CBO SCORING OF HEALTH REFORM BILL

BACKGROUND

CBO director Reischauer will be giving his view of the President's health reform bill to the Ways and Means Committee this afternoon. The CBO report poses two problems:

1) it assumes much higher costs than the Administration did -- an increase in the deficit of $70 billion during the next six years, compared to the Administration's estimate of deficit reduction of almost $60 billion during that period. The major contributor to this difference is CBO's much higher estimates of the total subsidies that would go to employers ($72 billion more).

However, the CBO report says its estimates of the deficit impact of the bill "differ only modestly from those of the Administration" since most of the deficit reduction potential of the bill comes in the period beyond the current five-year budget period -- and CBO "believes that the bill holds the promise of reducing the deficit in the long term."

Further, CBO projects that total national health expenditures would fall by $30 billion by the year 2000, and would be $150 billion below the baseline in 2004. Over the ten year estimating period, CBO projects national health savings of $349 billion.

2) CBO treats premiums paid by employers to purchase health insurance for their employees as a payroll tax, and says the transactions of health alliances should be included in the Federal budget. They should, however, be treated separately like Social Security. This means that private transactions for the purchase of health insurance, paid not to the Federal government but to health insurance plans through health alliances, should be in the Federal budget.

What is CBO's logic?

o CBO argues that the Federal government would mandate that everyone be covered by health insurance, therefore the premiums paid for health insurance would be compulsory and should be on budget.

o CBO also argues that, even though health alliances wouuld not be part of the Federal government, they would be exercising the sovereign power of the government by collecting insurance premiums, therefore these premiums should be on-budget.

CBO does point to the uncertainties of it's analysis of both the costs and the budget treatment of the bill. The report says:

o "Estimates of the interactive effects of so many complex changes to

an industry that encompasses one-seventh of the economy are highly uncertain."

o "... There is no precedent for estimating the effects (of the bill) on health spending or the economy."

TALKING POINTS

I find CBO's decision to include privately-paid health insurance premiums as part of the Federal budget an incredible judgment. It just doesn't make sense.

- **Employers pay premiums for health insurance today and no one ever suggested that they be on budget.**
- **These premiums would never come near the Federal treasury.**
- **The alliances would be State government entities and the Federal government's financial exposure would be explicitly limited.**
- **If the issue is whether or not they are**

mandatory, CBO has analyzed other bills that required employers to provide health insurance for all employees and never considered these mandatory premiums on budget. (A bill introduced by Packwood in 1974 and the Mitchell bill over a year ago.)

There are plenty of other examples of Federal mandates that effect the costs of doing business that no one has ever considered putting in the Federal budget:

o Worker's Compensation Insurance (State mandated coverage and payments, not in State budgets)

o Minimum wage requirements

o Federally-mandated workplace health and safety standards

o Environmental protection laws require business

expenditures to comply with regulations

o Business must comply with standards for handicapped access, at a cost.

o And on the State level, no one argues that automobile insurance premiums should appear on State budgets, even if State governments mandate universal coverage.

Should we put all of these costs on budget also?

At any rate, these questions should not be the focus of our debate on health policy. We have enough tough decisions to make without letting the debate sink to the level of budget wonk classification issues. Whether or not payments made to purchase health insurance should be called premiums, taxes, or offsetting receipts is not really

important. What is important is what kind of health security we end up giving to the American people.

Small Business
RG

NFIB STATE-BY-STATE STUDY

SUMMARY: *The study prepared for the NFIB on the state-by-state impact of the employer mandate is not credible.*

#1 Every one of it's conclusions is refuted point by point by the non-partisan Congressional Budget Office, as well as many other independent analyses.

#2 And it fails to mention the many advantages for small business in the President's approach. Most small businesses provide insurance today -- including two-thirds of NFIB members -- and, as the NFIB itself says, "most of the rest want to." For the first time, the President's approach levels the playing field, bringing affordable insurance into reach for the smallest companies.

The President has said repeatedly that he will only sign a bill that is good for small businesses -- bringing them rock-solid affordable insurance with strong protections for low-wage, low profit firms.

I. THE NFIB DOESN'T TELL YOU THE TRUTH ABOUT THE PRESIDENT'S APPROACH . . .

PRESIDENT'S APPROACH PROTECTS SMALLEST BUSINESSES:

- *"I could not support a plan that I thought would be, on balance, bad for small business. I believe this plan is, on balance, good for small business. . . And I will not sign any bill passed by the Congress that I do not believe is good for the small business economy . . ."* [President Clinton, 3/22/94]

- Small low wage businesses will receive substantial discounts on the insurance they provide for their employees -- with the vast majority of the business discounts going to the smallest companies with the lowest profit margins. In fact, the smallest businesses will receive discounts of between 25 and 85 percent -- finally bringing affordable insurance into reach for America's smallest companies.

PRESIDENT'S APPROACH PROTECTS JOBS:

- In fact, some experts say there will be **job creation**. Two independent studies -- one from the Economic Policy Institute and one from the Employee Benefit Research Institute -- predict that health reform will cause a net increase in American jobs.

  -- The EPI projects that 258,000 manufacturing jobs will be created over the next decade. *"We can definitely say that we think there will be job creation and not job loss . . . there are lot's of positive effects of the Clinton plan."* [EPI, November 1993]

-- And the Employee Benefit Research Institute predicts that the President's proposal could produce as many as 660,000 jobs. [EBRI, November 1993]

- For example, the health care sector should produce a significant number of new jobs. One health expert at the Brookings Institution predicted that the plan will create 750,000 home health care jobs alone. [Reuters, 9/17/93]

PRESIDENT'S APPROACH SAVES BUSINESSES AND WORKERS MONEY:

- The Department of Health and Human Services has released a study predicting that businesses and employees will save dramatically.
  - Employers who now buy insurance for their workers will save an average of **$605 per worker** on premiums in the year 2000. This totals $59.5 billion in 2000 alone.
  - Workers employed in firms that provide insurance will save an average of **$293 per worker** on premiums in the year 2000. This totals $28.9 billion in 2000 alone.

HAWAII PROVES PRESIDENT'S APPROACH WON'T COST JOBS:

- Hawaii's real world experience suggests that employer mandates -- such as those proposed in the Health Security Plan -- do not have major adverse employment effects. Since Hawaii asked all employers to provide insurance for their employees in 1974, total private employment in Hawaii increased by 90 percent, compared to 54 percent in the United States as a whole. [The Hawaii Department of Health]

- In addition, the unemployment rate dropped to one of the lowest in the nation (2.8% in 1991); small business creation rates remained high (the number of employers grew almost 200% from 1970 to 1991), and the rate of business failures in Hawaii remained less than half the national business failure rate. [The Hawaii Department of Health, June 8, 1993]

II. WHO DO YOU BELIEVE?

A. NFIB SAYS SMALL BUSINESS WILL BEAR THE BURDEN BUT . . .

CBO SAYS ALL SMALL BUSINESSES WILL BENEFIT:

- "[The proposal] would benefit smaller firms that typically pay much higher premiums than larger firms. **This leveling of costs could benefit all small businesses** -- not just those that provide insurance today. With access to more affordable insurance, small businesses would be better able to attract workers who now demand health insurance as a condition of employment." (emphasis added) [*"An Analysis of the Administration's Health Proposal"*, CBO, 2/9/94]

B. NFIB SAYS PRESIDENT'S APPROACH WILL COST JOBS BUT . . .

CBO SAYS THERE WILL BE NEGLIGIBLE JOB LOSS:

- "The Clinton plan, [CBO] concluded, would not significantly slow the economy or result in the loss of jobs, as many critics have charged." [Washington Post, 2/9/94]

C. NFIB SAYS BUSINESSES WILL HAVE TO PAY MORE . . .

CBO SAYS BUSINESS COSTS WILL BE REDUCED:

- "But businesses' costs for health care would be significantly reduced overall, both because the proposal would provide substantial subsidies to firms and because it would limit the growth of premiums. . . By 2004, employers would save about $90 billion for active workers and more than $15 billion for early retirees... " [*"Analysis of the Administration's Health Proposal"*, CBO, 2/9/94]

D. NFIB SAYS WORKERS WILL LOSE WAGES BUT . . .

CBO SAYS WORKER'S WAGES WILL INCREASE BY $90 BILLION:

- "And to the extent that business' costs are reduced, these will result in higher wages. The vast preponderance of that $90 billion would be passed on to workers in the form of higher wages." [Reischauer Testimony, Senate Finance Committee, 2/9/94]

III. IS THE SOURCE CREDIBLE?

PREVIOUS NFIB STUDY HAS BEEN WIDELY DISCREDITED:

- When asked specifically whether he agreed with the NFIB's last job-loss study, CBO Director Reischauer responded: *"No, I don't, and I think the* ***estimates that you refer to are highly exaggerated****. They often come from a kind of logic that is flawed."* [Reischauer Testimony, House Subcommittee on Health, 2/10/94]

- John Shields -- Vice President of the independent health consulting firm Lewin-VHI -- said, *"The NFIB numbers are way too high. They assume that every possible job that could be lost would be lost and that's not what happens in reality."* [Business and Health, 7/93]

WHAT'S THE NUMBER THEY'RE USING TODAY?

- Since September 3, 1993, NFIB has used 9 different estimates of job loss in the Clinton plan. [PBS; BNA; Time Magazine; Reuters; Hartford Courant; AP; Dallas Morning News; 4/14/94 release]

WHO DO THEY REPRESENT ANYWAY?

- The NFIB -- with 700 employees, $59 million in revenues, and a CEO salary of $340,000 -- is not representative of its members -- who on average have 5 employees, $250,000 in revenues, and an average salary of $40,000. [National Journal, 6/12/93; NFIB IRS Form 990, 1990; NFIB's Legislative Priorities 1993-4; Association's Yellow Book, 193; Federal News Service, 5/25/93]

- The NFIB's own study said that 64 percent of small business owners would like to provide some or better insurance to their workers. And a poll conducted by the NIB Foundation of its members found that 61% believe *"government must play a more direct role in health care to bring health care cost under control."* [Charles Hall and John Kuder, *Small Business and Health Care: Results of A Survey,* The NFIB Foundation, 1990; NFIB Survey, 7/25/89]

- For a group calling itself the voice of small business, the NFIB has often fought hard on issues with no impact whatsoever to its own members. For example, the NFIB worked actively to oppose the Family and Medical Leave Act which applies only to businesses with 50 or more employees. Only 4% of NFIB members have over 40 employees. [HR 3, 1987-88]

- Although the NFIB presents itself as the champion of the Main Street small business community, many issues the group has championed are well out of the American mainstream -- with several again having no impact on small businesses. These include the enactment of Medicare, cost of living increases for Social Security benefit, minimum wage increases, worker's safety requirements, establishing federal regulations for child care providers, and the Americans with Disability Act.

