Mainstream File

MAINSTREAM GROUP
OBJECTIVES FOR HEALTH REFORM

ACHIEVE UNIVERSAL COVERAGE
NOT INCREASE THE DEFICIT
LOWER HEALTH CARE COSTS
MAINTAIN QUALITY
EXPAND CHOICE FOR ALL AMERICANS
THE MAINSTREAM AMENDMENT WILL:

Achieve universal coverage through:

- effective insurance reforms -- portability, renewability, eliminate preexisting condition limitations, adjusted community rating in small group market;
- expanded tax deductions; and
- subsidies for low-income families that make health care affordable for ALL Americans.

Limit government intrusion/bureaucracy/regulation:

- NO market-distorting price controls
- NO prescriptive regulations that stifle innovation
- NO new big mandated state or federal bureaucracies.

Protect against deficit growth through:

- full financing of new health spending; and
- effective "fail-safe" mechanism that prohibits deficit financing of health spending.

Lower health care costs by making health plans compete on quality and price through:

- standard benefits packages;
- better consumer information and health plan accountability
- voluntary purchasing cooperatives
- administrative simplification
- measures to eliminate fraud and abuse
- aggressive malpractice reform.

WHY MITCHELL HEALTH CARE LEGISLATION FALL SHORT OF MAINSTREAM OBJECTIVES

IMPOSES MARKET DISTORTING PRICE CONTROLS

- Premium Assessment relies on Government imposed price caps
- New National Health Care Cost and Coverage Commission has power to recommend government price controls under an expedited procedure

IMPOSES NEW MANDATES

- Triggered Employer/Individual mandate
- All employers with less than below 500 employees must join "Voluntary" purchasing cooperatives

EXPENSIVE NEW SPENDING

- New non-means tested entitlement for prescription drugs
- New non-means tested entitlement program for long term care
- New employer subsidies to encourage expanded coverage
- New subsidies to fund health benefits for families up to 300% of poverty
- New subsidy for the temporary unemployed
- New subsidies for cost sharing for low income participants
- New authorizations for existing Public Health Programs
- Six new trust funds for medical workforce (a superfund for medical education) and new trust fund for research funded by a 1.75% tax on premiums
- Expanded private remedies for benefit delay and denial destroys ability of health plans to control costs
- Deep cuts in Medicare exacerbates cost shift onto private sector
- Fail safe not established until massive new entitlements have been incorporated into baseline
- Fail safe subject to manipulation by the Executive Branch by changing baseline and setting inflation factors

SUBSTITUTES GOVERNMENT REGULATION FOR PRIVATE MARKET FORCES

- 500 Employee threshold herds majority of employees and employers into large collectives and destroys employers' ability to control costs
- Gives National Health Board excessive power to practice medicine
- Pure community rating beginning in 2002 penalizes the young and dooms the voluntary system

- The new employer subsidy decreases incentive to control costs once payment limit is reached
- Premium assessment is not used to provide consumer incentive to save costs and undermines competition be setting a Government imposed target
- Opening of FEHBP creates Federal Government run purchasing cooperatives that could become a back door single payer system
- Creates Federal Government central planning of health work force
- Creates an unlevel playing field in the marketplace by mandating all employers and HIPCs offer a Fee -For -Service plan
- Requires employers to offer only standard benefit package-- only individuals can use "alternative standard plan"
- Triggered mandate creates counterproductive business and hiring incentives by exempting employers with less than 25 employees
- Creates a government run long term care health insurance system
- Undermines competition in the prescription drug industry with a mandatory rebate agreements
- Provides no incentive for Medicare seniors or providers to choose cost effective private systems
- Destroys ability to manage health costs by requiring health plans to contract with a wide range of "essential" community providers
- Uncertain scope of "State Option" may severely hamper multi-state employers and providers
- Institutes bureaucratic Federal and State inspection and reporting systems for providers and health plans
- Weak malpractice reforms ensure continued defensive medicine

