Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Political Profiles (20 pages)	nd	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [22]

gf153

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

7/8/94 11:25 AM

JULY 7 OPTIONS

Benefit Package	HSA - 8% actuarial value; premium path through time attached
Community Rating Pool	Option 1: individuals and firms of <= 500 are in the community rated pool. There is no opt in for firms over 500. Option 2: individuals and firms of <= 100 are in the community rated pool. There is no opt in for firms over 100.
Transition Policies: Pre January 1, 2000 Measures to Voluntarily Increase Coverage	
Subsidies to very low income families	subsidies to those < 200% of poverty. <= 75% of poverty receive 100% of premium subsidy; 75%-200% of poverty receive subsidy, phasing-out linearly This is a voucher subsidy worth a fixed percentage of the average premium, as under Chafee and Finance Mark
~~Medicaid~~ Welfare to Work Policy: Incentives to ~~increase~~ Medicaid program ~~participation.~~ ~~Speed up Medicaid coverage~~ for low-income children and pregnant women	Provide a second year of ~~Medicaid~~ funding for those leaving welfare for work. **(*estimated out of model*)** Provide financial incentives for states to ~~increase participation in~~ Medicaid -- e.g., a X% increase in participation would lead to a Y% increase in FMAP; or decrease MOE payments as a function of expansion Make all children and pregnant women in poverty eligible for coverage in 1998 or 1999

[redacted]

Job loss related uninsured	80% coverage through community rated pool - subsidies based upon expected income over the next quarter, or some generous measure (perhaps like HSA, not counting unemployment comp., etc) Schedule is HSA like 250% of poverty marginal rates (attached) **(*estimated out of model?* Need job turnover data from DoL?)**
Incentives for expansion of employer coverage	Provide 8% individual wage cap subsidies to firms for their workers that are not currently covered as long as they contribute 50% of premium for standard package. Workers would be eligible for subsidies on their 50% share; household payments would be capped at 8% of AGI, and those under 200% of poverty would get larger subsidies as specified in attached marginal rates. **(can we do this in-model if we attach a specific assumption about take-up?)**
Special program for firms of less than 25 workers, not currently covering their workers.	Subsidies as in expansion of coverage section (above) would be provided for these firms. Additionally, any individual subsidies that the households under 200% of poverty would get (as detailed in section above on subsidies to the very low income) could be used to offset employer costs. Assume 20% of employers in this firm size group take up the offer.**(can we do this in-model if we attach a specific assumption about take-up?)**
Medicare	
Medicaid	Cash AFDC units receive full subsidies for community rated premium. (This can be done out-of-model if necessary) SSI is out. Non-Cash are bought a community rated premium if their income is <= 100% of poverty. If their income is > 100% of poverty, they are treated the same as other low income people.

Tobacco Tax	Same level as HSA
Mandate Policies: 1/1/2000 and Beyond	
Specifications of the Mandate	50% employer mandate on firms of X workers or more, where Option 1A: X = 25 Option 1B: X = 50 Option 2: X = 25 Individual mandate on individuals/families Switch to Per Worker Premium
Employer Subsidies	8% individual wage cap on employer's 50% share. Employers in the community rated pool are subsidized on the community rated premium mean; employers in the experience rated pool are subsidized on the experience rated pool mean.
Payroll Assessments	Non-covering employers (those in the carve-out range choosing not to cover their workers) pay a 2% of payroll assessment
Household Subsidies	Workers are subsidized on marginal rate schedule (attached) for household's 50% share. These special subsidies phase-out at 200% of poverty. In addition, no family pays more than 8% of AGI for their family 50% share. Non-workers and worker's are "carved-out" are also subsidized on the "employer" 50% share, according to another marginal rate schedule (attached) which also phases out at 200% of poverty. Non-workers' reference incomes are non-wage AGI; carved-out workers' reference incomes are AGI.
Experience Rated Plan Assessment	Experience rated plans with premiums below those in the community rated plans will pay an assessment into the community rated pool. This assessment will be characterized soon.