CONSAD PRODUCES DUBIOUS ANALYSES UPON GOP COMMAND:

- During the 1992 Presidential campaign, CONSAD produced "analyses" on demand to support the Republican agenda.

RHETORIC: One controversial Bush-Quayle radio advertisement cited a CONSAD report to state that Clinton's proposals "*would threaten up to 200,000 jobs in Illinois. It also says a congressional study concluded Clinton's economic plan could put 80,000 Illinois residents out of work.*"

REALITY: "*However . . . CONSAD is headed by Wilbur Steger, who has been an adviser to President Bush and Dan Quayle . . . and the congressional study cited was the minority report with Republicans `all concerned with reelecting George Bush'*" [UPI, 10/16/92]

REALITY: Since January 1, 1993, there have been 105,000 jobs created in Illinois -- more than were created in the last four years combined. [Department of Commerce, BLS, March 1994]

EXPLANATION: There are several factors to consider when determining the level of beneficary cost sharing. The lower the deductible, the higher total program costs. In addition, the lower the deductible, the higher the increase in Part B premiums that have to be paid by Medicare beneficiaries since this has traditionally been the source of financing for 25 percent of Part B costs. At some point, the costs of these additional penmiums may become prohibitive.

In terms of deductibles and copayments, the Medicare drug benefit could be less generous than the drug benefit for the under 65 population. That is because the elderly use more drugs than the under 65 population, and the dollar value of the benefit to the elderly -- even with the same or higher deductibles -- will be greater.

With a $50 deductible, over 75 percent of Medicare beneficiaries will qualify for the program. At $250, about 60 percent will qualify. A desirable goal is to help as many beneficiaries as possible, but there are about 20 percent of Medicare beneficiaries that have high total drug costs. Cost sharing at $250/year with an 80 percent deductible will help 60 percent of Medicare beneficiaries, especially those that have high drug bills. However, this option would pay for 80 percent of the drug costs for many older Americans that did not have high out-of-pocket drug bills. (between $250-$800). These funds may be better used to provide long term care benefits.

Finally, because many older Americans already have drug coverage under private plans, they may not view a drug benefit as a significant improvement in coverage, especially if there is little improvement in Medicare long term care coverage, for which private coverage is generally poor. Because of this, a reasonable balance must be crafted between providing better drug coverage and better long term care coverage.

Therefore, option 3 would provide some relief to 60 percent of beneficiaries, but would especially help those that had high out-of-pocket drug bills. Medicare would not be paying 80 percent of costs for those in the $250-$800 drug cost level, but would aftyer $800 (or even a lower amount, such as $600) is reached. Data show that it is the poorer older Americans -- those that do not qualify for Medicaid -- that have the highest out-of-pocket drug costs, and would most benefit from the $800 cap.

Section 3 - Prescription Drugs Covered:

o All FDA-approved drugs and biologicals and their medically-accepted indications would be covered under the program.

o Certain classes of drugs would not be covered by Medicare, such as fertility drugs, drugs to treat anorexia, drugs used for cosmetic purposes, and others that the Secretary of HHS determined were subject to misuse or abuse.

o The Secretary could also require for certain drugs that a physician obtain permission from Medicare before the drug can be prescribed for a Medicare beneficiary (This is a process known as "prior authorization")

EXPLANATION: Most prescription drug programs cover any drug or biological that is approved by the FDA, with some restrictions. Medicare coverage would be similar, except that like other prescription drug programs, certain classes of drugs would not be covered, such as drugs to treat baldness or skin wrinkles. In addition, the Secretary may have a compelling interest in monitoring the use of very expensive or unique drugs under a system-wider "prior authorization" program. The Secretary would have the ability to do this under this proposal.

Section 4 - Medicare Drug Program Cost Containment:

Medicare drug program costs would be contained through three primary mechanisms: a manufacturer-based rebate program, negotiations with drug manuafacturers over new drug prices, and generic drug dispensing incentives.

o **Manufacturer-Based Rebate Program**

o Medicare's drug costs would be lowered through a rebate program. That is, the manufacturer would have to rebate back to the Medicare program a certain percentage of the drug's cost. The legislation would require drug manufacturers to provide rebates to the Medicare program on a quarterly basis. Each manufacturer would have to sign a rebate agreement with the Secretary of HHS in order to have reimbursement provided for their drug products under Medicare.

o There are several rebate options that can be used.

For generic drugs: the lower of the pharmacist's usual and customary charge, or the median of all generic prices (times the number of units dispensed) plus the $5.00 per prescription dispensing fee.

o The professional fee for non-participating pharmacies would be $2 less than those for participating pharmacies. The dispensing fees would be updated each year.

o Pharmacists could not charge Medicare beneficiaries any more than they charge cash-paying customers for prescriptions before and after the deductible is reached. Participating pharmacies would have to accept assignment on all prescriptions.

o The Secretary would be instructed to develop a methodology to pay pharmacists for counseling Medicare beneficiaries on proper drug use.

EXPLANATION: Pharmacist reimbursement is structured so that pharmacists have incentives to dispense generic drugs to patients. To encouarge pharmacist participation in the Medicare program, reimbursement levels would have to be updated regularly.

Section 6 - Program Administration:

o The Secretary of HHS would establish a national system of on-line, real-time Medicare prescriptions electronic claims management as the primary method for determining eligibility, processing and adjudicating claims, and providing information to the pharmacist about the patient's drug and medical history under the Medicare drug program.

EXPLANATION: Claims processing for most fee-for-service prescription drug programs is done on-line in the pharmacy. These systems sigificantly improve the adminstration of drug benefit programs, and reduces paperwork. An on-line system was required under MCCA, and many state Medicaid programs are now moving to administer their drug programs on line. A similar on-line system should be required for the Medicare drug benefit.

Section 7 - Establishment of Prescription Drug Payment Review Commission:

o To monitor program outlays and make recommendations to Congress and the Secretary of HHS on program financing and operations, an 11-member Prescription Drug Payment Review Commission (RxPRC) would be established, and appointed by the Director of the Office of Technology Assessment (OTA).

EXPLANATION: Currently, there are two Congressionally-established bodies that monitor Medicare program expenditures, the Prospective Payment Assessment Commission (ProPAC) for hospitals, and the Physician Payment Review Commission (PPRC) for physicians. This provision would establish a similar body for the Medicare drug program. A similar Commission was established in the Medicare Catastrophic Coverage Act of 1988.

Section 8 - Reimbursement to Pharmacists:

o Payment levels to pharmacists for dispensing prescriptions to Medicare beneficiaries would be established as follows:

For brand name drugs: the lower of the pharmacist's "usual and customary" charge, the 90 percentile of actual charges for the prescription, or the estimated acquisition cost plus a $5.00 per prescription dispensing fee.

Option 1: The Medicare program would receive a rebate that would give it the same effective price that a manufacturer offered to its best customer. That is, Medicare would receive the lowest price that the manufacturer sold the drug to any purchaser in the marketplace.

Option 2: Medicare's rebate would not be equal to the "best or lowest price" that drug is sold in the market, but the "median" prices of all the prices at which the drug is sold in the market. That is, the Medicare price would be the median price of all the prices at which that drug is sold in the market by the manufacturer.

Option 3: Medicare's rebate would be such that the Medicare price would be a 15 percent or 20 percent discount off the price of the drug.

o Under any of the above rebate scenarios, Medicare's drug prices would also be indexed so that they could not increase faster than the rate of inflation, as measured by the CPI. Manufacturers would have to pay each quarter an additional rebate to Medicare if their drug prices did increase faster than the rate of inflation, as measured by the CPI.

o **New Drug Price Negotiations**

o The Secretary will have the authority to negotiate with drug manufacturers over the price of new drugs and biologicals that will be covered by Medicare. The price negotiated with the manufacturer would be reflected in the rebate that is paid to Medicare for the drug.

o **Generic Drug Dispensing Incentives:**

Strong provisions that encourage the use of less expensive generic drugs instead of more expenisve brand name drugs will reduce total program expenses.

o Under the legislation, only generic versions of brand name drugs could be dispensed under Medicare (if they are available) unless the physician indicates in his or her own handwriting on the prescription "brand medically necessary".

o The Secretary could require that a medical justification be provided for the brand name drug when a generic equivalent is available. In addition, the Secretary would also be given

authority to "prior authorize" any brand name drugs that have generic versions on the market.

EXPLANATION: Medicare will become the single largest prescription drug program in the United States. Because of this, Medicare should use this buying leverage to obtain discounted prices from drug manufacturers to lower total program costs. These discounted prices can be provided to Medicare in the form of a manufacturer rebate program, which currently exists for Medicaid.

The rebate program will be the central feature of pharmaceutical cost containment. The central question will be the size of the rebate or the discount that the Medicare program will receive. Medicare will receive the largest discount from the "best price" option, followed by the "median" price option, followed by the "flat rebate" option.

Each option would have different consequences for the non-Medicare market. The first two options rely on the non-Medicare market, and there is the possibility that manufacturers may raise prices in the non-Medicare market to avoid giving deep discounts to Medicare. This should not happen, however, if managed competition works the way it is should. The flat rebate would have the least impact on the non-Medicare market, since the Medicare price under this option would not be tied to prices inthe non-Medicare market.

Because manufacturers will be paying rebates to Medicare for drugs that are currently on the market, they may attempt to introduce new drugs at much higher prices. Medicare should use the same mechanisms used by other large buyers when determining a initial price: negotiations.

Finally, there is excessive use of high-priced brand name drugs in the Medicaid program, and a similar outcome could be expected in Medicare if strong generic drug dispensing incentives are not included in Medicare. Without these provisions, Medicare could be expected to unnecessarily pay hundreds of millions of dollars for brand name drugs that have generic equivalents.

Under the provisions, brand name drugs that have generic versions could only be dispensed if the physician indicated on the prescription in his own handwriting that the brand name version was medically necessary. This would effectively preempt state substitution laws, which have different provisionms regarding generic substitution.

DRAFT

MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Just as the benefit package for the under 65 population will have a prescription drug benefit, the Medicare program will be expanded to cover outpatient prescription drugs. The coverage will commence in January 1996, or no longer than two years after enactment of national health reform.

Eligibility

Any Medicare beneficiary that elects to take part B coverage (as 97 percent of the Medicare population currently do) will be automatically enrolled in (and benefit from) the new prescription drug benefit. The same financial incentive (penalty) for late enrollment will continue to apply for the Part B benefit.