HIDDEN COST SHIFTS

- Federal Government shifts costs of insuring Medicaid population onto private health plans and States
- Underfunded mandate to States to administer subsidies
- Institutionalizes cost-shifting by requiring self-insured employers to risk adjust and subsidize the community rated system

FEDERAL BUDGET EFFECTS OF MITCHELL PROPOSAL

	10-Year Estimate ($ billions)	
Outlay increases:		
Low-income subsidies (Finance)	$ 924	*
Prescription drugs for Medicare Beneficiaries (Mitchell)	$ 99	
Home and Community Based Care Program (Mitchell)	$ 48	
GME/AHC initiatives	$ 75	
Total outlay increases	$1,146	
Funding Sources:		
Eliminate Medicaid acute care (Mitchell)	$ 516	
State maintenance of effort payments (Mitchell)	$ 232	
Medicare cuts (Mitchell)	$ 278	
Means test Medicare Part B premiums (Finance)	$ 22	
Tobacco tax (rough estimate)	$ 50	
High Cost Plan Assessment	$ 40	
Eliminate Section 125/Flexible Spending Arrangements (Finance)	$ 35	
1.75% premium assessment	$ 75	
Other revenue changes (net)	$ 0	
Total funding sources	$1,248	

* The bill approved by the Finance Committee did not include the subsidies to employers or the subsidies for short-term unemployment.

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MAINSTREAM ISSUES

1. No provisions regarding supplemental insurance or cost sharing coverage.

2. 2001(e): Not clear that an insurer cannot offer additional classes of enrollment not specified in the bill.

3. 2011(a): Automobile or general liability coverage not excluded from exclusions from definition of health plan.

4. 2011(a)(3): Definition of self-insured health plan refers to retaining "significant risk." Should probably be stronger (maybe "substantial majority," as provided in rules by the Secretary).

5. 2011(c): Employees of larger businesses enroll in the health plan of that business, even if the employer does not contribute towards coverage. Might consider making these people community-rated. Significant issue of selection in plans where the employer does not contribute.

6. 2011(c)(6): Definition of experience-rated employer should just be an employer who is not an community-rated employer (the current definitions do not define the entire universe).

7. 2100(3): Is section 151(c)(3) of the Internal Revenue Code a reference to the definition of dependent?

8. 2100(4)(B)(ii): Why do you need definition of wages and exclusion of tips?

9. 2101(b): Risk adjustment refers to health plans in general, not just community-rated health plans. But there does not appear to be provision for a cross-pool risk adjustment.

10. 2111(a)(2)(B)(i): Reference to individual residing outside the community rating area should probably refer to individual residing outside the plan's "service area."

11. 2111(a)(2)(B)(ii): How would rating work for a fee for service plan in the adjoining community rating area? Why wouldn't that fee for service plan simply offer coverage in the first community rating area to begin with?

12. 2111(a)(3)(B): First-come-first-served rule encourages selective marketing. Suggest using Senate Labor language which requires establishment of a process that allows anyone who applies during an open enrollment has an equal chance of being selected for enrollment in a plan, regardless of the method of application.

13. 2112: Specifies when coverage begins under a new plan, but not when coverage ends under an old plan. Suggest that the Secretary issues rules to minimize gaps in coverage when people change health plans.

14. 2113(b)(2)(C): Age adjustment factor should apply over age 65 also.

15. 2113(b)(3): Suggest that administrative charges not vary by size of employer. Charges should vary only by the method of enrollment, not employer by employer. Charge for public access site should not exceed the lowest charge for any method of enrollment, not just purchasing cooperatives.

16. 2114(b)(1): Premiums are already prospective, so it is not necessary to require advance payment of additional monthly premium. If section is not changed, then it should be applied by an insurer in a non-discriminatory manner with respect to all insured business of the health plan sponsor.

17. 2114(b)(2): A health plan should not be able to terminate coverage unless it has provided notice of an overdue premium payment.

