRMS CURRENTLY PROVIDING HEALTH INSURANCE WILL CONTINUE TO DO BUT FROM 1989 TO 1992, THE NUMBER OF AMERICANS WITH EMPLOYER COVERAGE DROPPED BY 3 MILLION.

- **TOTAL COVERED DOLLARS GOES FROM 94.1% TODAY TO 96.8%.** THIS IS AN INCREASE OF $37 BILLION FOR WHICH THE FEDERAL GOVERNMENT IS SPENDING $42 BILLION OF NEW MONEY IN 1998.

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BREAUX-COOPER COST/TAX CAP TABLE

	Comprehensive Benefits	Basic Benefits
Program Cost Without Tax Cap	350	150
Tax Cap	-50	-150
Total	300	0

THE LEWIN ANALYSIS OF COOPER/BREAUX

THE MIDDLE CLASS LOSES

MILLIONS OF PEOPLE

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
PEOPLE BELOW POVERTY	9.3	7.9	1.4
100-150% OF POVERTY	6.0	3.7	2.3
ABOVE 150% OF POVERTY	21.9	3.2	18.7
TOTAL	37.2	14.8	22.4*

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
UNDER AGE 18	9.7	4.3	5.4
18 - 34	14.4	4.9	9.5
OVER 34	13.1	5.6	7.5
TOTAL	37.2	14.8	22.4*

*CBO ESTIMATES 25 MILLION REMAIN UNINSURED

THE LEWIN ANALYSIS OF COOPER/BREAUX

FEDERAL SUBSIDIES INCREASE COVERAGE NOT THE MARKET

	NEWLY INSURED	
	NUMBER PEOPLE\MILLIONS	**PERCENT**
INSURANCE MARKET REFORMS	1.1	7
INCREASE TAX DEDUCTIBILITY	1.1	7
GOVERNMENT PAYS 100% OF THE PREMIUM	7.9	53
GOVERNMENT PAYS A SIGNIFICANT PORTION OF PREMIUM	4.7	33
TOTAL	14.8	100%

THE LEWIN ANALYSIS OF COOPER/BREAUX

PERCENT OF POPULATION REMAINING UNINSURED

	TODAY %	AFTER REFORM %
UNDER 18	13.9	7.7
18 - 24	29.4	20.2
25 - 34	19.5	12.5
34 - 65	13.0	7.7
TOTAL UNDER AGE 65	16.0	9.6

ADDITION TO DEFICIT UNDER COOPER/BREAUX

TO ACHIEVE 91% COVERAGE

BILLION $

	1996	1997	1998	1999	2000	2001	2002	2003	2004	TOTAL
WITH TAX CAP	35	46	42	36	30	32	31	27	22	301
WITH-OUT TAX CAP	41	61	58	53	48	52	54	51	47	465

SOURCE: CBO

	NEW GOVERNMENT COST 1998	NEWLY INSURED PEOPLE	FEDERAL COST PER PERSON
1998 FEDERAL COST FOR EACH NEWLY INSURED PERSON	$42 BILLION	14.8 MILLION	$2,838 PER PERSON

Sen. Boren Backs 'Soft Trigger' Health-Care Approach

WASHINGTON -DJ- Sen. David Boren, D-Okla., a key swing vote on the Finance Committee on the health care issue, said a ''soft trigger'' for implementing employer mandates for health coverage is the key to a bipartisan health care reform bill.

Boren, speaking to reporters before he was scheduled to meet with President Clinton in a one-on-one meeting on the subject, said, ''there is no doubt that the solution and the way we can build a bipartisan coalition has to do with a 'soft trigger'' mechanism - a way for us to measure progress toward the president's goals and a way for us to react if those goals aren't being met on a voluntary basis.''

A trigger is a way for Congress to postpone an action it is unwilling to take now. President Clinton wants Congress to require companies to pay for their employees' health insurance, but many members of Congress are reluctant to go along. As a compromise, the White House and Congress are exploring proposals that wouldn't require companies to provide insurance right away, but would require them to do so in the future if other health reforms don't succeed in raising the percentage of citizens covered by insurance.

In one version, authored by Sen. John Breaux, D-La., mandates would kick in automatically if firms with fewer than 25 employees failed to provide 93.5% of their employees with insurance by 1997.

In his remarks, Boren appeared to favor an even softer approach, saying the mandates shouldn't kick in automatically, but should only remain one option to be considered if voluntary insurance reforms and incentives don't work.