Deductibles/Copayments/Caps:

The deductible for the new benefit is set at $250, and indexed each year to assure that the same number of beneficiaries at the deductible level that are covered with the initial $250 deductible. There will be a 20 percent copayment per prescription. In addition, there will be a $1,000 out-of-pocket annual cap for each Medicare beneficiary.

Financing

The newly established Medicare prescription drug benefit program will be financed by both beneficiaries and the working population (of all ages). Beneficiaries who opt for Part B, which will now include outpatient drug coverage, will pay 25 perecent of the cost of the new coverage -- just as they are now paying 25 percent of the rest of the costs of the Part B benefits. (It is difficult to determine the break-down of who is paying the other 75 percent, since the remaining cost of this program will be paid primarily from assumed new Medicare savings.)

Prescription Drugs Covered

The benefit will cover all FDA approved drugs and biologicals and their medically-accepted indications as found in the three national compendia, which are the American Medical Association Drug Evaluations, the American Hospital Formulary Service, and the United States Pharmacopeia.

Certain pharmaceuticals, as is the case in the Medicaid program -- see section 1927(d) of the Social Security Act, will not be covered by Medicare. Examples include: fertility drugs, medications used to treat anorexia, and drugs used for cosmetic purposes. Exceptions to the current Medicaid exclusions would be barbiturates and benzodiazepines. (See also specific references to how drugs now covered by Medicare will be affected, outlined in the old catastrophic health care legislation.)

In addition, the Secretary of Health and Human Services, working with a newly established Medicare drug use review board, has the authority to subject medications to "prior approval." (Prior approval is a term of art for the practice of requiring physicians to obtain approval before prescribing a particular medication; this practice is used in the state administration of the Medicaid program).

Placing any prescription on prior approval will be based on a decision subject to data which demonstrates that the drug is subject to clinical misuse or inappropriate use, or because the Secretary determines that the drug is not cost effective. Prior approval can be placed on drugs currently on the market or new drugs that will be on the market.

Finally, all new drugs approved by the FDA will be covered. However, the Secretary has the authority to negotiate better prices with the manufacturer of a new product that the Secretary concludes is excessively/inappropriately priced and has the potential to undermine the fiscal integrity of the program. Manufacturers who refuse to negotiate will not be eligible to have any of their drug product line reimbursed by any Federal program or any Federally/State-certified alliance.

Cost Containment:

As a condition of participation in Medicare, the legislation will require drug manufacturers to sign a rebate agreement with the Secretary in order to have reimbursement provided for single source and innovator multiple source drugs covered under Medicare. No rebate is required for non-innovator multiple source drugs (generics). Rebates will be paid to the Secretary on a quarterly basis through carriers or intermediaries.

The program will require manufacturers to pay a rebate to Medicare based on the difference between the AMP to the retail class of trade and the median price of the drug in the non-retail marketplace, or 15 percent off the AMP, whichever is greater. (HCFA actuaries currently estimate that Medicare would achieve at least an average of a 17 percent rebate.)

An additional rebate will be required on a drug-by-drug basis for manufacturers that increase prices faster than inflation on single source and innovator multiple source drugs. In other words, just as the Medicaid program has an indexed price to protect it from unanticipated inflation hikes, so too will the Medicare program. The indexed price will be based on the average price charged for the prescription in June, 1993.

Generic drug dispensing incentives:

The new program will provide incentives to encourage the use of less expensive, high quality generic drugs. More specifically, only generic versions of brand name drugs will be permitted to be dispensed (and paid for) unless the physician indicates in his or her own handwriting: "brand medically necessary." The Secretary will also have the authority to subject a brand name product to a prior approval requirement in the case where a high quality generic is available. (The pharmacist would then be required to submit the prior approval number with the electronic reimbursement claim.)

Reimbursement to Pharmacists:

For brand name drugs: Payment will be the lower of the 90 percentile of "usual and customary" charges, or the pharmacists' actual acquisition cost plus a professional fee of $5 for participating pharmacies, increased each year by the CPI-U.

For generic drugs: Payment will be the lower of the pharmacist's usual and customary charge, or the median of all generi prices (times the number of units dispensed) plus a $5 per prescription dispensing fee, increased yearly by the CPI-U.

Participating pharmacies would have to accept assignment on all prescriptions. Non-participating pharmacists will receive $2 less per prescription than those for participating pharmacies.

Lastly, the Secretary will study the feasibility and advisability of developing a methodology to pay pharmacists for counseling Medicare beneficiaries on proper and cost-effective use of medications.

Medicare HMOs

Medicare HMOs will be required to provide a drug benefit that, at minimum, parallels the benefit outlined above. Such HMOs can -- as they do now -- offer drug coverage that far exceeds this benefit, however. This, along with other changes to the Medicare HMO program currently under consideration by the Secretary and the HCFA administrator, should provide further incentives for Medicare beneficiaries to opt into these plans, which have their own very effective prescription drug negotiating mechanisms in place.

Changes in Private Insurance Requirements:

Private insurance plans will be required to either reduce the amount of the premium charged to Medicare beneficiaries that purchase these plans to account for the coverage of prescription drugs under Medicare, or increase coverage of other health care insurance services by the actuarial value of the prescription drug benefit provided under the private insurance plan. Private plans will not be prohibited from covering the prescription drug deductibles and copayments not covered by the Medicare program.

Qualified Medicare Beneficiaries:

Low income Medicare beneficiaries will receive the same financial assistance for the out-of-pocket costs associated with the new drug program that is envisioned for the rest of the program after the enactment of health reform.

Drug Use Review:

The Medicare DUR program will parallel the program established in OBRA 90 for Medicaid. Participating pharmacists will be required to offer to counsel Medicare recipients on the use of their medications. Retrospective DUR program will be operated by the newly established Medicare DUR Board.

The Secretary of HHS will establish a national system of Electronic Claims Management as the primary method for determining eligibility, processing and adjudicating claims, and providing information to the pharmacist about the patient's drug and medical history under the Medicare drug program.

Prescription Drug Payment Review Commission (RxPRC):

As was the case in the Medicare Catastrophic Coverage Act, the re-establishment of RxPRC is advisable if its duties are not folded into the Pharmaceutical Review Commission outlined in another section.

Memorandum from

Winthrop, Stimson,
Putnam & Roberts

G. LAWRENCE ATKINS

To

Chris -

for our meeting at 9am Friday.

This is an old description that has not been updated for the latest terms, but should give you a sense of how this would work.

It is also largely self-financed. If you want Federal financing for all enrollees, that would have to be added

A PRESCRIPTION DRUG BENEFIT FOR OLDER AMERICANS

Well over half of retired Americans are believed to be without insurance coverage for their prescription drug expenses. Yet, the elderly today consume over 30 percent of all prescription drugs sold in the U.S. The lack of insurance coverage causes economic hardship for a significant number of older persons who are on extensive drug regimens to control their chronic conditions. This distortion in coverage also encourages physicians to prefer expensive Medicare-covered surgical procedures to cost-effective drug therapies.

This proposal is for a managed prescription drug benefit and is based on the assumption that it will be enacted as part of a health care reform package that includes a managed competition approach. Coverage under this benefit would be required for all Medicare beneficiaries, subsidized for some, offered through an insurance pool, and managed by private insurers. Costs would be contained through managed care techniques that have been proven effective with this population.

HIPC-based Program

A separate drug benefit for Medicare beneficiaries would be provided through the Health Insurance Purchasing Cooperatives (HIPCs) that are established through health care reform to pool risk and manage insurance coverage for small employers and individuals.

- HIPCs would be required by law to offer a separate prescription drug benefit, available only to Medicare enrollees.
- Each HIPC would maintain a single risk pool for prescription drug expenses for all Medicare beneficiaries.
- Each HIPC would offer a choice of several alternative drug plans, operated by the participating AHPs. All AHPs would not be required to offer a drug benefit. National drug plans or insurers would be permitted to offer a drug benefit in HIPCs where they did not operate qualified AHPs.

Participation

- All Medicare enrollees would be required to participate in the HIPC drug benefit plan, with the exception of those in managed employer-provided drug plans.

- Medicare enrollees who enroll in an AHP for all health care through either an employer plan or through the HIPC would be covered for prescription drugs through their AHP benefit package.

- Self-insured employers would have the option to purchase prescription drug coverage for Medicare enrolled retirees through the HIPC.

- Medicare enrollees with prescription drug coverage through individual Medigap policies would be required to purchase coverage through the HIPC and could either drop or revise their Medigap coverage or receive a rebate or reduction in their Medigap premium.

- Medicare enrollees participating in Medicaid would be enrolled in an AHP through the HIPC. Medicaid would pay the entire HIPC premium and 50 percent of any additional AHP premium.

Drug Benefit Definition

If a board is established to develop national benefit standards, that board would also be required to develop the definition of the Medicare-enrollee drug benefit.

- The drug benefit would cover prescribed medications, with a nominal copayment per prescription.

- AHPs would be required to cover the all FDA-approved drugs for which there were not therapeutic equivalents.

- AHPs could select from among therapeutically-equivalent drugs and limit coverage to specific drugs based on scientific data on cost effectiveness.

- AHPs would be permitted to require generic substitution.

- AHPs would be required to cover any prescription drug at the physician's insistance. However, AHPs could require enrollees to pay the difference

between the price of the AHP-approved drug and the prescribed drug.

Purchasing

AHPs could reimburse pharmacists for dispensing medications, or they could purchase and make drugs available to Medicare enrollees through AHP or mail order pharmacies, provided adequate arrangements were made for emergency prescriptions.

Drug Utilization Review

AHPs would be required to maintain a system for drug utilization review.

- AHPs would interview new enrollees for medical and medication histories.
- AHPs would be required to keep records on medications purchased under the benefit plan, and to check new prescriptions against previous prescriptions for possible drug interaction effects.
- AHPs would be required to notify prescribing physicians of possible drug interactions.
- AHPs would provide complete medication profiles to enrollees for use in informing their physicians of other drugs they may be taking.

Financing

Financing of the benefit would be largely - although not entirely - by the enrollees themselves through premiums.

- HIPCs would charge Medicare enrollees a uniform premium.
- HIPCs would qualify for federal funds to enable them to reduce premiums for older persons with incomes below 200 percent of poverty. State Medicaid programs would transfer sufficient funds to pay for prescription drug coverage of elderly Medicaid recipients through the HIPC.
- HIPCs would also collect a fee from each AHP participating in the HIPC, whether offering a drug benefit for Medicare enrollees or not, to offset a portion of the higher-than-average risk in the

Medicare enrollee pool. The fee would be determined by allocating 20 percent of the Medicare pool costs to AHPs on the basis of their total non-Medicare enrollment.

- AHPs would receive a uniform premium from the HIPC. HIPCs, however, would be permitted to adjust the premiums to compensate AHPs for having higher- or lower-than-average-age enrollees. To the extent other factors were found to predictably affect drug benefit costs, HIPCs could additionally adjust premiums to reflect them.