18. 2115(b)(3): Period of continuous coverage should refer to benefits "similar to" rather than "equivalent to" for the purposes of applying the pre-existing condition exclusion.

19. 2121: Risk adjustment applies only to community-rated plans, which seems to contradict earlier section.

20. 2123(a): Should say "which provides coverage to individuals residing in a State" rather than "offered or operated in a State."

21. 2125(e): Language about no patient liability for unpaid plan obligations does not work. An insolvent plan cannot hold anyone harmless. Suggest that the provider, not the plan, should hold the enrollees harmless.

22. 2128: Requirements regarding access to specialized services should apply only to network plans.

23. 2129: Requirements regarding capacity should apply only to network plans.

24. 2131(a)(6): This refers to reinsurance requirements for self-insured plans, but refers to the section describing risk adjustment (which does not seem to apply to self-insured plans, anyway).

25. 2131(b): Unclear why plans provided pursuant to a collective bargaining agreement are exempt from guarantee issue and financial requirements. And, reference should be limited to a multiemployer plan under ERISA, not any plan provided pursuant to a

collective bargaining agreement.

26. 2141: No interim reforms apply to insured plans. The only reforms that apply to self-insured plans are guaranteed issue and non-discrimination based on health status. These could be a little broader (e.g., portability) and some should apply to insured plans.

27. 2201(a): It is unclear whether or not there is a standard benefits package, or whether health plans can offer any package that is less than the actuarial value of Blue Cross/Blue Shield Standard Option.

28. 2201(b)(1): Same issue as in 2201(a). Is the basic package standardized?

29. 2201(b)(2): Is the un-named package standardized? What is its purpose?

30. 2213: Does not appear to direct the Commission to establish a standard benefits package.

31. 2311(a): Prohibition on forming purchasing cooperative should be expanded to affiliates of insurers.

32. 2311(e): Would allow a purchasing cooperative certified in one state to operate in another state without getting certified there. This should be changed to require certification in each state in which a cooperative does business (just like insurers).

33. 2311: There are no fiduciary or cash management standards for cooperatives.

34. 2311: Does not appear to allow a state to have only one cooperative in an area.

35. 2313(c): Unclear what "enrollment procedures" of plans refers to.

36. 2317: Allows all state and local pools with 100,000 or more people to be exempted from community rating. Unclear how many people this is overall.

37. 2317(c)(2): Has state and local pools participating in risk adjustment. How?

38. Part 3: Association provisions are generally bad.

39. 2321(b): What does it mean for an association to maintain an insured plan? Can an insurer have a separate insured plan for an association? It is strange (an problematic) for an association to offer a self-insured plan alongside community-rated plans.

40. 2322(a): Specifies that Secretary of Labor is responsible for certifying multi-state self-insured association plans, but non one is responsible for certifying single state

self-insured association plans.

41. 2322(d): 125% limit is like having no limit at all.

42. 2323(c): To be a qualified association, it should be required to have sponsored a plan for three years.

43. 2324(b): Should the MEWA provision in ERISA be repealed?

44. 2325: Clarify that church plans only apply to employees of the church.

45. 2325(b)(3): Plans under collective bargaining agreements are exempt from the requirement to offer a choice of plans.

46. 2405(a): Refers to the Self-Insured Health Plan Insolvency Fund, but does not appear to create such a fund.

47. 2511: Appears to allow alternative state systems that provide waivers from essentially all of the insurance reforms (without adequate safeguards or specificity).

48. 2522: Would a single payer system have to provide universal coverage? ERISA issues are unclear.

UPDATE ON NEGOTIATIONS WITH MAINSTREAM GROUP

Resolved Issues:

- **Individuals Deduction.** Mainstream has agreed to drop this proposal.

- **Risk Adjustment.** We agreed to the mainstream's original position to risk adjust between community-rated plans. We also agreed to the Mainstream's new proposal to risk adjust between the community-rated pool and association plans, as well as large public employee plans. (See Insurance Reform, below.)