High Cost Plan Assessment	To be characterized soon, and any price effects included in the premium path delivered.
Tobacco Tax	Same level as HSA ~~$150~~ wg'd more
Medicare Savings	Same as in Finance Mark ~~No drug benefit~~ 7 'modest' drug benefit Long term care benefit (show separately)
Medicaid	Non-Cash: "In" - treated like all other low income units. AFDC Cash: "In" - treated like all other low income units. SSI Cash: "Out"

Mitchell

(1) – Plans assure [illegible] subsidies + drug

11% of premium — cash abatement for [illegible] cost sharing

cost: — care for needy –

(2) Back of envelope to have subsidies

for pregnant women → 185%

Lindeo MOE 1.8 →

of lost insurance

→ Outside [illegible] — phase it back.

(3) Subsidies be [illegible] of poverty – family of size is family of 4. [illegible] estimate

224-8485 – [illegible]

– Medicare numbers

3 drug options

[illegible] Militar Road

38th Street

3813

1/9/94

Chris -

I have the following questions about the specs:

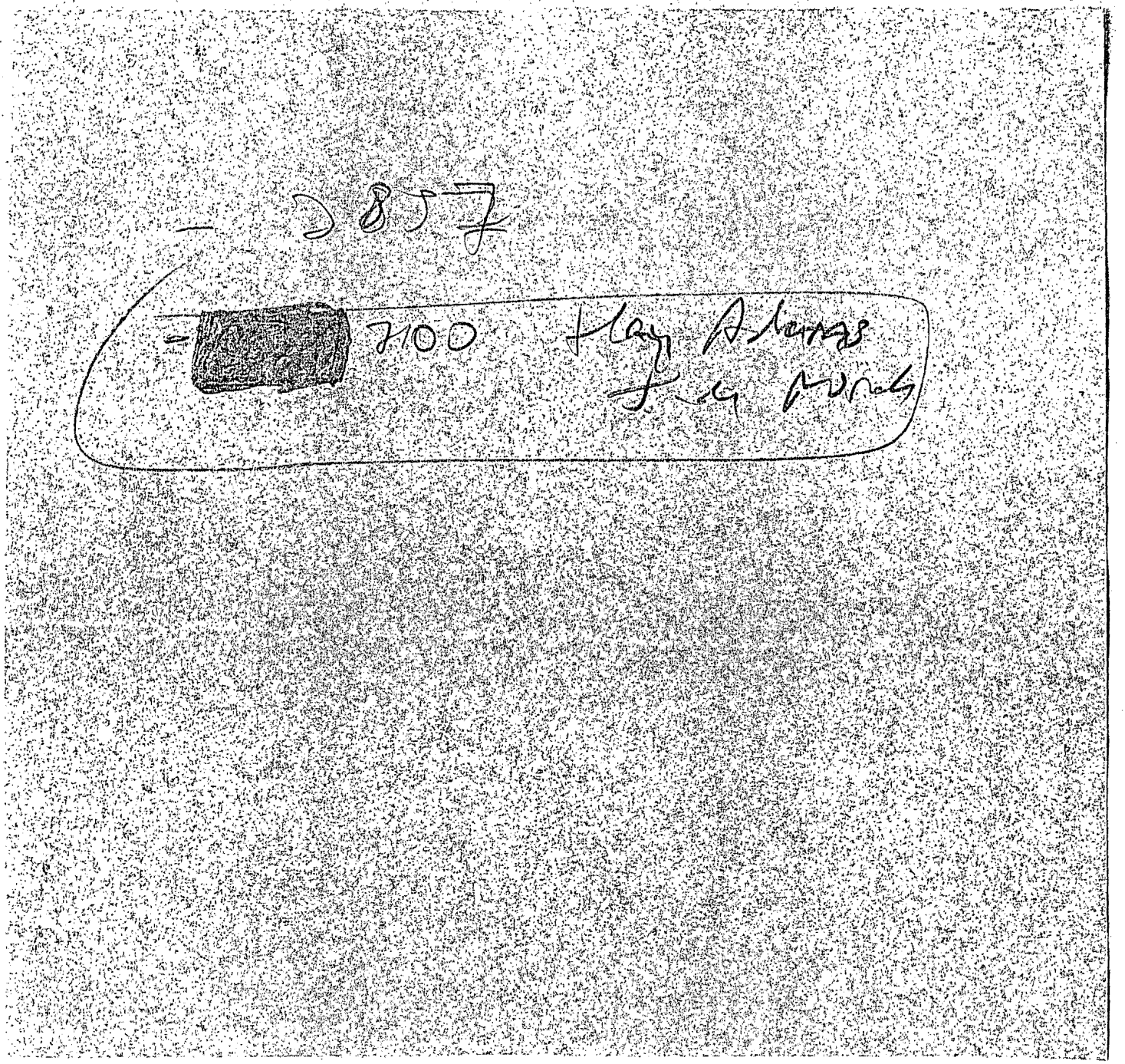
Voluntary period:

p.2 Medicaid non-cash: if they have to pay for a significant share of the premium above 100% of poverty, will we see droppage? Analysis: how many of the 9MM non-cash have incomes above 100% poverty? Assume that if they pay 0% today, then we will see dropping if they have to pay much more than that in the voluntary world.

Jyn

Can you let me know of any meetings on this stuff this weekend? Call me (at home P6/b(6) & I'll have my pagers.

Thanks



PHOTOCOPY
PRESERVATION

Suggested Changes to Pre-Mandate Policy for
June 7 Option

Benefit Package	HSA – 8% actuarial value; premium path through time attached.
Community Rating Pool	Option 1: individuals and firms of <=500 are in the community rated pool. There is no opt in for firms over 500. Option 2: individuals and firms of <=100 are in the community rated pool. There is no opt in for firms over 100.
Transition Policies: Pre January 1, 2000 Measures to Voluntarily Increase Coverage	
Subsidies to very low income families	Subsidies for those <200% of poverty. <=75% of poverty receive 100% of premium subsidy; 75%–200% of poverty receive subsidy, phasing out linearly. This is a voucher subsidy worth a fixed percentage of the average premium (as under Finance bill).
Welfare to work policy:	Provide two years of coverage for individuals leaving welfare (Medicaid now provides one year). Individuals receive 100% premium subsidy. **(*estimated out of model*)**
Incentives to enroll individuals now eligible but not participating in Medicaid program:	Require point of service enrollment by providers of individuals currently eligible but not enrolled in cash assistance programs. Individuals receive 100% premium subsidy. **(*estimate AFDC costs; federal government could increase share of AFDC for those who enroll through this policy)**
Enhanced subsidies for low-income pregnant woman and children:	Pregnant woman and children below 185% of poverty eligible for full premium subsidy in 1998 or 1999. Individuals receive 100% premium subsidy.
Job loss related uninsured	Individuals that work for at least six months and lose their jobs are eligible for enhanced income protection for subsidies while unemployed. For the purpose of calculating AGI for subsidy eligibility: --UI income is not counted toward AGI; --Exclude from wages earned in the year up to 2X the applicable monthly poverty income for each month worked. **(*estimated out of model?* Need job turnover data from DOL?)**

Incentives for expansion of employer coverage	Employer contributions for currently uninsured workers are capped at 8% of individual wages. Employers must contribute at least 50% of premium for standard package to be eligible for subsidies. For employers with less than 25 workers, employer shares in individual low-income subsidy. Assume 20% of employers in this firm size take up offer. **Note: There seems to be no reason to give workers who get coverage through this source more generous subsidies than other families.** **(can we do this in-model if we attach specific assumptions about take-up?)**
Medicaid	Cash AFDC units receive full subsidies for community rated premium. **(this can be done out-of-model if necessary)** SSI is out. Non-Cash are bought a community rated premium if their income is <=100% of poverty. If their income is >100% of poverty, they are treated the same as other low income people.
Tobacco Tax	Same level as HSA