- Each AHP Medicare drug plan would be able to charge Medicare enrollees an additional premium (which would be combined with the HIPC premium) reflecting that plan's actual costs. These additional premiums would reflect the cost differences between the plans and provide an incentive to purchase the lowest-cost plan. These additional premiums would be subsidized (through the HIPC) for enrollees receiving Medicaid or with incomes below 200 percent of poverty.

Cost Containment

The cost of the pharmaceutical benefit for Medicare enrollees would be restrained through competition between alternative drug plans, and each plan's cost management activities.

- Medicare enrollees would be offered a choice of drug benefit plans providing standard benefits.

- Differences in plan costs (after risk adjustment) would be paid as part of the premium charged to the enrollee, encouraging price competition between AHPs.

- AHPs would manage their costs through the use of formularies, discounted purchasing from manufacturers, drug utilization review, and consultation with physicians.

- Pharmaceutical prices overall would be restrained through reduced marketing costs and increased competition between manufacturers to get drugs approved by AHPs.

Advantages

This benefit offers substantial advantages to older Americans over the catastrophic drug benefit enacted under Medicare in 1989 and later repealed. Like the catastrophic benefit, this benefit would be administratively separate from Medicare Part A and B, and would be largely self-financed by the elderly. There, however, the comparison ends.

- The benefits provided in this managed prescription drug program would be comprehensive benefits, with small copayments, and thus of value to all enrollees; as opposed to the catastrophic benefit under Medicare which was of benefit only to those with over $1,000 in drug expenses a year (1993).

- Costs would be controlled by negotiating price discounts, encouraging generic substitution, and managing utilization to some extent, and through competition between drug plans; rather than avoiding reimbursement for routine drug use, and attempting to control drug prices.

- The health of older persons would be improved through better coordination of medications (through extensive drug utilization review) to reduce the incidence of overmedication and adverse drug reactions.

- Drug prices would be restrained by increasing competition among manufacturers, rather than federal regulation of prices.

- Drug coverage for the elderly would be made more affordable through a limited cross-subsidy from the non-elderly (through an AHP contribution), and through expanded subsidies for low-income enrollees.

POSSIBLE RESPONSES TO DEMAND THAT TRUSTEES SPECIFY MEDICARE REFORMS

Background: The Congress may pass a bill requiring that the Medicare Trustees issue a report to Congress by June 30, 1995, detailing specific actions to ensure the short-run solvency of the Medicare Trust Funds (both the HI and SMI Trust Funds). If the Senate considers a similar bill, the Administration needs to develop a strategy for a response.

Legal Analysis (incomplete): Congress generally has no legal recourse against the Trustees if they do not meet the June 30 deadline. Many Congressionally-set deadlines for studies are missed, with no legal consequences. However, there is a political risk if the deadline is missed. Congressional Committees can be expected to hold hearings where the Trustees are grilled harder and more personally than ever, since the Republicans are desperate for dollars. They will do anything to humiliate, cajole, or shame the Administration into providing needed cover for Medicare cuts. This process will no doubt severely strain relations with the Hill.

Financial analysis: The HI Trust Fund needs around $80-100 billion (7-year figure) in additional revenues or spending cuts to ensure solvency through 2005 (the exact figure depends on the time path of savings/revenues). Around $160 billion (7-year figure) in additional revenues or spending cuts is needed to ensure that the HI Trust Fund maintains a reserve fund equal to one year's expenditures through 2005. Once the Baby Boom generation starts to retire in droves (i.e., by 2020), the entire system will be under severe financial stress, requiring additional reform steps.

Options: Several alternatives are presented on the following pages. These alternatives are nowhere near exhaustive. Moreover, portions of the alternatives can be mixed and matched with others to create composite alternatives (perhaps an infinite number of them).

ALTERNATIVE 1: RELY ON SENATE DEMOCRATS TO DELAY OR SCUTTLE ALTOGETHER

• Administration works with Senate Democrats to ensure that bill is not passed. Potential strategies could involve filibusters, lengthy amendment strategies, etc.

Pros:

• Does not use up much political capital.

• Administration keeps low profile and is not perceived as defending status quo.

• Recognizes the political nature of this bill and draws battle lines on political grounds.

Cons:

• Very unclear if there is even a majority of Senate Democrats willing to do this.

• Public could perceive this effort as evidence that the Administration and Senate Democrats are not serious about addressing Medicare solvency issue.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

ALTERNATIVE 2: DIRECT BLOW-OFF STRATEGY

• Administration vetoes bill and states that the time frame permitted and the callousness of their approach illustrates all too well that the Republicans are using the Trust Fund as a political football and a bank for their tax cuts. We will simply say that we won't participate in such a sham.

Pros:

• Administration does not respond to what is essentially a political strategy with a policy response.

• Administration sends strong message that it will address Medicare only on its own terms or within the context of wider reforms in a serious manner.

•If we carry-off throughout the entire Administration (no off-the-record second guessing) the President could appear strong, particularly if it is combined with a restated, but more clear, commitment to produce, or work with Congress to produce, a plan once the President's previously outlined criteria have been met.

Cons:

• Elite press probably attacks Administration for missing opportunity to address Medicare Trust Fund solvency.

• Uses up political capital to sustain veto.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

ALTERNATIVE 3: INDIRECT BLOW-OFF STRATEGY

• Administration signs bill or allows it to become law, but issues report shortly thereafter which states that Medicare reform must be done in the context of overall health care reform.

> **Possible Variation:** Report states that solvency of Medicare Trust Funds could be improved if revenues that would be used for proposed tax cuts instead are directed to Trust Funds.

__Pros__:

• Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.

• Does not use much political capital.

• Administration does not respond to what is essentially a political strategy with a policy response.

• Repeats current message on health care.

• Does not provide political cover to Republican attempts to cut Medicare expenditures.

__Cons__:

• Public and media could perceive this report as non-responsive and evidence that the Administration is not serious about addressing Medicare insolvency.

• Elite press attacks Administration for missing opportunity to address Medicare Trust Fund solvency.

• Congressional Republicans become more antagonistic toward Trustees (and perhaps rest of Administration).

• Could be criticized for using funds that do not exist as a specific part of the budget proposal (this might only be an elite press problem).

• Transfer of general fund revenues to Medicare Trust Fund might be criticized as an undesirable precedent.

ALTERNATIVE 4: RESTRUCTURING BAND AID RESPONSE

• Administration signs bill or allows it to become law. Report focuses on the transfer of some items from Medicare Part A to Part B (e.g., home health care). Premiums charged for Part B could (but need not) increase to cover costs of this service.

Pros:

• Seems like a reasonable response to bill's requirements.

• Would substantially increase the solvency of HI Trust Fund by removing a large (e.g., $15-20 billion per year for home health care) and fast-growing cost component.

• If Part B premium is increased to cover part of increased cost of benefits, this would reduce Federal deficit (a premium equal to 25 percent of the actuarial cost of home health care would reduce deficit by about $5 billion per year).

• If Part B premium is increased to cover part of increased cost of total Part B benefits, beneficiaries would be paying part of the cost of a fast-growing component of Medicare benefits.

Cons:

• Beneficiaries may view this shift as breaking an implicit contract, to the extent they counted on receiving these benefits in return for HI taxes.

• Could be portrayed as increasing the burden of beneficiaries.

• Could be portrayed as an accounting fiction, especially if Part B premiums are not increased to cover the cost of benefits shifted to the SMI Trust Fund.

ALTERNATIVE 5: SERIOUS BUT PARTIAL RESPONSE THAT BEGINS TO ADDRESS THE TRUST FUND ISSUE

• Administration signs bill or allows it to become law. Report lists $X billion (perhaps $50 billion) in Medicare Part A cuts; suggests that proposed tax cuts be scaled down and the additional revenues dedicated to Trust Funds.

__Pros__:

• Appears to be responsive to law.

• Elite press may see this as responsible policy toward Medicare.

• Could be viewed as a "down payment" on a larger plan to address long-term Medicare solvency.

__Cons__:

• Provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).

• Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans). The rest of our base supporters may also conclude it is premature to throw any semblance of a lifeline to the Republicans.

• To the extent that general fund revenues are transferred to Medicare Trust Fund, this option might be criticized as setting undesirable precedent.

ALTERNATIVE 6: POTUS HEALTH REFORM PROPOSAL RESPONSE

• Administration signs bill or allows it to become law. Report presents a viable health care reform proposal. This could incorporate increased insurance coverage as well as reforms to Medicare, Medicaid, and other health programs. It could include a major downpayment on adderessing the short-term Trust Fund solvency problem. For example, a 100 billion dollar reduction (over seven years)from Medicare Part A could be used.

Pros:

• Consistent with Administration message that reform of Medicare can only take place in the context of overall health care reform.

• Could be an opportunity for Administration to achieve a bipartisan breakthrough on a major policy issue.

Cons:

• Provides policy response to what is essentially a political demand.

• The "sources of funds" portion of the proposal provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).

• Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans).

ALTERNATIVE 7: SUGGEST THAT POLITICALLY "POPULAR" REVENUE OPTIONS (BOTH REAL AND UNLIKELY) BE UTILIZED TO STRENGTHEN TRUST FUND

• Administration signs bill or allows it to become law. Report suggests that certain revenue streams be earmarked for deposit into Medicare HI Trust Fund. Possible candidates include: increased excise taxes on tobacco or alcohol; increased HI payroll tax; reduction in tax expenditures claimed by special interests (e.g., tax subsidies provided to American living abroad, to oil and gas industries); and closing tax loopholes (e.g., expatriation proposal, limiting corporate dividend received deduction to pro rate dividends).

__Pros__:

• It is possible to raise enough revenue to make the HI Trust Fund solvent.

• Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.

• Senator Bradley is already pushing idea of dedicating a tobacco tax and/or "corporate welfare" tax breaks.

__Cons__:

• Administration likely to be characterized as promoting "tax and spend" policies.

• Transfer of general fund revenues to Medicare Trust Fund might be criticized as setting undesirable precedent.

• Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration) because the bill focuses on Medicare spending restraints and the response focuses on revenues.

MEMORANDUM FOR IRA MAGAZINER

FROM: Judy Feder

SUBJECT: Federal Employee Health Benefits Plan

In reviewing the section of the plan on the Federal Employees Health Benefits Plan (FEHBP), I realized that several significant issues had not been addressed. This memorandum reviews those issues and presents my recommendations for dealing with them. [I have checked these ideas with OPM and they see no problem.] We need to come to agreement on more detailed specifications for what will happen to FEHBP as I am already getting inquiries from the Hill on FEHBP. I would like to delay talking to the relevant Congressional staff until we are in agreement on the operational details. If you agree with the recommendations below, we can proceed with those discussions.