- **Malpractice.** We agreed to drop objections to (1) mandatory fee shifting (English rule) in ADR cases and (2) limits on several liability. Mainstream has agreed to drop cap on damages. State caps would be retained.

- **Insurance Reform.** We agreed to the mainstream proposal which sets the community rated level at 100.

  We agreed to accept the mainstream's original position that allows association plans to continue selling experience-rated and self-insured plans to their members but does not allow new plans to develop. The mainstream staff agreed to (1) several substantial modifications to the criteria for determining which associations will be grandfathered and (2) risk adjust association plans with the community-rated pool. We agreed to leave in place the 20 percent association plan growth limit in the mainstream bill.

  We also agreed to the mainstream's original position allowing large purchasing groups that serve public employees to continue offering experience-rated plans. As with association plans, we also agreed to risk adjust these large, public employee purchasing groups with the community-rated pool.

- **Federal Employees Health Benefits Program (FEHBP).** The mainstream staff agreed to our proposal that working individuals in the community-rated pool be allowed to take their employer's contribution (if any) for health care to any FEHBP plan in the area. We agreed to their modification of our proposal that employers be allowed to charge a reasonable administrative fee if an employee chooses an FEHBP plan not offered by the employer.

- **Outcomes and Quality Research.** The mainstream group has agreed to a 0.1 percent set-aside (out of the 0.6 total set-aside) for the Agency for Health Care Policy and Research.

- **Plans and HIPCs.** We can accept the mainstream approach.

Outstanding Issues:

- **State Flexibility.** The mainstream group has proposed an option which would amend ERISA to allow states to tax the employer, but not the employer's health plan. This would clarify the uncertainty which exists today for states with regard to taxing authority. This option would allow states to impose taxes of general applicability (a broad based tax) to finance their state health reform programs - for example, an income, payroll, privilege or sales tax. However, states will continue to be prohibited from imposing direct taxes on self-funded health benefit plans, or taxing only self-funded plans.

  While this is a step forward by the mainstream group, we believe it still will not allow Washington State to implement its reform because it does not appear to grant a mandate authority, and prohibits a premium tax. We are attempting to get clarification of these issues with regard to Washington and other states that have implemented state wide reforms today.

- **Medicare Outpatient Prescription Drug Benefit.** We have agreed to drop this as part of a package with lower medicare cuts and a Long Term Care benefit closer to Mitchell. Our staff is working on an appropriate level of medicare cuts.

- **Home and Community-Based Long Term Care Benefit.** We are still negotiating the level of the program, but have gotten them to agree in principle to increase towards the Mitchell level. The issue of means testing remains unresolved with little flexibility on the part of the senior groups. Our staff is working on that issue today. AARP is opposed to means testing a program that is funded with Medicare cuts. It undermines the concept of social insurance and asks the upper income beneficiaries to pay more for Part B while precluding them from benefitting from the long term care benefit.

  On insurance standards, the mainstream group has made no significant movement toward the consumer protections included in the Mitchell provision.

- **Fail-Safe.** We continue to oppose sequester of low income subsidies to offset unanticipated cost increases in the Medicare program. As an alternative, the mainstream group has suggested that unanticipated increases in Medicare be offset through sequester of the Medicare program itself. This is not acceptable. While we support the concept of having this ***new*** program pay for itself, expanding the fail-safe to cap spending in the ***existing*** Medicare program goes well beyond that concept. Under the Mitchell bill, changes in Medicare spending which were related to health care reform were included in the calculation of an overage, but Medicare changes which were unrelated to health care reform were not included. This bill should not be used as an excuse to cap the Medicare program.

- **Limit on Tax Deductibility and Employer Deductions/Employee Exclusion for Cost-Sharing Supplemental.** No resolution has been reached on mainstream proposals to (1) limit employer deduction to plans that cost no more than 110 percent of average in community rated area; and (2) to deny deduction for employers and exclusion for employees in the case of supplemental cost sharing benefits.