Kim Thorpe

401 - 7321

Bob Rosen

224 - 6603

Mitchell meeting

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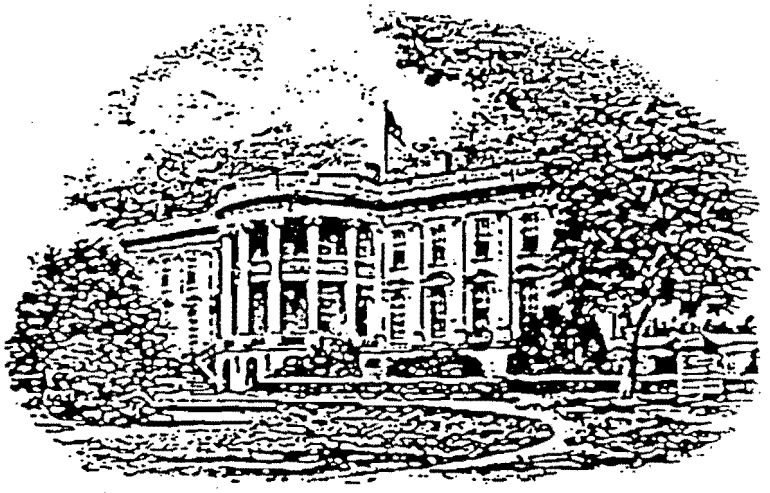
DATE: _____
TIME: _____

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Theresa F_____

_____

PHONE: (___) _____

FAX: (___) _____

FROM: _____

PHONE: (202) 456-_____

PAGES FOLLOWING COVER SHEET: _____

Parents P6/b(6) 7 Par

Redistribute money better within system

Higher copayment for people

Bob

G.

Bob R.:

$178 B   35 - 5 yr.

$257 B

↓ - Two tax

254 B

Cap Medicaid at some constrained level.

Larry / Norm Ahn

Nancy Ahn

P6/b(6)

HSA [illegible] of cost-sharing [illegible]

P6/b(6)

FAX TO CHRIS JENNINGS

Attached is the paper on the scaled back drug benefit that you requested yesterday. It contains the following differences from HSA:

- o Would start 1/1/98 instead of 1/1/96
- o Deductible would be set at $400 in 98 and 50% level thereafter (HSA 58 %)
- o Coinsurance would be 30% rather than 20%
- o I rounded the out-of-pocket cap up to the nearest $100 so it would help somewhat fewer beneficiaries than HSA
- o My guess at the premium was around $6.50, I called that approximately $7.00
- o In the fourth year of the program, beneficiaries would have the option of receiving their drug benefits through capitated drug benefit plans. Beneficiaries in HMOs would receive drugs in 1998.
  - ++ I included the three year delay for drug benefit plans in order to give us time to work out payment and enrollment issues and to give us time to have the fee-for-service benefit up and running smoothly. I believe that it would be very difficult to implement the fee-for-service benefit with its massive point-of-sale processing system, if the number of beneficiaries to be served was a moving target due to uncertainty in regard to enrollment in drug benefit plans. Once we had things up and running it would be less of a problem.
  - ++ Some of our payment people thought that competitive bidding would be the way to go with the drug benefit plans, so I left that as something for the Secretary to decide. If you went that route, you would go with a single winner for each

state (I don't think multiple winners would work.) Remember that this single entity would be competing against the HMOs in the state and the fee-for-service benefit so it is not the same world as envisioned in the MEDCO proposal.

++ The rest of the specifications follow what we had in the demo paper. Open enrollment, with enrollment only through a third party designated by the Secretary. I've included that a risk HMO couldn't be a drug benefit plan in the same geographic area -- this would prevent HMOS from using the drug benefit to target healthy people for enrollment in the risk program.

o I folded more existing drugs into the new benefit as Ways and Means did. HSA had only immunosuppressives, oral cancer and osteoporosis drugs. (Not a lot of thought had been given to this issue in HSA, I believe that what W&M did is preferable.)

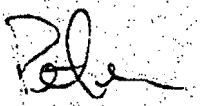
o Rebates would be 15 and 6, this is the same level of total rebates as proposed in HSA (.17*.75=.15*.75+.06*.25). W&M has more rebates in total than we had proposed. The Secretary would have authority to implement the generic rebate as a sliding scale -- with generics closer in price to the innovator paying more -- if we can work out the details of how it could be done.

o Prior approval is scaled back relative to HSA but broader than W&M -- if drug costs grew faster than total Medicare we could implement prior approval on innovator drugs. We could have done this from day one in HSA.

o I added a mail order maintenance drug option. It was in the MEDCO stuff and I thought it was a good idea. We could have paid lower dispensing fees for mail order in HSA put we couldn't have used competitive bidding, nor shared the savings with beneficiaries who use the service.

o Dispensing fee starts at $5 in 98, it would have been $5.35 in 98 under HSA.