Our core proposal is to end this program as currently structured and place employees and family members into regional health alliances. As alliances begin operations, enrollees will shift from FEHBP plans to plans contracting with alliances. This will be a particularly easy change for Federal employees, who are used to dealing with choices among a broad range of HMOs and fee-for-service plans. There will be some budgetary cost to the government, due to increasing the employer share from the current average of 72 percent to 80 percent. Increasing the employer share will be a major plus in describing the proposal's effects on employees.

There are, however, several groups that must be dealt with separately--employees abroad and retirees with Medicare, for example--and a number of potential points of criticism. The current law, Chapter 89 of Title V of the U.S. Code, will need to be modified, not repealed.

A. How will employees abroad be covered?

A dozen or more Federal agencies have employees abroad, ranging from diplomats to commercial and law enforcement officials. At present, these employees have the same plan choices, except HMOs, as those in the United States. For example, Blue Cross operates as a world-wide plan. In addition, there are special plans in the Canal Zone and in Guam, and a plan for those in the Foreign Service.

To cover these employees, a residual program should be maintained. This program can operate through the same kinds of

contracts as at present, e.g., through Blue Cross, Foreign Service, and others. OPM would arrange such contracts and conduct an annual Open Season. In order to avoid disruption in insurance arrangements, it would also be desirable to allow employees who regularly shift between domestic and foreign posts to retain this insurance while in the United States, rather than shift in and out of the regional alliance in their home state.

B. How will Postal Workers be covered?

One group of employees, postal workers, now gets an employer share as high as 92 percent of premium. This cost-sharing is a result of collective bargaining. In a recent arbitration agreement this was amended and it will gradually go down in future years. For the present, however, the proposed cost sharing would in many cases <u>double</u> the premium paid by postal workers. The sensible approach is to provide the Postal Service with the same option afforded to private employers: to pay more than 80 percent if it has agreed to do so through collective bargaining. Our proposal should specify that there will be no change from currently bargained benefits unless it is reached through bargaining.

C. How will annuitants be covered?

There are about 1.7 million federal annuitants. Of these about two-thirds (1) have Medicare coverage, and about one-third are (2) annuitants ineligible for Medicare, including (a) those aged 55-64 who are not yet old enough for Medicare and (b) annuitants over age 65 (most 75 or more) who retired before federal employees became Medicare eligible. Each of these groups have joined the same plans as employees, piggy-backing on that system. When it is replaced, alternative arrangements will be needed.

(1) Annuitants with Medicare. These persons most often sign up for Blue Cross standard option and get 100 percent wrap-around coverage, including drugs and travel abroad. They pay the same dollar amount as employees, which is a roughly comparable deal, taking into account the offsetting factors of higher costs with age and Medicare paying first. Like employees, they also help pay for annuitants without Medicare.

The best way to handle this group is to develop a separate Medigap system to be administered by OPM. The broad-based plans on which to piggy-back will no longer exist. Premiums under this new system should cost these employees about what they pay now for comparable coverage. This will probably mean cost sharing of about 50 percent (taking into account that they currently subsidize annuitants without Medicare).

(2) Annuitants ineligible for Medicare. These annuitants

have actuarial costs much higher than those of employees, but pay the same premium. They have the same plan choices. A large fraction of them are in HMOs. Unlike annuitants with Medicare, those enrolled in fee-for-service plans pay deductibles and coinsurance.

The best way to preserve the kinds of choices they now have is for them to obtain insurance through regional alliances. with OPM paying a premium contribution sufficient to hold them harmless, rather than the increased contribution which most employees will get (i.e., about 72 percent of the community rate, rather than 80 percent). I assume that OPM will continue to use pension deductions to pay premiums, with payments to alliances on behalf of the enrollee.

An alternative with roughly equal effects on costs and benefits would be to separate out the above age 65 group, enroll them in Medicare, and offer them Medigap plans with minimal subsidy. This is a technically feasible option, but one which would be complex, and considerably more disruptive than using the alliance structure. (Many of these annuitants are enrolled in HMOs which are not Medicare contractors but which will contract with alliances; none of them would welcome Medicare paperwork.) It would also leave OPM with three rather than two retirement groups for the indefinite future because it will be decades before the last of these annuitants die.

C. Explaining the Proposal

These approaches assure that the most significant concerns of Federal employees and annuitants will be met effectively and humanely, with no major cost shifting or surprises. There will, nonetheless, be some additional concerns which are unavoidable.

Any description which fails to clarify that each of the main groups, and employees abroad, will be fairly treated through either the health alliances or residual or new programs will create a major perception problem. Words like "abolish" or "terminate" will not be helpful if descriptions of the residual programs are not equally prominent. The remaining concerns are as follows:

1. Government Share. At present these disparate enrollment groups are lumped into a single payment system with an average government share of about 72 percent. This system includes many cross-subsidies among employees and annuitants. Under our proposal, some of these cross subsidies will be eliminated, but all groups will be held harmless. Perceptions of unfairness may arise because the apparent government share will range from 80 percent for employees to 72 percent to annuitants without Medicare to about 50 percent for annuitants with Medicare.

2. Retirement Eligibility. Federal employees must be enrolled in the FEHBP system for five continuous years before retirement to get lifetime coverage after retirement. Many employees sign up for this program only as retirement nears, because a spousal policy through a private employer is often a better deal during working years. After reform, any insurance coverage through an alliance will count towards meeting this test. This will eliminate some inequities.

3. Benefit coverage. Most employees will have benefits roughly comparable, or slightly better than those they have now. Our comprehensive option is very similar in general coverage to the most popular FEHBP plan, Blue Cross standard option, as well as to most other fee-for-service plan offerings. The other proposed option is very similar in general coverage parameters to most HMOs. Therefore, the overwhelming majority of employees will have coverage equal to, or very slightly better, than at present.

The one significant exception to this is dental coverage. The proposed options cover only preventive care for children. Most federal employees have preventive and minor restorative care, and a significant fraction, particularly in D.C. area HMOs, have substantial restorative coverage.

Most employees will improve their mental health coverage--going from 15 or 20 outpatient visits to 30 visits. However, those few who are now enrolled in the high-cost, 50-visit Blue Cross high option plan will lose 20 visits of coverage. These persons, however, will actually come out ahead, taking into account that they will save over $2,000 in premium cost.

4. Large Families. There is a change for employees with large families. At present they are lumped in with two-person families. Under the administration's proposal, one parent families with children wqill pay a lower rate than two parent families with children. This needs to be explicitly stated.

5. Insurance Fund Reserves. As the program phases down, some disposition of reserve funds will be needed. Much of the surplus reserves can and should be used up by slight reductions in premiums. The residual amounts will be distributed on the basis of 72 percent to the government and 28 percent to the individuals enrolled at termination.

6. Administration. After transition is completed, OPM will continue to perform functions such as contracting for coverage of employees abroad and for Medigap plans, determining eligibility of individuals for plans, arranging transfers of funds to alliances on behalf of annuitants, instructing agencies on how to transfer funds to alliances on behalf of employees, providing informational material to employees on their benefits, etc.

456-6402

Senator Metzenbaum & Senator Wellstone:

- Stresses imperative to move early in September.
- Physicians - can we pick & choose whether to be in plans? Michelle
- Coverage of DME? - Ellen Schaefer
- Drug costs - how affected under enforceable budget
- Schedule Retiree health meeting w/ Michelle, Darryl, Jo, Debbie Chang
- Metz suggests requiring employers to pay more for part-time employees.

* Schedule meeting w/ Kathy Sykes re workers' Comp. - 1 Later w/ Gary Claxton

Metz → Appeals mechanism to allow consumers to question whether alliance is not controlled by insurers/drug companies

Metz - wants to see Federal regulations on LTC insurance. Wants to see (change language)

FEHBP Bk. FEHBP Fil

POTENTIAL FOR USING THE FEHB AS PROVIDED
IN THE KENNEDY BILL

ASSUMPTIONS

- **Our analysis is based on some assumptions about the provisions of the bill. We would like to verify those assumptions and correct any misperceptions.**

  -- Large group sponsors, including employers with more than 1,000 full-time employees, may either offer coverage through a self-insured plan or negotiate with a State-certified plan to provide coverage. Everyone else is eligible for coverage under a consumer purchasing cooperative, including the FEHBP. This means that individuals eligible for coverage through a large group sponsor would not be eligible under the FEHBP.

  -- There would be no national contracts as there are under the current FEHBP. All contracts, including fee-for-service contracts, would be on a health care coverage area basis. However, a carrier could offer contracts in more than one health care coverage area.

  -- The FEHBP would receive a bid from each of the State certified health plans in a community-rating area and at its election could contract with the carrier.

  -- Current FEHBP plans would have to be State certified to offer coverage to Federal enrollees. Those FEHBP Employee Organization Plans that now limit enrollment to certain groups, for example, FBI employees, could not continue to do so.

  -- The FEHBP consumer purchasing cooperative would have to offer at least one fee-for-service and two other plans in each designated health care coverage area.

  -- There are financing arrangements in the bill for consumer purchasing cooperatives that would also apply to the FEHBP cooperative. That is, start-up capital as well as an ongoing premium surcharge to cover the cost of administration would be available without reference to the appropriations process.

  -- There is recognition that the current staff of 164 people who administer the FEHBP would not simply be multiplied by the percentage increase in enrollees to determine resource requirements. Resources would need to increase geometrically rather than arithmetically in order to perform the requisite functions.

  -- Given community rating and the uncertainty of the risk pool that would elect coverage under the FEHBP cooperative, consideration has been given to the potential effect on premiums for all enrollees (and specifically for Federal

enrollees who are currently enrolled in plans to which they and the Government have been contributing to the accumulation of reserves).

-- Since the implementation date, as in the Clinton bill, is no earlier than January 1, 1996, and no later than January 1, 1998, the FEHBP cooperatives would need to be up and running at the same time as State established cooperatives are implemented in a given health care coverage area.

DISCUSSION QUESTIONS

- **OPM has many concerns about implementation of the bill as we understand it. We also have some purely technical concerns about the legislative language that would affect our ability to implement the legislation should it be enacted. Will there be an opportunity to work through those concerns as the bill moves through the legislative process?**

- Since OPM's current contracting structure and authority would disappear under the Kennedy proposal, we are unclear as to how we are opening the FEHBP to new enrollees. Is the thought that our experience and expertise would facilitate the process of organizing consumer purchasing cooperatives, or is something more intended?

- Is Chapter 89 of title 5 repealed as under the original Health Security Act, and if so, does OPM retain the residual functions in relation to Federal employees and retirees that it had under the Act?