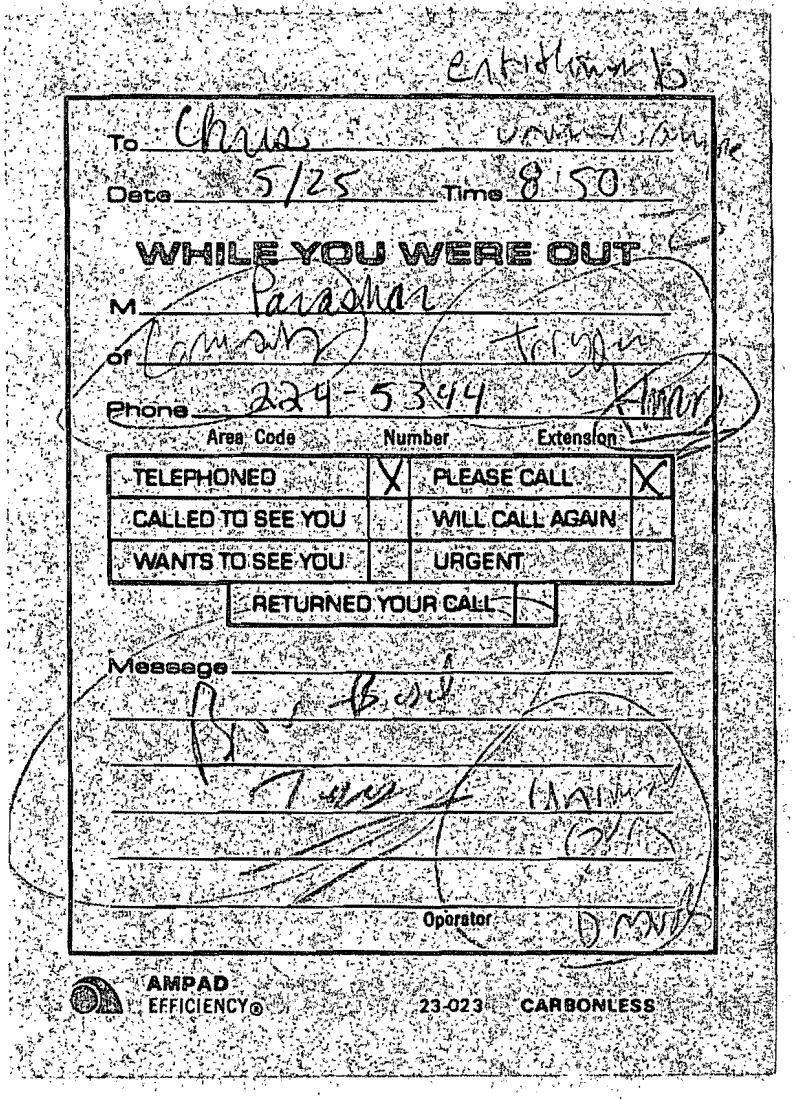
Boren said the soft approach is needed because it's the only way to attract Republican votes. He reiterated his position opposing any health bill without broad bipartisan support.

(MORE) DOW JONES NEWS 06-16-94
2:50 PM

**** filed by:TAPE(--) on 06/16/94 at 14:54EDT ****
**** printed by:WHPR(LMCH) on 06/16/94 at 15:36EDT ****

Baron - sat in vice president's chair

- Morgan will face credits no cold day
- Charles very pleased
- Wants to work w/ him
- Informed him of shortcomings of Brown/Cooper
- Least expensive Federal plan. Buy into it.
- Dole is saying schizophrenic. Now Dole is for individual mandates
- Choice that has to be made we need to get a bipartisan consensus
- Sam Nunn to the right of me
- Marked



To Chris

Date 5/25 Time 8:50

WHILE YOU WERE OUT

M Parashar

of Lamar Tryon Amer

Phone 224-5344

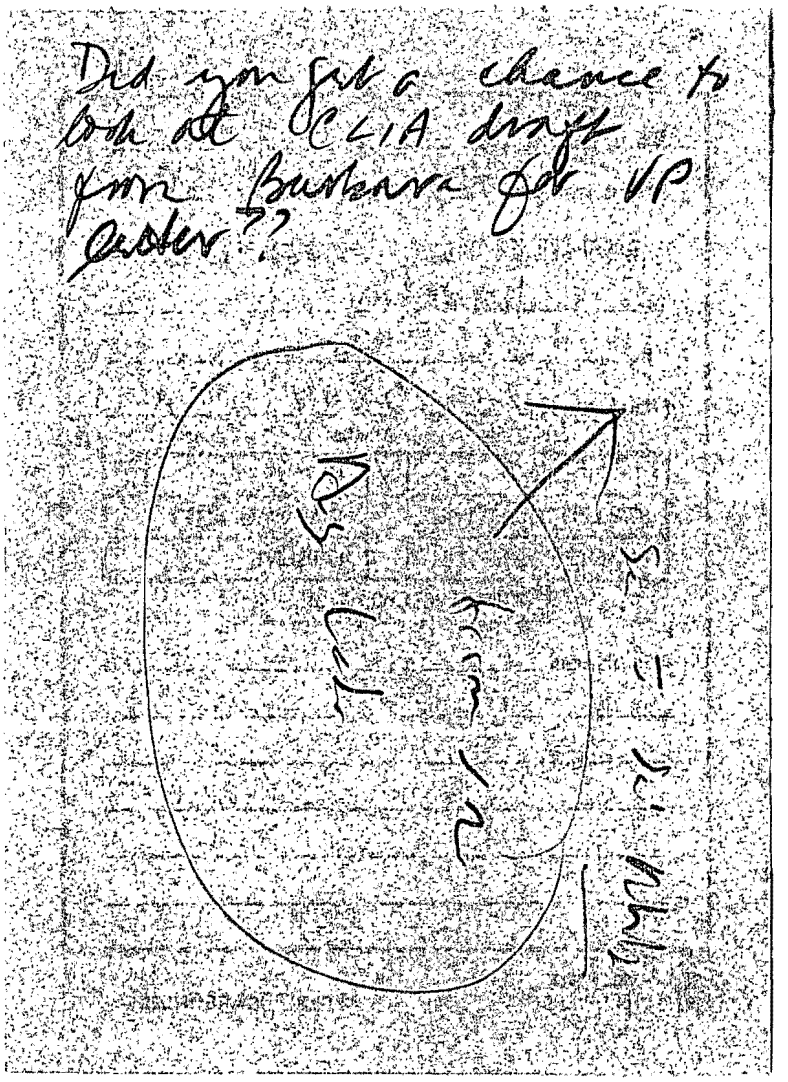
Area Code Number Extension

TELEPHONED	X	PLEASE CALL	X
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message