- I give the Secretary the authority to require diagnosis on the prescription by 2000 if she thinks it would be desirable and feasible. Many people believe that this would be a great help with DUR and its the only way to monitor whether a drug is being given for an accepted indication.



Peter Hickman

I will be home for the most part after I get back from church (10:30). I do have to run Paul over and back from a birthday party, so if I don't answer leave a message. If you get voice mail after one ring that means someone is on the phone.

What is R&PRC?

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

- o 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.
- o 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

- o 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.
- o 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

- o 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.

 [t/p] t= transition; p= permanent

INSURANCE MARKET REFORMS

Requirement for Plans

Guaranteed Issue[t/p]

All health plans must accept all eligible individuals for coverage. §1004 and §1516

Plans cannot deny coverage based on:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- anticipated need for health care services;
- disability; or
- lack of evidence of insurability.

Plans required to issue coverage except when:

- enrollment causes plan to exceed approved service capacity; or
- individual or group has not requested enrollment during open enrollment.

Open Enrollment[t/p] - §1660

State specifies a uniform, annual open enrollment period for each community rating (CR) area based on rules established by NHB.

NHB must establish rules on other periods and occurrences for enrollment changes.

NHB shall establish methods for direct enrollment of certain CR eligible individuals in certified health plan of their choice.

Issue through HIPCs[t/p]

Plans required to offer coverage through all HIPCs in a community rating area and outside the HIPCs. Plans are also available, through direct enrollment, to firms and individuals not connected with the workforce.

No certified health plan can offer a rate to a HIPC that is more than the per-capita community rate.

Extended Coverage of Dependents[t] - §1011

Plans required to offer family coverage that includes coverage of dependent unmarried kids up to age 24 and spouses. (This helps cover college kids on parents' policy.)

Guaranteed Renewal[17]

Prior to implementation of universal coverage

Plans prohibited from terminating or failing to renew coverage for groups or individuals except for:

- nonpayment of premiums;
- fraud; or
- misrepresentation.

Pre-ex condition Exclusions

Insured plans could not exclude coverage of pre-ex condition for more than 6 months from date of enrollment. Plans cannot apply exclusion if person was recently insured by another plan. Plans cannot apply limitations to newborn and must offer automatic coverage of infants on parents' policy.

Health plans may not impose rider that serves to exclude coverage of particular eligible individuals. §1004 and §1516

Lookback period of 6 months during first year; 3 months thereafter. Plans cannot limit coverage if pre-ex condition is pregnancy.

After universal coverage is attained, no limits or exclusions for pre-existing conditions.

One-Time Amnesty for Pre-ex

Plans required to enroll any uninsured person, without limiting coverage for pre-existing conditions, applying for enrollment during first open enrollment period. Such period shall be 90 days in length.

Standardized Benefit Package

Plans must provide coverage of the comprehensive benefits package.

A plan may provide a standard catastrophic benefits package, but if it does, it must also provide the comprehensive benefits package in the same CR area it provides a catastrophic plan.

If offered, supplemental benefits must be offered and priced separately from the comprehensive benefits plan.

Cost sharing policies can only be offered by the plan that provides the standard benefits package.

↓ Differences in premium can only be due actuarial value of packages rather than through the risk pool.

— risk adjustment covers packages.

Community Rating (CR)

States must establish "health care coverage areas". States determine number of areas, but cannot subdivide MSA and must have at least 250,000. The NHB must review and approve health care coverage area boundaries. Can have interstate health care coverage areas under rules established by NHB. §1202

CR market includes:

- all firms with less than 500 workers;
- unemployed, self-employed, nonworkers, and Medicaid (cash, non-cash, & some MN) recipients;
- existing Taft-Hartley and rural cooperative plans with less than 500 participants.

Experience rating would apply to:

- firms with 500 or more workers (except staff leasing agencies); or
- existing Taft-Hartley and rural cooperative plans with 500 or more participants; and
- existing bona fide multiple welfare employer plans with 1,000 or more employees (with each plan limited to its present size).

To be determined: treatment of part-timers, seasonal, temporary, migrant and seasonal agricultural workers.