- Would OPM have the same flexibility and resources as consumer health cooperatives to subcontract administrative functions?

- Lead time is a major issue since OPM would need to add staff to administer such a large program. It would also need time and authority to let contracts. Is 1996 realistic?

- Entirely new lines of communication would have to be established. To what degree could we expect the States to act as intermediaries and facilitators? Would there be time and money to build automated systems where they might not be available through vendors?

- Would OPM have the resources needed to develop educational and informational linkages with potential non-Federal enrollees, e.g. infomercials, Congressional town meetings, expanded software programs (Internet) and videos?

- Would OPM be expected to develop and run a disputes resolution process for all of the enrollees covered under the FEHBP cooperative?

TALKING POINTS - CONGRESSIONAL HISPANIC CAUCUS

THE CLINTON PLAN

- President Clinton will present a proposal for comprehensive health care reform to the Congress in May. His plan will offer a bold new direction that will improve access to care, control costs, and maintain the high quality Americans expect.

- The proposal will be based on the following principles:

  Access for All: Americans -- legal residents and citizens -- will be guaranteed coverage without regard to where they live, how much they earn, whether and where they are employed, and whether they have a so-called pre-existing condition.

  Benefits: The Clinton plan will guarantee a comprehensive benefit package and support community-based delivery systems which are sensitive to the needs of the communities they serve. Preventive and primary care will be the centerpiece of health care in America. No longer will we rely on emergency and episodic care.

  Security: The Clinton plan will provide Americans with the security of knowing that wherever they move or whenever they change jobs, coverage will be available for them and their families.

  Continuity: The Clinton Plan will maintain the best of our system and improve it, through support for the public health institutions, Community and Migrant Health Centers, and traditional community providers. The plan will strengthen public health institutions that provide the backbone for the care of special populations unable or unwilling to use health plans regularly.

  Simplicity and Affordability: People will know what they are getting, how much it will cost them, and how to use it.

- The policy development effort is now in its narrowing and audit phase. Working groups in earlier phases put all options "on the table" so that all issues were considered, discussed, and evaluated. The current phase synthesizes all this work and begins a systematic check of the recommendations and all the legal issues that must be addressed in implementing the Clinton plan, before putting options before the President.

"HOT" BUTTON ISSUES

The following issues are of particular concern to the HIspanic community.

1. Sensitivity to the term "CITIZEN."

You may prefer to use the terms "LEGAL RESIDENTS AND CITIZENS" together in that order at all times to avoid an adverse reaction to the term "CITIZEN" which connotes excluding a large part of the Hispanic population.

2. Sensitivity to the term "ILLEGAL ALIEN."

You may prefer to use the term "UNDOCUMENTED PERSONS."

3. Will currently covered "undocumented persons" lose that coverage?

Under reform, we will retain current law that covers "undocumented persons" and we will strengthen the safety net programs for vulnerable populations.

4. Why aren't we including "undocumented persons" in the health plans, if we plan to pay for enhancing the current public health system?

Health care reform must enhance the health of all communities, so we must support and improve the public health system. Undocumented persons are some of the most highly mobile in our society. A strong public health system will ensure that all people wherever they are and wherever they go have access to services.

5. Will a health security care become a model for a national identification card and allow certain individulas to be discriminated against in many Federal programs because of their immigration status.

We are sensitive to these concerns and are meeting with concerned organizations to ensure that appropriate safeguards are developed and instituted. We look forward to your specific suggestions.

6. Will states or local governments control the funding for the public health and safety net programs.

Protections will be put in place which guarantee the participation of all government levels in the decision-making processes, local/county governments and health providers.

Mitchell

READER'S GUIDE TO THE MITCHELL BILL

Title 1 -- Improved Access to Real, High Quality Insurance

Sections 1001-1003 Guaranteed Access, Solid Benefits, Choice of Plan and Doctor

- All health insurance policies have to be certified as meeting certain consumer protection and quality standards, and no standard health plan may discriminate based on medical history, health status, pre-existing condition, or risk of illness. Every plan will have open enrollment, with no waiting periods before coverage begins. And health benefits will be portable from one plan to another. Choices and decisions about health care remain with the individual -- people choose the plan and doctors they want, can buy extra benefits (or get them from their employer) if they choose, and can pay for any health service from any provider at any time.

Sections 1101-1102 Everyone Everywhere has the Same Guarantees

- The standards health plans must meet (described in brief above) will be uniform nationally, so that every health care consumer in every part of the country has the same guarantees. Data will be collected and reported the same way as well, which will streamline administration and bureaucracy and allow for better, more useful comparisons on cost and quality data nationwide.

Sections 1111-1129 Closing the Loopholes -- Real, Dependable Insurance

- Sec. 1111 - Anyone seeking insurance has the right and ability to buy it -- insurers must take all comers. Discriminatory practices like "red-lining" (refusing to sell to people in certain geographic areas or certain professions) and "cherry-picking" (trying to selectively market and sell insurance to individuals or groups likely to be healthy and lower cost) are prohibited. And health insurance companies cannot refuse to renew a policy.

- Sec. 1112 - All plans will have an open enrollment period once a year, and anyone who wants to switch plans can do so during that time. All plans will also allow for changes from one plan to another under certain circumstances, such as moving or changing jobs. If people are unhappy with a plan because they are not getting the services they feel they need, they may also switch to a new plan. If they can show they were not properly served by the old plan, then in some cases the insurance company would have to pay the difference in cost between their plan and the new plan an individual enrolls in. People will have the opportunity to enroll directly, through the mail, through their employer, or through other means to make it as easy as possible for people to sign up for the plan they want.

- Sec. 1113 - Dependent children can remain on their parent's policy until they are 25, and possibly longer if they are still in school. The bill closes loopholes that leave

children uncovered today -- it spells out coverage for children even if they are adopted, live with grandparents, step-parents or other guardians, are living with parents who are divorced or separated, or are in state-supervised care. This bill recognizes the many and varied situations in which America's children live, and it guarantees that no matter what, they're covered.

- Sec. 1114 - Health plan cannot terminate, limit or restrict coverage, or charge more, based on an individual's health status, medical condition, claims experience, medical history, or disability. Nor can it limit, restrict, or terminate coverage, or charge more, because someone has used a lot of health care services in the past, or because an insurer thinks they might use a lot of health care services in the future. During the first open enrollment period, all individuals who enroll gain immediate coverage for any illness, there are no limitations on pre-existing conditions. Likewise, anyone receiving a full subsidy cannot have coverage delayed due to pre-existing conditions. Otherwise pre-existing condition limitations are shortened to six months or less until universal coverage is reached, at which time they are eliminated.

- Sec. 1115 - Every health plan has to offer the same set of standard benefits (or better, with supplemental plans). Benefits are described in 1201. No one will have to worry they have a plan that covers less than a plan they were in before, and people will be able to "price shop" based on the same basic product for the first time, which is essential to competition.

- Sec. 1116 - Community rating will narrow the differences in premium prices based on age to no greater than 2:1, and even that differential will be gradually phased out after 2004.

- Sec. 1118 - [Unlike in the Dole bill], the Mitchell bill provides consumer protection against unpaid provider claims. In other words, if a health plan fails to pay a doctor or hospital for covered services they provided, the individual cannot be held liable for health plan's portion of the bill.

- Sec. 1122 - Health plans will be held to high standards for quality, and every health plan will establish procedures for ongoing quality improvement, and will provide information to providers and enrollees about the quality and cost effectiveness of its services.

- Sec. 1126- Plans will promote shared decision-making between providers and

Sections 1201 to 1203 -- Guarantee of Comprehensive Benefits

- The Mitchell bill guarantees comprehensive benefits to all Americans. All health plans must offer the "standard benefits package" or the "alternative benefits package." Both packages provide a broad range of services, including preventive services, hospital and health professional services, mental illness and substance

abuse services, prescription drugs, home health care, rehabilitation services, family planning and pregnancy related services, vision and hearing care, and dental care for children.

- The standard package has an actuarial value equal to the actuarial value of the Blue Cross/Blue Shield Standard Option (BC/BS) under the Federal Employees Health Benefits Program during 1994 (adjusted for cost differences).

- The alternative benefits package covers all of the services in the standard package but has a high deductible and a lower actuarial value than BC/BS.

- A National Health Benefits Board further defines the covered services and establishes cost sharing schedules. The Board also develops criteria and procedures for determining whether treatments are "medically necessary or appropriate" -- leaving judgments in particular situations to doctors and patients.

- Both benefit packages cover clinical preventive services -- including immunizations, tests and regular check-ups -- and prenatal care without cost sharing.

- The Board must design the benefits package so that there is "parity" for mental illness and substance abuse services. That means that no day or visit limits or cost sharing requirements may be applied that do not apply to other services. However, the Board may limit mental illness and substance abuse services or increase cost sharing on certain types of treatment if excessive cost sharing must be added to other benefits to reach parity.

- Individuals may purchase supplemental benefits packages that cover additional services or cost sharing.

Section 1301 - 1309 Access Through Employers

- *Employee choice*: Each employer shall make available to each employee at least 3 health plans, including, if available, a fee-for-service plan, a combination cost-sharing plan (point-of-service), and a low cost-sharing plan (HMO). Firms of 500 and under (community rated plans) shall offer their employees the option of enrolling in a one of the three types of plans through a purchasing cooperative. If a community rated employer offers plans in addition to those offered through a purchasing cooperative, the employer must offer, if available, each of the three types of plans mentioned above.

- Employers shall provide, upon request, payroll withholding of their employees' premiums.

__Part 2 -- Access Through Health Insurance Purchasing Cooperatives__

Section 1321 -- Purchasing Cooperatives -- Run by Businesses and Consumers to Expand Choices and Increase Bargaining Power

- Voluntary purchasing cooperatives will be set up to consolidate the buying power of small and mid-sized employers and increase choices for consumers. Purchasing cooperatives must accept any small and mid-sized business (less than 500), any small business employee, and any individual who applies. Participation shall be voluntary -- no one shall be required to purchase insurance through a purchasing cooperative.

- These cooperatives will be consumer-run -- managed by elected representatives of small businesses, their employees, and individuals. All members shall have full voting rights.

- The purchasing cooperative replaces thousands of small inefficient purchasers of insurance (small employers and individuals) with one larger, stronger, more sophisticated buyer that's able to wield bargaining power. It will assume the administrative responsibilities -- negotiating with health plans, enrolling members, collecting premiums, paying plans -- that most small businesses and individuals must do on its own today.

- To give consumers the most choices possible, two or more purchasing cooperatives in the same area may be formed to compete for consumers on the basis of choice, quality, and price.