Operator

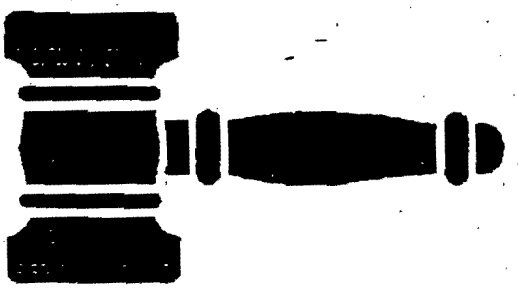
AMPAD EFFICIENCY® 23-023 CARBONLESS



Jeff Powell

Faxed conversation with Ron

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF THE GENERAL COUNSEL
ROOM 707-F
PHONE: (202) 690-7780
FAX: (202) 690-7998



DATE: 5/24

		Telephone No.	Fax No.
TO :	Ron Weich	224 3657	224-3533
cc-	Chris Jennings		456-7431

FROM: Nan Hunter

OFFICE: OS/Immediate Office

PHONE NO. 690-7780

FAX NO. 690-7998

COMMENTS: Following are ① two provisions of Medicare law in which both judicial and administrative review are barred and ② another Medicare provision barring only judicial review. Chris Jennings thinks there may be cost implications if §5232 is dropped. To discuss this further, you should call Chris directly - 456-5560.

No. of Pages (including cover) 5

view Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) Monitoring of utilization and access

(A) In general

The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) Report

The Secretary shall by not later than April 15,[3] of each year (beginning with 1991) report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) Recommendations

The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Physician Payment Review Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) Sending information to physicians

Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3) of this section) furnishing physicians', suppliers, and other persons services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2) of this section. Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1395u(h) of this title (relating to the participating physician program) for a year.

(i) Miscellaneous provisions

(1) Restriction on administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title or otherwise of—

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i) of this section),

(B) the determination of relative values and relative value units under subsection (c) of this section, including adjustments under subsection (c)(2)(F) of this section and section 13516(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d) of this section,

(D) the establishm
of this section, and

(E) the establishm
under this section.

(2) Assistants-at-surgery

(A) In general

Subject to subparag
physician, if payment
physician serving as a
exceed 16 percent of t
section for the global

(B) Denial of payment in

If the Secretary dete
a surgical procedure (
percentage of such pro
of a physician as an assi
be made under this par
procedure.

(3) No comparability adjustme

For physicians' services fo
this section—

(A) a carrier may not
section 1395u(b)(3)(B) o
higher than the charge
comparable circumstance

(B) no payment adjust
title, and

(C) section 1395u(b)(9)

(j) Definitions

In this section:

(1) Category

The term "category" means,
es, and all physicians' service
Secretary and including anesth
section 1395u(l)(4) of this title)
shall define surgical services ar
later than May 1, 1990, after
cians.

(2) Fee schedule area

The term "fee schedule area"
title for purposes of computing

(3) Physicians' services

The term "physicians' servic
graphs (1), (2)(A), (2)(D), (2)(G)
than clinical diagnostic laborat
(a)(3), (g), and (h) of this section
specify).

(4) Practice expenses

The term "practice expenses
services, excluding malpractice
cian fringe benefits.

(Aug. 14, 1935, c. 531, Title XVIII, §
§ 6102(a), 103 Stat. 2169; and amended

(D) the establishment of geographic adjustment factors under subsection (e) of this section, and

(E) the establishment of the system for the coding of physicians' services under this section.

(2) Assistants-at-surgery

(A) In general

Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) Denial of payment in certain cases

If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) No comparability adjustment

For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1395u(b)(3)(B) of this title on the basis that the payment amount is higher than the charge applicable, for a[4] comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1395u(b)(8) of this title, and

(C) section 1395u(b)(9) of this title shall not apply.

(j) Definitions

In this section:

(1) Category

The term "category" means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title), and all other physicians' services. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) Fee schedule area

The term "fee schedule area" means a locality used under section 1395u(b) of this title for purposes of computing payment amounts for physicians' services.

(3) Physicians' services

The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (3), and (4) of section 1395x(s) of this title (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(8), (g), and (h) of this section such other items and services as the Secretary may specify).

(4) Practice expenses

The term "practice expenses" includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(Aug. 14, 1935, c. 531, Title XVIII, § 1848, as added Dec. 19, 1989, Pub.L. 101-239, Title VI, § 6102(a), 103 Stat. 2169; and amended Nov. 5, 1990, Pub.L. 101-508, Title IV, §§ 4102(b), (g)(2),

ied as a sole community hospital under
a rural referral center under subpara-

significantly disproportionate number of
d if the hospital has a disproportionate
that period which equals, or exceeds,—
h an urban area and has 100 or more

in a rural area and has more than 100
classified as a sole community hospital

in an urban area and has less than 100

in a rural area and is not described in

more beds also "serves a significantly
s" for a cost reporting period if the
ge (as defined in clause (vi)) for that
cified by the Secretary.

ortionate patient percentage" means,
ital, the sum of—

ge), the numerator of which is the
such period which were made up of
to benefits under part A of this
y security income benefits (excluding
XVI of this chapter, and the denomi-
l's patient days for such fiscal year
lays) were entitled to benefits under

e), the numerator of which is the
eriod which consist of patients who
ance under a State plan approved
were not entitled to benefits under
f which is the total number of the

tionate share adjustment percent-
ed in clause (iv)(I) is—

portionate patient percentage (as

April 1, 1990, and on or before

nuary 1, 1991, and on or before

mber 1, 1993, and on or before

iber 1, 1994, (P−20.2) (.825) +

ril 1, 1990, and on or before

ary 1, 1991, and on or before

r 1, 1993, (P−16) (.65) + 2.5,
rcentage (as defined in clause

e share adjustment percent-
ause (iv)(IV) or (iv)(V) is the
ormula: (P − 30)(.6) + 4.0,
ge (as defined in clause (vi)).