Don't plan other rating Mkts

During transition to universal coverage, plans selling to the CR market can modify CR based on geography, family size, and age. Age adjustment begins at 2:1 for population under age 65 and phases down to 1:1. HHS consults w/ NAIC to develop uniform age categories and phase-down schedule within 6 mos. of enactment.

Similar premium rating rules apply to plans offered by large employers, except the "community" is defined as the employers' workforce (and annuitants if appropriate) and their dependents.

Employers maintaining qualified worksite health promotion programs can obtain a health promotion rebate. §§1687-1688; States shall administer discounts in accordance with federal rules. §1206

Risk Adjustment

All plans in the CR market must participate in any risk adjustment, reinsurance, or other premium adjustment program implemented by the state. §1520

The NHB must develop a risk adjustment and reinsurance methodology for use by states.

Risk adjustment must account for differences in demographics, health status, geographic area, socio-economic status, AFDC/SSI status, and other factors.

HHS must develop a second mechanism to account for higher costs in the CR market because of nonworkers and Medicaid recipients. Plans (including self-insured) in the non-CR market would be required to pay an assessment based on the differences in health care costs between the CR market and the non-CR market. The mechanism must account for the higher costs in the CR market because of the inclusion of nonworkers and Medicaid recipients in the CR market.

States required to operate reinsurance pools meeting federal standards until risk adjustment mechanism is in place.

If Secretary determines, or if state requests approval from Secretary, reinsurance and risk adjustment systems can operate concurrently.

Exit from Market

During transition to CR, plans can terminate coverage for people in CR market only if exiting from all CR market in entire State. Cannot re-enter for 5 years from exit.

After universal coverage, a health plan may elect not to renew or make available, a health plan (or delivery system) in a coverage are only if the plan elects not renew all of its plans or delivery system in such an area and provides notice to the state and enrolled individuals. §1516(f)

A discontinued plan may not re-enter the area for 5 years. §1516(f)

Guaranty Funds

States are required to establish guaranty funds for all health plans in CR market based on HHS standards.

Requirements for Self-insured Plans

In general, self-insured plans must meet, as appropriate, insurance market reform standards for CR market. Labor Department will issue standards.

Federal/state Responsibilities

States required to certify self-insured plans operating in only one state; Labor required to certify multi-state plans.

Guaranteed Issue

Self-insured plans must accept all eligible group members for coverage.

Self-insured plans cannot deny coverage based on:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- anticipated need for health care services;
- disability; or
- lack of evidence of insurability.

Self-insured plans required to issue coverage except when:

- enrollment causes plan to exceed its service capacity. (§1516)

Guaranteed Renewal

Self-insured plans prohibited from terminating or failing to renew coverage for individuals except for:

- nonpayment of premiums;
- fraud; or
- misrepresentation.

Extended Coverage of Dependents

Self-insured plans required to offer family coverage that includes coverage of dependent unmarried kids up to age 24 and spouses.

Limits on Benefit Reductions

During transition, self-insured plans cannot reduce or limit coverage for any condition or course of treatment for which anticipated cost for individual is likely to exceed $2,500 in any 12 month period.

Limits on Pre-ex Exclusions

90 day - ED.

During transition, self-insured plans cannot exclude coverage for more than 6 mos. Cannot apply exclusion if person recently covered by another plan. Plans cannot apply exclusions to newborn coverage and must offer automatic coverage of newborn on a parent's policy.

Self-insured plans can "look back" 6 mos. in first year of reform; 3 mos. thereafter. Plans cannot limit coverage if pre-ex is pregnancy.

After universal coverage is attained, no limits or exclusions for pre-existing conditions.

One-time Amnesty for Pre-ex

Self-insured plans required to enroll w/out pre-ex limits, any eligible group member during first open enrollment period (90 days).

Standardized Benefit Package

Self-insured plans provide standardized benefit package as separate package. *Self-insured plans may provide a catastrophic package, but if they choose do so, must also provide the standard benefits plan.* Plans could provide additional benefits through certified supplemental policies.

Reinsurance/Solvency Standards

Labor will develop reinsurance and solvency standards for self-insured plans.