Section 1323 -- Ensuring The Maximum Choice Of Health Plans And Doctors

- In order to guarantee consumers a choice of plans, each purchasing cooperative must offer <u>at least</u> three types of plans: a fee-for-serice plan, in which consumers may choose any doctor, a managed care plan, and a combination plan -- which has higher cost sharing for doctors outside of the network. Purchasing cooperatives are not limited to offering only three plans and may contract with any number of plans that meet the quality requirements.

- In rural areas which may not have enough people to support three plans, there must be at least a fee-for-service plan -- allowing rural residents to choose any doctor they want.

- To protect consumers who buy insurance inside the alliance, the law stipulates that plans may not offer a better deal [i.e., lower marketing fees] to people buying outside the cooperative. This prevents plans from trying to market itself primarily to large companies (who do not purchase through the cooperative).

- Employees of small firms may choose any plan from among the choices offered by their employer, through the purchasing cooperative offered by their employer, and through the FEHB program (see section 1341).

Section 1341– Guarantee Individuals and Small Businesses the Same Choices as Federal Employees and Members of Congress

- Individuals and employees of businesses with 500 or fewer employees may join any heath plan offered under the Federal Employees Benefit Program -- which currently offers more than 300 plans nationwide. They must all be charged the same (community-rated) premium, which will be determined separately from the Federal employees premium until 2005.

- In order to ensure that this will be an option for all Americans, the Office of Personnel Management -- which currently administers the Federal Employee program -- must contract with a purchasing cooperative in every area or, if one does not exist, must establish a purchasing cooperative through which consumers would have access to the choices offered through the FEHBP.

- Employers who make contributions on behalf of their employees would have to continue to make this contribution to any plans their employees choose through the FEHBP.

Part 2 --Essential Community Providers

- Sec. 1462 - Rural Health Clinics (RHC) are automatically protected as Essential Community Providers so that health plans will be required to either negotiate a provider agreement with them or pay them their cost-based RHC rate. Health plans are also required to contract with at least one Medicare-dependent small rural hospitals (i.e., those which have 60 percent Medicare admissions)in their service area. The Secretary may also certify other health professionals or institutional providers as Essential Community Providers if they offer essential services to underserved areas or populations. The Secretary is to perform a study of the Rural Health Clinics Program and report the findings of the study by January 1, 1996.

1491 Office of Rural Health Policy

- Sec. 1491 - The Office of Rural Health Policy is elevated to the level of Assistant Secretary for Rural Health to advise the Secretary on health care access and quality, as well as on the effects of health care reform on rural areas.

- Sec. 1507 - If the Secretary determines that a designated underserved area in a State has inadequate access to health services by standard health plans, the State may make a special arrangement with one or more health plans develop a program to improve access.

Subtitle F, Part 3 -- State Flexibility

1521-1524 Flexibility for states

- Allows states to keep waivers previously granted under the Social Security Act or ERISA, including grants specific to ongoing waiver to Hawaii (KONCH)

- Allows previously approved state hospital reimbursement systems operational since 1977 to stay in place. These systems may apply to all payers, including those with ERISA plans. Allows states with all-payer hospital rate-setting systems to maintain them.

Section 1531-4 -- Single Payer Option

- States have flexibility in determining who would participate in a single-payer system. Such systems may at state option include: large (experience-rated) firms as well as community-rated firms and individuals; and, with the Secretary's permission, Medicare eligible individuals.

- Such single payer systems must include all community rated individuals and achieve rates of growth in health care spending consistent with the national target.

- State single payer systems will not receive more in federal payments than if they would if they if were not single-payer states.

Section 1541 -- Fast-track State Option

- This provision could expedite the transition to universal coverage. It provides states with the flexibility to implement employer responsibility ahead of federal timetable. They must meet certain requirements of the Act (standard benefits, consumer protection, insurance reforms, subsidies,etc.). Requires large multi-state employers (under ERISA) to have approved plans for their employees for such states.

Title 2 -- Coverage of Outpatient Prescription Drugs in Medicare

Section 2000-2008 -- New Coverage for Prescription Drugs

- The Mitchell bill adds prescription drug coverage to Medicare, providing additional protection for older Americans. In the current system, prescription dug costs represent the highest out-of-pocket medical costs for older Americans. The Medicare prescription drug benefit will include 20 percent coinsurance after individuals meet a deductible, and an out of pocket limit of $1275 in 1999. Individuals will have the option of receiving their prescription drug benefits through private plans. Individuals that opt to receive their prescription drugs through cost-saving mail order services will share in those savings in the form of a rebate or reduced cost-sharing.

Title 3 --Health Professions Workforce and Public Health Initiatives

3001 ***Broad-Based Advisory Council on Workforce Training***

- Creates National Council on Graduate Medical Education, made up of a panel of consumers, primary care M.D.s, specialists, representatives from health plans and cooperatives. The purpose of the panel is to assist and advise the Secretary on ways to increase numbers of primary care physicians.

Rural Representation

- Rural representation is guaranteed on the National Council on Graduate Medical Education. At least one rural doctor must be appointed to the National Council which will oversee the development of a medical workforce more appropriate to rural areas. The Act also encourages more primary training opportunities in outpatient setting.

- **Abolishes** duplicative Council on Graduate Medical Education.

3013 ***Increase in Primary Care Physicians***

- Increases (from 39-55%) the number of physicians being trained in primary care from 39 percent to 55 percent between 1998 and 2001. Sec. 3014 (a) allows for some modification (by the Council) of the distribution of primary care and specialty physicians. [Section 3061 builds in a guarantee of substantial emphasis on primary health care education for physicians.]

3013 ***Voluntary Compliance to New Workforce Rules:***

- Outlines how reducing the numbers of specialists can be done voluntarily, by organizations of specialists.

3033 ***Funding of Graduate Medical Education***
- Provides for long-term, sufficient and stable funding for GME.

3052 ***Funding for Academic Health Centers:***
- Provides for long-term, sufficient, and stable funding for these centers --including high intensity rural non-teaching hospitals. Recognizes unique needs and contributions --research, teaching costs, high-tech high-cost cases, care for the indigent.

3055 ***Transitional Payments to Institutions:***
- Secretary to make additional payments to academic health centers and teaching hospitals that may lose residency positions due new allocations of primary care/specialty positions. (see 3013b above) Allows Secretary discretion necessary to protect underserved communities --by increasing their funding-- in applying transitional payments.

Sec. 3061 ***Funding for Ambulatory Training***
- Priority funding status for 25 percent of the amount allocated to medical schools is given to ambulatory care training programs in community health centers and rural area health centers.

3081-2 ***Funding for Special Programs***

- Provides funding to train additional primary care physicians and physician assistants; retrain mid-career physicians; expand supply of physicians in rural and inner-city areas; deliver primary care to those with mental, physical, developmental disabilities;

3081 ***Rural and Underserved Communities:***
- Provides funding to increase the number of minorities and disadvantaged persons in medical professions; encourage retention of health professionals in rural and underserved areas; retain health professionals in rural areas; and improve communications between rural areas and academic health centers.

3082 ***Retraining and Workforce Adjustment:***
- Establishes a program for health care industry job banks and one-stop career centers to assist any displaced health care industry workers.

3093 ***Minimizing the Disruption to the Health Care Workforce:***
- Imposes reasonable requirements on health care businesses to protect individuals and help secure employment for displaced health care workers.

3201-2 ***Stable Funding for Health Research:***

- Provides that 0.25% of private insurance premiums (in addition to current funding) be directed to health research --including prevention, cure, appropriateness and effectiveness of clinical strategies, health outcomes, improving access to health care for vulnerable populations.

3221 ***Study on Medical Technologies***:
- Secretary of HHS to arrange for study on costs, benefits, outcomes of technologies and treatments. Goal to assess impact on outcomes, including impact of government policies.

Sec. 3081 New funding is provided to expand the supply of physicians to meet the special needs of rural medically underserved areas, including support for programs that train physicians and physician assistants in community settings. The Act contains new initiatives to increase the number of rural people accepted into training programs, and it incorporates other programs to improve the retention of rural doctors through telemedicine systems, inter-disciplinary team building, and providing temporary practice coverage while doctors are away for vacations and continuing medical education.

Sec. 3101 The Act contains a new initiative to link academic health centers with rural providers and health plans. This provision will help establish and operate information and referral systems necessary to assure rural access to specialized services at academic health centers.

Sec. 3341 Consortia containing rural hospitals and other public and private providers are eligible for new grants to expand access to health care services though the use of telecommunications technology. Rural networks will have priority for funding under this program.

Sec. 3411 Rural hospitals and other health care providers are eligible for new Public Health Service Initiatives to improve access to health services in underserved areas. New programs will build community-based health plans and networks and provide funding for supportive services like transportation, outreach, and translation services. The Act requires the Secretary to assure that funds are distributed between rural and urban areas in an equitable manner.

Sec. 3465 A new program will fund up to three demonstration projects to develop new ways to provide health plan coverage in rural areas.

Sec. 3471 Over $1 billion in new funding is made available to expand the National Health Service Corps. Currently, rural areas receive about 60 percent of the doctors, nurses, and other health professionals placed by the Corps.

Sec. 3681 Rural communities are eligible for funding to develop and operate school-based or school-linked health service programs targeted to the needs of rural communities through partnerships between schools and health care providers.

Sec. 3902 New funds are provided for the community scholarship program, under which State may contract with community-based organization to provide scholarships in the health professions for local residents.

Sec. 3908 The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission on border health issues.

Sec. 4105 The Act updates and extends the special payment treatment for Medicare-dependent small rural hospitals through September 1999. These protections were scheduled to expire this year.

Sec. 4106 The Rural Health Transition Grant Program -- which provides transitional assistance to rural hospitals --is extended through 1999. Rural Primary Care Hospitals are made eligible for funding.

Section 4111

- The Act greatly expands programs to help small rural hospitals convert from acute care to more primary care services. The new limited-service hospital program in the bill will provide new resources to support alternative rural health care models. Two programs specifically tailored for rural hospitals -- Rural Primary Care Hospitals and Medical Assistance Facilities -- will be authorized to expand to all States wishing to participate. Many technical and payment amendments are included to make the programs more useful for rural communities. The Secretary will no longer designate Essential Access Community Hospitals.

Section 4204 - Bonus Payments to Rural Providers

- Medicare bonus payments for rural doctors in underserved areas are doubled from 10 percent to 20 percent for primary care services, and they are retained at 10 percent for non-primary care services.

Sec. 4212

- Payments for physician assistants and nurse practitioners are expanded to include services provided in a hospital setting.