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D) of this section, or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in the greater payment to the hospital.

(ii) The amount determined under this clause is—

(I) for discharges occurring during the first 3 12-month cost reporting periods that begin on or after April 1, 1990, the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D) of this section) exceeds the amount determined under paragraph (1)(A)(iii), and

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, 50 percent of the amount by which the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(D) of this section) exceeds the amount determined under paragraph (1)(A)(iii).

(iii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iv) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A of this subchapter.

(H) The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I) The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

(6) The Secretary shall provide for publication in the Federal Register, on or before the September 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B) of this section.

(7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) of this section, and

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4).

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv) Subparagraph (H) (relating to exceptions and adjustments).

(D)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of Title 5, governing appointments in the competitive service. Two of such members shall be representative of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial appointments to the Board as provided in this paragraph within 180 days after December 19, 1989.

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the area wage index applicable to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of Title 5. The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

Medicare

1886(d)(7) withdrawal
restrict review of

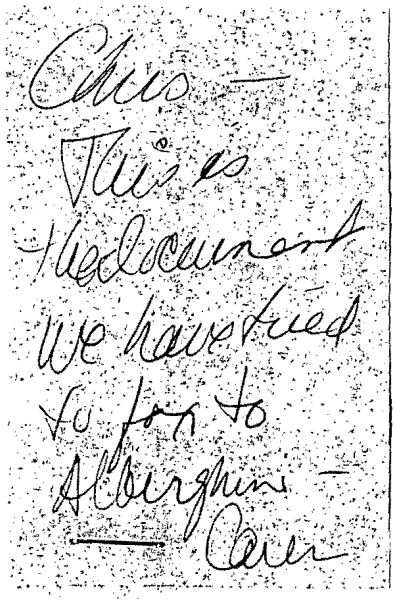
budget neutrality adjustment
DRG classification + weights

DRGs

1848(i)(1)

DRGs authority + federal
not review of:

- hospital payment basis
- relative values + unb
- conversion factors
- GPCI
- coding systems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Case

Conversations with companies and organizations concerned about health care reform.

These companies support universal coverage and employer responsibility, but they are very worried at this point as to whether they will be better or worse off under a new bill. Multi-state employers continue to be concerned about their ability to offer a standard benefit package and administer across state lines.

1. They are fully committed to employer responsibility because they are tired of paying the cost shift for non-insuring employers. They know that it will be difficult to have a financially responsible program without it and universal coverage.

2. Their Washington reps are concentrating on the view that there will probably be a bill, the reps want a bill, the CEOs are very worried, and are asking should there be a bill this year?

3. They are having discussions around three issues with Senate and House staffs, and with the Milbank Group of state authorities.

The issues are: cost containment, data collection and financing.

Interestingly their discussion is around **interim rules or language**, which indicates that those with whom I was speaking accept the fact that there will be a final solution in a bill.

4. Financing is the major issue for companies.

The problem: They will have to pay for state interim solutions when they already cover employees. They have successfully avoided taxes because of ERISA waivers in the past, and are concerned they could become liable for CNI or other payroll taxes on a state by state basis.

They thought that they were making progress until negotiations with the rep from Maine, Rep. Rydel (sp.) seemed to blow up.

For those paying for coverage for workers now, the real deal breaker would be no universal coverage, no or weak employer mandate, and a collection of taxes from those already paying for coverage, to pay coverage of the uninsured.

Potential solutions: The businesses do not have consensus yet on this. Some businesses find this a break point, but others are willing to discuss compromise on financing solutions.

One solution posed for discussion: temporary assessment of the 1% social cost in POTUS bill, to be revenue shared back to states with verifiable need.

"Feds could define who is ERISA qualified in federal regulations, (currently the self-insured self define,) this would stop tax avoidance problem in states. Then you could tax the non-ERISA companies."

Another solution would be some "federal revenue source."

Another solution: "Ways and Means financing solution with employer mandate and universal coverage."

"25% excise tax is not acceptable."

"Tax on premiums is not acceptable."

5. Data

The problem: lack of national guidelines and standards on data collection, which could cause companies to keep separate benefit data systems by state.

Fear that states will require additional data. How much? Harmonization issues.

Potential solutions: Can the multi-state employer offer linked data?

They want an integrated data base, consistent comparable outcomes data.

Consider voluntary additions and experimentation?

This issue is more easily solved in the opinion of company reps.

6. Cost Containment

Problems: Very worried about "any willing provider" issue cutting into managed care capability.

Worried about Maryland conflicts. Can't satisfy other issues, if have to deal with MD as standard.

Some can deal with an expenditure target faster than POTUS proposal.

Again this issue is not one on which they see no compromise. One or two companies might be willing to try to work on something with the National Medical Association and Black Caucus, because they have some understanding of the fear of discrimination.

Costing of mix and match alternatives for phased-in unversal coverage

1. Require 50 percent employer contribution for all workers (not dependents)

a. No employer subsidy/no employee subsidy

b. 12 per cent employer cap/lower cap for smaller firms/no employee subsidy.

c. Employee subsidy--same as HSA

--with no employer subsidy

--with option b employer subsidy

c. Options above with carveout for low-wage firms with:

--less than 10 workers

--less than 25 workers

--less than 50 workers

Subsidies for carved-out workers should be set at Kennedy level

c. Options above only for full-time workers and for part-time workers with same proportional contribution as in HSA.

d. Carve-out for all firms in these subsidy categories, with no wage limit.