Guaranty Funds

Labor must establish standards for guaranty funds for self-insured plans.

Grievance Procedures

Self-insured plans must adhere to general grievance procedures in the Act.

Requirement for Employers

Employer Responsibility

To be determined. *At a minimum, small employers required to provide choice of at least 3 plans and (HIPC) Large employers must provide a choice of at least 3 plans.*

Self-insuring employers

Option to self-insure limited to:

- employers with 500 or more workers; and
- existing Taft-Hartley or rural cooperative plans with 500 or more workers.

HEALTH INSURANCE PURCHASING COOPERATIVES

Participation in HIPCs

No employer or individual required to purchase coverage through a HIPC. Firms and eligible individuals can purchase through broker or directly.

Eligibility to Purchase through HIPC

Each HIPC must offer to enter into an agreement with each small (fewer than 500 workers) employer that wishes to join that HIPC.

Employees of small firms can enroll in plan offered through employer-chosen HIPC or with a plan chosen by employer (if not offered through HIPC chosen by employer). §1303

Each HIPC must offer CR eligible individuals not connected to an employer, the opportunity to enroll in plans through that HIPC. The NHB must establish appropriate enrollment rules that HIPCs must follow.

Competing HIPCs

States may designate more than one HIPC per CR area. §1301(f)

A single not-for-profit corporation can be the HIPC for more than one CR area. §1301(f)

HIPCs can compete based on HIPC fees (HIPC fees would be lower than marketing fee that plans would charge if firm/individual enrolls directly with plan). §1305

If a HIPC were not established in every CR by 1996, state would be required to sponsor or establish a HIPCs for those unserved areas.

Agreements with Plans

HIPCs not required to contract with every plan. If HIPC negotiates a price lower than CR, that price becomes the plan's CR and must be offered to all purchasers in the area.

HIPC Rules

HIPCs required to accept all eligible individuals and employers in their areas. HIPCs must ensure that their services were accessible in all parts of their CR area. HIPCs must make enrollment material available at state designated public access sites.

HIPCs required to provide enrollees with a choice of at least three types of plans, one of which must be a FFS and one of which must be POS. For rural areas, Governors could waive requirement that HIPCs offer at least 3 plans.

HIPCs could require payroll deductions for employed individuals.

HIPCs cannot enter into contracts with health plans that are not certified.

Each HIPC must charge members a uniform membership fee which must be calculated and identified as a separate charge from plan premiums. §1305

Choice of Plans and HIPCs

Small firms (less than 500 workers) choose a HIPC(s), but their employees choose plans within that HIPC. Workers in these firms cannot enroll in plans through a HIPC not chosen by their firm.

Governing Structure of HIPCs

HIPCs must be a non-profit corporation and certified by a state. Each HIPC must be governed by a Board of Directors composed in equal numbers of representatives of community-rated employers, eligible employees, and eligible individuals. Members select Board members nominated by Nominating Committee appointed by Board.

Units of state or local government would be permitted to form a HIPC. State or local government sponsored HIPCs have special rules concerning legal and governing structure.

Insurers could not form a HIPC, but administer a HIPC.

Duties of HIPCs

Duties include:

- entering into agreements with health plans;
- entering into agreements with community-rated employers;
- enrolling individuals in health plans;
- collecting premiums;
- making payments to health plans;
- coordinating with other HIPCs; and
- providing information on health plans.

HIPCs cannot:

- perform any activity relating to payment rates for providers;
- perform any activity relating to compliance of plans w/ plan requirements;
- assume insurance risk; or
- perform other activities identified by the state as being inconsistent with this Act.

Fiduciary Responsibilities

NHB must establish fiduciary standards for HIPCs.

FEHB Program §1321

All plans offered through FEHBP must also make themselves available to the CR market. Non-federal employee purchasers would pay the local community rate for that plan (plus appropriate marketing fee) and would not be a part of the FEHB insurance pool. Government-wide FEHB plans would not be required to open to non-federal employee enrollment.

OPM, after meeting and conferring with federal unions, must make rules regarding supplemental benefits and the cost sharing policies to be offered (including any federal premium contributions). FEHBP supplemental and cost sharing policies to be offered to federal workers, annuitants, and any other CR eligible individual.

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