<u>Title Five - Improving Our World Class Quality and Ensuring Consumer Protection</u>

Sections 5002-5005 – Report Cards and Consumer Surveys Promote Real Consumer Choice

- An integrated quality improvement system will provide information and accountability to consumers to enhance the quality, appropriateness and effectiveness

of, and access to, health care services across the country. Health plans and providers will measure themselves against defined goals and benchmarks to determine where and how they can improve; consumers will compare report cards for each plan which show scientific measures of one plan's quality and accessibility and also incorporate surveys about how patients feel about the plan and the services they've received. This easy-to-understand information will give plans and providers benchmarks for improvement, and families the information to make the best choice of health plan for their family's needs.

Sections 5006-5007 -- Research Provides Tools for Improvement

- An expanded focus and investment in health services research, including research on outcomes, practice guidelines and quality improvement provides the building blocks needed to continually assess and update the quality measures and provides the industry with tools to improve quality.

Section 5008 -- Jump-Starting Quality Improvement at the Local Level

- Replacing the punitive system that characterizes the "quality assurance" programs in place today, non-regulatory foundations serve as resources to the health industry and consumers in the community. These foundations will provide technical assistance to providers and health plans that want it; monitor practice patterns and patient outcomes across the population; develop programs in lifetime learning for health professionals; serve as a focal point and clearinghouse for successful quality improvement programs, practice guidelines, and research findings; and assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their own care.

Section 5009 -- Consumers' Interests are Protected

- Consumers will have a place to go to get information, register complaints, learn about their rights, or just have their questions answered and problems resolved. Each state will set up a consumer information and advocacy center with a toll-free hotline and staff that's there to protect consumers' interests.

Subtitle B - Administrative Simplification

Sections 5101 - 5121 -- Streamlining Information Flow and Cutting Red Tape

- The development of a health information network will ensure that information gets to those who need it in a timely and efficient manner. Too often, files are misplaced and information is incomplete, slowing the patient's treatment or the processing of a claim. With an electronic system bolstered by national standards and requirements for plans and providers to submit information electronically, these kinds of problems will virtually disappear.

- Hospitals, doctors' offices and other health care providers will have far less paperwork and information to submit to plans in order to get paid. Uniform, standard forms, codes and formats will replace the hundreds of different requirements plans currently place on providers. That, combined with universal coverage and a standard benefits package, will dramatically ease the paperwork burden.

Sections 5206 -5268 Ensuring the Privacy of Health Care Information

- Health care information will be protected much better than it is today. Safeguards, guidelines for the appropriate use and disclosure of information, combined with penalties for improper use of information will ensure that medical information is only seen by the professionals authorized to see it.

Sections 5301 to 5327 -- Expanded Efforts to Combat Fraud and Abuse

- The Mitchell bill coordinates federal, state and local enforcement of fraud and abuse laws.

- With a standard benefit package, standard claims forms, and streamlined administrative procedures, the opportunity for fraud that exists in today's system -- with its hundreds of different claims forms, coding systems and billing procedures -- will be dramatically reduced.

- A Federal Outlay Program Fraud and Abuse Control Account "recycles" monies recovered from wrongdoers to fund additional fraud detection, enforcement and prevention.

Sections 5401 - 5412 -- Malpractice Reform

- The Mitchell bill includes a series of malpractice reforms -- such as requiring that parties participate in state-based alternative dispute resolution, limiting attorneys' contingency fees, and allowing periodic payment of awards -- that will reduce meritless claims and streamline the malpractice system, while compensating deserving individuals.

- Since the bill preempts only inconsistent state laws, the bill does not displace laws that have been passed in some states that place caps on noneconomic damages.

TITLE VI -- INDIVIDUAL AND EMPLOYER SUBSIDIES

Section 6001-6009 - Individual Premium and Cost-Sharing Assistance

- The Mitchell bill provides a number of subsidy programs that are targeted toward greatly expanding coverage and providing additional protections for Americans that already have health insurance, but may be at risk of losing it under the current system. The bill has low income subsidies, additional subsidies for children and pregnant women, and enhanced income protection that makes sure that individuals who lose their jobs can still keep their coverage. The bill contains the following provisions that assist individuals:

- *Low income subsidies*: premium subsidies of 100 percent of the average community rated premium in an area are available for individuals with family incomes of up to 100 percent of poverty; this subsidy is phased out up to 200 percent of poverty.

- *AFDC eligible*: Families receiving Aid to Families with Dependent children are taken off of Medicaid and brought into the private insurance system and are eligible for full premium subsidies.

- *Non-Cash Medicaid Eligibles*: Individuals who are on Medicaid but do not receive assistance from AFDC will be taken off Medicaid and brought into the private insurance system. These individuals will be eligible for full private insurance premium subsides for the 6 month period beginning January 1, 1997. After the first 6 months, these individuals are eligible for standard low income subsidies based on their family income.

- *Cost-sharing*: Individuals with incomes of up to 150 percent of poverty are eligible for cost-sharing subsidies to help offset the cost of copayments and deductibles under their private insurance plans.

- *Subsidies for Children*: Children with family incomes of up to 300 percent of poverty who do not have access to employer provided insurance will be eligible for subsidies to purchase private health insurance. Children under 19 years of age who have not been enrolled in a health plan offered by an employer during the 6 month period ending on the date the individual applies for premium assistance and are not eligible for an 80 percent employer contribution for coverage will be eligible for full subsidies if their family income is up to 185 percent of poverty and partial subsidies if their family income is between 185 and 300 percent of poverty.

- *Subsidies for Pregnant Women*: Pregnant women with incomes under 300 percent of poverty who are not enrolled in a health plan on the date they apply for premium assistance and are not eligible for an 80 percent employer contribution for insurance will be eligible for subsidies for private health insurance. Full premium assistance

will be available for women in families with income of up to 185 percent of poverty. The subsidy is phased out up to 300 percent of poverty. Women are covered under this program for three months after they give birth.

- *Assistance for Individuals Who Are Temporarily Unemployed*: An individual who becomes unemployed is eligible for enhance income protection, which allows the individual to disregard a share of his or her income up to 75 percent of poverty and all unemployment compensation in determining eligibility for low-income subsidies. This protection is available to unemployed individuals for up to 6 months.

- *Enrollment Outreach*: In order to expand coverage as effectively as possible -- and reduce the uncompensated care cost shift -- every State will provide enrollment outreach programs that will allow providers who furnish services to subsidy-eligible individuals to sign them up for coverage at the time they seek care. Individuals who submit applications to health care providers under enrollment outreach programs will be eligible for assistance for 2 months.

Subtitle B -- Employer Subsidies

Sections 6101-6105 - Subsidies for Employers that Expand Coverage

- In order to assist employers that have not been able to afford to cover all or some of their workers, the Mitchell bill provides temporary subsidies to help them expand coverage. In order to be eligible for the subsidies, employers must agree to expand coverage to all employes within a particular class (full time, part time) and contribute at least 50 percent of the cost of health care coverage for each employee. The form of the subsidy will be the amount of the weighted average premium that exceeds 8 percent of each worker's wages. The subsidy will be phased out in the 4th and 5th years after enactment of reform.

SUBTITLE VII -- REVENUE PROVISIONS

Sections 7101-7103: ***Tobacco Tax***

Raises revenues to fund subsidies by gradually increasing the tax on tobacco products from 25 to 45 cents a pack by 1999.

Section 7111 ***Supports Workforce Training And Research With 1.75% Tax On Premiums***

- Revenues from this assessment are dedicated to funding workforce training, academic health centers and research.

Sections 7112 ***Promotes Selection Of Lower Cost Plans By Imposing Modest Tax On High Cost Health Plans.***

- For community rated plans tax is based primarily on cost of the plan relative to a federally defined baseline or "reference premium".

For experience rated plans the tax is based more on the rate of growth in the premium of the plan relative to the federally-defined target rate of growth (4511).

Section 7131 ***Collects Revenues To Fund Subsidies By Increasing Tax On Certain Handgun Ammunition.***

Section 7203 - Increased Deduction for the Self-Employed

- Under the Mitchell bill, self-employed individuals can deduct up to 50% of the cost of a certified standard health plan, up from the 25% allowed the self-employed today.

Sections 7401-2 -- Tax Deductibility for Long-Term Care

- Increases tax deductibility of long-term care expenditures and insurance. Long-term care expenditures would be treated as medical expenditures for tax purposes, qualifying them as tax deductible expenses. Does the same for long term care insurance; gives it the same tax treatment as health insurance.

Sections 7511-2 -- Tax Incentives for Rural Providers

- The Act offers tax credits of up to $1,000 per month for doctors and $500 per month for nonphysician providers who begin practice in designated underserved areas for up to 3 years. Physicians already practicing in these areas may receive tax credits of $500 per month.

- The Act raises by $10,000 the amount that rural primary care doctors may claim on their taxes for medical equipment.

Title VIII - Other Federal Programs

Sections 8101 to 8142 -- Improving the Health of American Indians and Alaska Natives

- The Mitchell bill recognizes the unique trust responsibility of the federal government to Indian people. All health services continue to be provided at no cost to the individual, and federal officials are required to maintain active and ongoing consultation with Indian people about Indian health programs.

- Tribes, tribal organizations and the Indian Health Service are given the authority and flexibility to form health plans.

- New funding sources -- including an Indian Health Care Investment Fund that provides $133,330,000 each fiscal year between 1996 and 2004 in addition to other appropriations -- can be used to expand and improve Indian health care facilities and should enable the Indian Health Service to provide the broad range of services in the standard benefit package.

- The bill also preserves the wide range of supplemental services -- including education, outreach and public health services -- that are provided today.

Section 8202 – Maintaining Our Commitment to Our Nation's Veterans

- The Mitchell bill maintains our commitment to our nation's veterans by preparing the Department of Veterans Affairs for health care reform while preserving the right of veterans to receive supplemental services that meet their special needs at no charge. The bill relieves the Department from the burdens of bureaucracy and regulation and gives the VA the authority and flexibility necessary to form health plans to compete for veterans.

- New funding sources should make it possible for VA facilities to serve all veterans who wish to enroll, ending today's arbitrary eligibility requirements.

  - The VA may receive premium payments from employers and some veterans.

  - For the first time, VA facilities can receive Medicare reimbursement for all Medicare- eligible veterans who enroll in a VA health plan.

  - A Veterans Health Care Investment Fund provides approximately $3.5 billion over a three year period to expand and improve facilities and to help VA health plans become competitive.

- All veterans remain eligible to receive supplemental benefits -- such as treatment for post-traumatic stress syndrome and long-term care services -- that are provided today at no cost to the individual.

TITLE XI -- ENSURING HEALTH CARE REFORM FINANCING

Sec. 11001 - In order to protect the federal deficit from an unanticipated increases, the Mitchell bill contains a fail-safe mechanism that guarantees that Federal health spending will not exceed estimated expenditures.