2. Require 50 percent employer contribution for all workers and dependents (with same options as above).

3. Non-workplace coverage

a. All children and pregnant women, with MOE, in conjunction with

options one and 2 and if there is no employer mandate.

o at Riegle level

o at Kennedy level for non-workers

o at Kennedy level for carved-out families (i.e., same limits apply to coverage of women and children in all familes as applied to whole families of carved-out workers).

b. All families, in conjunction with option 1 and 2, at subsidy levels specified in 3a

Assumptions

a. Kennedy benefit package

b. Full year implementation figure, with rule of thumb for converting subsidy costs into 1996-2000 number

--using HSA rate of increase

--using Medicaid rate of increase in finance bill

--using national health expenditure baseline estimates

Fiscal Summary

Changes from Baselines

($ Billions)

	1995-1999	1995-2004
Outlays		
Low Income Voucher Program	+142.1	+613.6
Medicaid	- 43.6	-268.9
Medicare	- 46.9	-279.9
Other Federal Health (1)	- 10.0	- 25.0
Revenues		
Tobacco tax (2)	- 70.9	-138.4
High Cost Plan Assessment	- 4.7	- 17.1
Tax Expenditures	+ 6.8	+ 70.2
Other Revenues	+ 2.7	+ 7.1
Net Deficit Effect	-24.5	-38.4

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

(1) This includes Postal Service reforms included in the proposal. Because of insufficient information, it does not include an estimate of the proposal's effects on FEHB, 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 increase starting in 1995.

Requested by Christy F

- premium [illegible]
- cost of non-workers

- Phase of [illegible]
-
- ~~[illegible]~~ [illegible] phase at [illegible] 15%

Phase in [illegible]

Chris -

FYI

Jen

7/13/94

Choices About Coverage for Abortion Services

- The cost of abortion coverage is $8.67 per policy, based on the estimated community rate required to fund abortions.

- An individual may waive abortion coverage if the individual has a moral or religious objection to this service. If the individual waives abortion coverage, the individual's premium obligation is reduced by the appropriate share of the community-rated amount attributable to abortion coverage.

- A religious employer may choose not to pay for abortion coverage. If the employer chooses not to pay for abortion coverage, the employer's premium contribution is reduced by the employer share of the community-rated amount attributable to abortion coverage. An employee may elect not to pay the difference.

  A religious employer is an employer that: (1) qualifies for tax exemption (under 501(c)(3) or ERISA "church plan" definitions); and (2) is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religion or by a particular religious corporation, association or society.

- Subsidies are reduced by the appropriate share of the community-rated amount attributable to abortion coverage. Individuals who do not waive abortion coverage must pay the difference.

- All policies include coverage for abortions that are necessary to save the woman's life or as a result of rape or incest.

- A religious plan sponsor may decline to include abortion services other than abortions that are necessary to save a woman's life or as a result of rape or incest. A religious plan sponsor is a sponsor that meets the definition above.

MEMORANDUM FOR NANCY-ANN MIN

FROM: Len Nichols

RE: Preliminary "Bottom Line" on Senate Finance Mark

DATE: 7/6/94

As you know, we received the language of the amendments to the Chairman's mark last night. OMB and Treasury staff have reviewed those amendments, and our very preliminary ballpark bottom line is:

$25 billion increase in the deficit between 1995-1999

$90 billion increase in the deficit between 1995-2004

By contrast, the Chairman's mark, sans employer mandate trigger, produced:

$80 billion decrease in the deficit between 1995-1999

$275 billion decrease in the deficit between 1995-2004

The salient differences between the final bill and the Moynihan mark are:

- HSA-like long term care program added ($158B 1995-2004)
- corporate assessment dropped ($150B)
- smaller tobacco tax increase ($20B)
- early and generous expansion for pregnant women and kids (Reigle amendment) added to subsidies ($22B)

The softest numbers, as always, are the subsidy estimates, especially the Reigle amendment subsidy estimates, since they are based upon assumptions about premiums and health insurance purchasing behavior in a voluntary yet partially reformed environment.

We will continue to refine these estimates as time and better information allows.

Final Finance Mark, 6:45 pm. 7/6

Preliminary!

	1995-1999	1995-2004
Long Term Care	19	158
Net Subsidies	211	772
Medicare Savings	(37)	(207)
Medicaid Savings	(121)	(559)
PHS/AHC Spending	40	120
Tobacco Tax*	(86)	(157)
Corporate Assessment	0	0
Net Other Revenues	(16)	(64)
Net Deficit Effect	22	87

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

*Tobacco revenues are too high, and they are adjusted for in the Net Other Revenues line.

DATE: 7/6/94
TIME: 6:10 pm

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

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

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

To: Nancy-Ann Min; Chris Jennings; Ken Thorpe

FAX #: 5-7289; 6-7431; 401-7321

Voice #:

From: Linda Blumberg and Len Nichols

Notes:
Following is a second version of 50/50, including transitional measures outlined by Ken. Everything needs to be fleshed out, but we wanted to make sure that this is the general direction everyone is thinking about.

Number of Pages (including cover sheet): 3

- Standard benefit package = HSA-8%
- No mandate until January 1, 1999
- Transition period = January 1, 1997 through January 1, 1999
  Transition policies are as follows:
  - Implement insurance reforms and standard benefit package rules, including non-discrimination rules. No subsidies available to employers.
  - Provide 100% subsidies to households under 75% of poverty without current coverage. Phase-out percentage of premium subsidies between 75% and 150% of poverty. The same subsidies would be available to those losing their jobs that had insurance through their employment.
  - Provide a second year of Medicaid funding for those leaving welfare for work. Coverage continues through separate Medicaid program.
  - Provide constrained growth plan package to employers not currently offering insurance in the small group (< 25) market. Package would be solicited by the federal government from private sector insurers -- plans would agree to limit premium increases to 6-7% per year -- see Florida experience for details of how to do this. If employer contributed at least 50% of premium, worker 50% share would be subsidized on an income-based schedule).
  - 2% free rider assessment
  - Tobacco tax
  - 1% assessment on 500+, if provide (2% if don't provide).
- Mandate period -- January 1, 1999 and forward.
  - As of January 1, 1999, implement 50% employer mandate on firms of >= 20 workers; individual mandate on families. Those firms with fewer than 20 workers have no mandate, but must pay a 2% of payroll assessment if they do not provide 50% coverage to their workers.
  - Employers subsidized according to retreat model 3 (3.5%-7.9%) for 50% share of standard benefit.
  - Community rating for those at or below 500 workers; experience rating above 500 workers. No opt-in to community rate, and 1% assessment on those over 500.
  - Implement a Bradley-esque high cost plan assessment.

Community Rating Pool: Target is adjusted mean in the community rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997).

Experience Rated Group: Target is adjusted mean in the experience rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997). Plan premium will be adjusted to take the pool's experience into account for firms of < 1000.

Rate is set such that revenue and subsidy losses due to growth in excess of targets is recaptured.

- Household subsidies available for 50% worker share for households up to 200% of poverty. Non-worker/Carve-out subsidies available for other 50% share to households up to 200% of poverty.

- Tax credit expansion for individual premium contributions.

- Tobacco tax

- 1% payroll assesssment on the 500+ firms.

DATE: 6/20/94
TIME: 5:50 pm

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

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

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

To: Chris Jennings

FAX #: 6-7431

Voice #: 6-5560

From: Linda Blumberg and Len Nichols

Notes:

Number of Pages (including cover sheet): 3

Subsidy and Revenue Effects of Pool Size Changes*
(Assumes Administration Best Guess of Pool Size Effect on Premiums)
dollars in billions

	1000	500	100
5 YEAR			
Subsidies	360	370	400
Select Other Revenue**	40	40	50
Corporate Assessment	40	50	60
Net Deficit Effect	**(10)**	**(10)**	**(0)**
10 YEAR			
Subsidies	960	990	1,070
Select Other Revenue**	70	80	100
Corporate Assessment	80	90	120
Net Deficit Effect	**(90)**	**(80)**	**(50)**

Only glitch there and

* Plan used for calculations is structured as follows:
- o premium = HSA-5%
- o individual wage cap; all firm sizes eligible
- o Prior to 1999, employer mandate on firms of 20+ and individuals. 1999 and beyond, full employer mandate plus individual mandate.

** "Select Other Revenue" includes only those changes in revenue that will differ from the HSA. However, those revenue changes that are identical to the HSA are taken into account in the "Net Deficit Effect" estimates.

All numbers rounded to the nearest $10 billion.

- No constraints
- Voluntary world

6/20/94--5:30 p.m.

ESTIMATE OF PREMIUM CHANGES BY ALLIANCE SIZE

(ASSUMING UNIVERSAL COVERAGE AND MANDATORY ALLIANCES)

ALLIANCE SIZE	BEST ESTIMATE (relative to CBO's HSA estimate)*	RANGE
All	-	-
5000	0%	0 - 10%
1000	0.5%	0 - 10%
500	2%	0 - 10%
100	6%	0 - 15%
50	10%	0 - 20%

only give these

* Note:
Includes AFDC-and-Non-cash in pool.
All workers in split families follow higher wage earner.

Drug Benefit

(dollars in billions)

	FY 95 – 2000	FY 95 – 99	FY 2000 – 4	10 – Year
Clinton Bill 1/1/96 eff, 58% deductible	69.9	52.5	101.1	153.5
$415 d Alternative 1/1/98 eff, 50% deductible	38.6	23.6	86.9	110.6
$500 d Alternative 1/1/98 eff, 45% deductible	34.6	21.2	78.0	99.2

98

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + 3 DATE: 7/8/94

TO:
Chris Jennings
Fax: 456-7431
Phone:

FROM:
Peter Hrckman
Pete Griffin
Fax: (202) 690-8168
Phone: 690-5950

REMARKS:

Estimates we discussed this morning

- 2 tables showing estimates for 95-99 & 2000-04 from CBO + OACT - rojusted for the $80 billion package
- Comparison of drug benefit alternatives, effective 1998, with 50% or 45% of beneficiaries include meeting the deductible. (Alternatives include 35% reduction in dispensing fees

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

7/3 3334

Rick 232-4927

Medicare Savings Under Health Reform: Adjusted OACT Estimates

	1995-99	2000-04	Total 1995-2004
Hospital Update at MB-0.5 (1997 -2000)	2,428	16,898	19,326
Reduce Indirect Med Ed	13,560	30,920	44,480
Reduce Payment for Capital	4,360	14,430	18,790
Phase Down DSH (20% reduction)	3,354	10,971	14,325
GME Lag	(270)	(70)	(340)
Extend OBRA 93 SNF Savings	690	1,310	2,000
Prohibit PPS Exemptions for New LTC Hosp	360	1,160	1,520
HI Interactions	(558)	(4,158)	(4,716)
S&L Employees	6,122	7,312	13,434
Real GDP per Capita V&I Factor	3,150	21,400	24,550
Set Cumulative Growth Targets	3,975	9,150	13,125
Eliminate Formula Driven Overpayment	6,900	29,550	36,450
Competitive Bidding Labs	1,210	2,130	3,340
Competitive Bidding O2/MRI/Ct	770	1,280	2,050
Income Related Premium	2,603	7,293	9,896
Incen for Phys for Primary Care	(55)	(150)	(205)
Prohibition on Balance Billing	(860)	(1,550)	(2,410)
Extend 25% Part B Premium with Interaction	(3,550)	23,030	19,480
10% HHA Copay	6,210	10,370	16,580
MSP Proposals	1,325	13,850	15,175
HMO Payment Improvements	885	2,450	3,335
Reduction in Routine Limits for HHA	1,870	4,730	6,600
Centers of Excellence	500	550	1,050
Total Savings	54,979	202,858	257,834

07/08/94
03:16 PM

+ Unified Comp would produce additional MSP savings.

Medicare Savings Under Health Reform: Adjusted CBO Estimates

	1995-99	2000-04	Total 1995-2004
Hospital Update at MB-0.5 (1997 -2000)	1,850	10,160	12,010
Reduce Indirect Med Ed	10,450	23,568	34,018
Reduce Payment for Capital	4,599	12,332	16,931
Phase Down DSH (20% reduction)	2,714	7,523	10,238
GME Lag	608	2,531	3,139
Extend OBRA 93 SNF Savings	605	1,250	1,855
Prohibit PPS Exemptions for New LTC Hosp	360	1,350	1,710
HI Interactions	(352)	1,453	1,100
		0	
S&L Employees	6,099	6,507	12,606
Real GDP per Capita V&I Factor	2,667	21,878	24,545
Set Cumulative Growth Targets	9,372	53,718	63,090
Eliminate Formula Driven Overpayment	7,351	29,028	36,379
Competitive Bidding Labs	1,180	2,393	3,573
Competitive Bidding O2/MRI/Ct	753	1,346	2,099
Income Related Premium	2,660	7,490	10,150
Incen for Phys for Primary Care	0	0	0
Prohibition on Balance Billing	(756)	(1,452)	(2,208)
Extend 25% Part B Premium with Interaction	(5,594)	17,300	11,706
10% HHA Copay	5,859	10,750	16,609
MSP proposals	1,631	12,024	13,655
HMO Payment Improvements	885	2,465	3,350
Reduction in Routine Limits for HHA	1,512	4,415	5,927
Centers of Excellence	380	100	480
Total Savings	54,833	228,129	282,962

07/08/94
03:12 PM

Drug Benefit

(dollars in billions)

	FY 95 - 2000	FY 95 - 99	FY 2000 - 4	10 - Year
Clinton Bill 1/1/96 eff, 58% deductible	69.9	52.5	101.1	153.5
Alternative 1/1/96 eff, 50% deductible	38.6	23.6	86.9	110.6
Alternative 1/1/96 eff, 45% deductible	34.6	21.2	78.0	99.2

Where is RAPRC?

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

ENROLLMENT

- A outpatient prescription drug benefit would be added to the Medicare Part B benefit package effective January 1, 1998.
- Beneficiaries would have a choice as to how they would receive their drug benefit:
  - + Individuals enrolled in HMOs with risk or cost contracts with Medicare would receive their drug benefit through these entities.
  - + Beneficiaries could enroll with capitated drug benefit plans that have a contract with Medicare (This option would be available starting January 1, 2001).
  - + Beneficiaries who do not enroll with a capitated drug plan would receive their benefits on a fee-for-service basis.

COVERAGE

- The Medicare drug benefit would cover all drugs, biological products and insulin approved by the Food and Drug Administration (FDA) for all labelled indications and certain off-label indications (consistent with the OBRA 93 provision on coverage of cancer drugs).
- Current coverage of drugs used in conjunction with infusion pumps and parenteral and enteral nutrition would be subsumed under a home infusion benefit which would be part of the new Medicare outpatient drug benefit. Similarly, current limited coverage of outpatient drugs and biologicals under Medicare such as immunosuppressive drugs, EPO, antigens, blood clotting factors and drugs provided incident to a physician service would be incorporated into the drug benefit.
- The Secretary would have the discretion not to cover certain pharmaceutical products listed in Section 1927(d) of the Social Security Act. Examples include fertility drugs, medications used to treat anorexia and drugs used for cosmetic purposes. However, benzodiazepines and barbiturates would be covered under the Medicare drug benefit.

PREMIUM

- The Part B premium would be increased to cover 25% of the cost of the new benefit. The increase in the premium for the drug benefit in 1998 would be approximately $7.00.

FEE-FOR-SERVICE BENEFIT

Cost Sharing

- The annual deductible would be $400 in 1998. Once the deductible is met, beneficiaries would pay 30 percent coinsurance until the annual out-of-pocket limit was met. The out-of-pocket limit would be $1,200 in 1998.

- In 1999 and subsequent years the deductible would be indexed so that 50% of all beneficiaries receive benefit. The out-of-pocket cap limit would also be indexed to assure that the same percentage of beneficiaries are assisted.

Cost Containment

- **Rebate Agreements.** As a condition of participation in Medicare, drug manufacturers would sign rebate agreements with the Secretary. Once a rebate agreement is signed, all the manufacturer's currently marketed drugs would be covered. Drugs used by beneficiaries enrolled in HMOs or capitated drug plans and the working aged would not subject to rebates.

  + **Basic Rebate.** Manufacturers pay a basic rebate to Medicare for each drug based on a percentage of the average manufacturer retail price (AMRP)

    ++ For single source and innovator multiple source drugs (brand name drugs), the rebate would be equal to 15 % of the AMRP.

    ++ For multiple source drugs, the rebate would be equal to 6% of the AMRP.

      +++ The Secretary would be required to determine whether it would be feasible and desirable to establish a sliding scale for the rebates based on the relationship between the AMRP of a drug and the AMRP of the innovator drug. The maximum rebate would be 15% and the minimum rebate 2%, with drugs whose AMRP was closer to AMRP of the innovator paying a larger percentage. Total revenues from these variable rebates rates would be projected to achieve the same level of rebates as a flat 6% rate.

      +++ If the Secretary determined that such a system of variable rebates was feasible and desirable, she would be authorized to implement it in place of the flat 6% rebate.

  + **Inflation Protection.** Under the rebate agreement, additional requirements would apply to manufacturers of single source and innovator multiple source

drugs who increase the price of a drug at a rate higher than the Consumer Price Index (CPI). Such manufacturers would be required to rebate the marginal revenues derived from sales to beneficiaries resulting from such pricing policies. The baseline price would be the AMRP between April and June 1993.

- **Generic Incentives.** The drug benefit encourages the use of generic drugs. Unless a brand name drug is specifically requested by the physician, payment would be based on the cost of the generic substitute.

- **Prior Approval.** The dispensing of drugs that the Secretary, after consulting with medical experts, determines are prone to inappropriate use or clinical misuse would be subject to prior approval. In addition, if growth in program expenditures for drugs exceed the rate of growth for the program as a whole, the Secretary would be authorized to require prior approval before dispensing brand-name drugs if a generic substitute is available.

- **Mail Order Maintenance Drugs.** The Secretary would be authorized to establish a mail order option for beneficiaries using maintenance drugs. The Secretary could establish the price for drugs dispensed to mail order firms on the basis of a competitive bid. One quarter of the savings resulting from the mail order option would be shared with beneficiaries using the service in the form of a lower coinsurance rate or rebate.

Pharmacy Reimbursement

- **Brand Name Drugs.** For brand name drugs, payment is the lower of actual charges or the estimated acquisition cost (EAC) plus a dispensing fee.

- **Generic Drugs.** For generic drugs, payment is the lower of actual charges or the median of all generic EACs in the same therapeutic class times the number of units dispensed plus a dispensing fee.

  + **Estimated Acquisition Cost.** The Secretary would determine the EAC. The EAC could equal a percentage of the published Average Wholesale Price (AWP) or it could be determined based on a survey of pharmacies and wholesalers. However, the EAC cannot be established at greater than AWP minus 7 percent.

  + **Dispensing Fee.** The dispensing fee for 1998 would be $5. For subsequent years, it would be indexed to the Consumer Price Index (CPI). All pharmacies that receive Medicare payment would be required to accept assignment on all prescriptions, answer beneficiaries' questions regarding medication usage, and submit drug claims on behalf of beneficiaries. Dispensing fees would not be paid for EPO provided to dialysis patients by dialysis facilities, for drugs

provided incident to a physician service or for home infusion drugs.

Drug Utilization Review

- The Secretary, in consultation with medical experts, would develop a program for Drug Utilization Review (DUR) to assure quality and contain costs. The program would include prospective and retrospective components and would be similar to that mandated under the Medicaid program.
  - + Prospective DUR would be implemented to determine whether any potential drug therapy problems exist before dispensing a medication.
  - + Retrospective DUR would identify patterns of inappropriate prescribing and medically unnecessary care and result in educational intervention directed at the physician or pharmacist.
  - + Both prospective and retrospective DUR would identify instances of fraud and abuse.
- The Secretary would be required to study the desirability and feasibility of requiring that diagnosis be included on the prescription in order to expand the scope of DUR. If the Secretary determined that such a requirement would be desirable and feasible, she would have the authority to implement it effective January 1, 2000.

Claims Processing

- The Secretary would establish a point-of-sale electronic claims processing system which would be used to determine eligibility, process and adjudicate claims from pharmacies, and to provide information to the pharmacist about the patient's drug use under the Medicare drug program.
- The Secretary would be authorized to contract with entities other than carriers to administer the drug benefit. These entities could be paid on other than a cost basis.

RECEIVING THE DRUG BENEFIT THROUGH A CAPITATED DRUG PLAN OR HMO

Enrollment

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

permitted.

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

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

Standards

- In order to be eligible to enroll beneficiaries, drug benefit plans would have to have a contract with the Secretary. Contracts would require state-wide service areas. There would be no limit on the number of contractors in a state (unless the Secretary opted to use a bidding process to determine payment in which case there would be one entity per state). A HMO with a risk contract, however, could not also have a contract in the same geographic area as a drug benefit plan.

- Drug benefit plans would have to meet access, quality and financial standards similar to those applicable to HMOs with risk contracts. In addition, both drug benefit plans and HMOs with risk contracts would have to meet other standards that would be developed by the Secretary which would address:

  + Drug utilization review requirements

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

  + Beneficiary safeguards in regard to use of prior authorization

  + Compliance programs

  + Procedures for out-of-area claims

  These standards would be developed by the Secretary by January 1, 1997.

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

Beneficiary Cost-Sharing

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

  + require a monthly premium in lieu of part or all other cost-sharing.

  + offer a point-of-service option with coinsurance higher than the 30% under standard Medicare.

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

- Both HMOs and drug 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.

Payment

- By January 1, 1997, the Secretary would determine whether HMOs should be paid for drugs according to the current payment methodology or through an add-on based on a different methodology or different demographic and/or geographic factors.

- By January 1, 2000, the Secretary would determine whether payment to drug benefit plans would be based on the methodology used for HMOs or on a bidding model.

EQUAL ACCESS TO DISCOUNTS

- As a condition of participation in Medicare, manufacturers would have to offer the same discounts to all purchasers on equal terms and conditions. Manufacturers' discounts would have to be directly proportional to the impact of the purchasers' terms (i.e., single site delivery, volume purchases, use of formularies) on the manufacturers' costs.

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