- **Underserved/Public Health.** The mainstream group continues to oppose new mandatory spending. Senator Kennedy will meet with mainstream to discuss.

- **Benefit Package/Role of the Health Board.** We have agreed on three standardized benefit packages (Standard, Catastrophic and Basic) that will differ in actuarial value. A congressionally-appointed Benefit Commission will establish cost sharing schedules within each package and will decide which categories of services to offer in the Basic Package, which will be embodied in implementing legislation for Congressional action on a fast track. If Congress fails to pass the Commission's recommendations, health reform could not be carried out because there would be no standardized benefit packages.

  As a compromise, we recommend that: (1) Congressional implementing language be limited to change in benefit categories and actuarial value of the standard benefit package; (2) the Commission develop criteria for defining medical necessity or appropriateness, rather than defining these terms in legislation.

- **Workforce/Graduate Medical Education.** The Mainstream establishes a 0.6 percent premium assessment for graduate medical education and health research. It also creates a commission to make recommendations on workforce reform for fast-track Congressional approval. We have not resolved the issue of whether funds should be earmarked for primary care. Under the mainstream bill, expanded funding starts even if Congress does not approve the commission's workforce recommendations and there is no mention of a goal to increase primary care residencies to 55 percent.

  As a possible compromise, we recommend that: (1) Expanded all-payer funding for graduate medical education be contingent on Congressional passage of a health professions workforce policy developed by a congressionally-appointed Commission; and (2) the Commission be directed to consider steps to increase primary care physician residencies to 55 percent of federally supported positions, and to bring the overall number of residency positions closer to the number of American medical school graduates.

- **State Preemption of Insurance Reforms.** We will be discussing (and hopefully resolving) our differences with mainstream staff.

Senator Dave Durenberger

U.S. Senator for Minnesota

MAINSTREAM FILE

BIPARTISAN MAINSTREAM AGREEMENT

The bipartisan Mainstream group's legislative recommendations are the collective efforts of Democratic and Republican Senators. Many of us have been working on health reform throughout our careers. We have all devoted substantial time to reform during this Congress. Our deliberations have led us to the following conclusions:

RESPONSIBLE HEALTH REFORM:

MUST be bipartisan.

Health reform is too important to the nation to be rammed through on a partisan vote. It must have broad support from elected representatives and from the American people.

MUST fix what is broken.

Health care reform is very complex and will affect every single American citizen. The public does not want us to disrupt the system and risk reducing the quality service they currently enjoy. But, we need to fix what is broken, particularly problems of high cost and limited access.

We have the highest quality health care in the world. But, we have serious problems in the system of delivering care. We spend too much without getting value for our health care dollars.

MUST not cost too much. Do reform right.

The American public has lost faith in its representatives to responsibly address the problems they face. We are in the habit of promising more than we can deliver and scapegoating others for our failure on the system.

It is clear that the public does not want massive change with potentially negative results for their families.

It is irresponsible to try to change too much too fast. The Mainstream believes we must begin the job NOW and address other issues next year when we have better information about how the reforms are working. These include medical education and research, public health expansion, workers compensation integration, low income subsidy expansions, long term care, civil rights expansion, Medicaid reform through vouchers, and tax equity reform.

The problem is that health care COSTS too much for all Americans.

We will never get to universal coverage UNTIL we get costs under control. You can't reach those liberal ends unless you do it through conservative means.

The American way to control costs is to get greater productivity in the system. Only sound markets can do it. Informed buyers can demand lower prices and higher quality. This is the system upon which the American economy is founded. Government price controls have NEVER worked in America.

Exciting changes are occurring in medical markets all over the country. Our goal is to take advantage of what those changes teach us. Put the right incentives in place; don't smother them with government controls.

National rules make markets work. NO new bureaucracy.

People don't trust government to give them quality health care at lower prices. Government's role is to make sure the laws encourage the careful buyers and the efficient providers. We must eliminate barriers to choice and competition in current law.

We don't need big bureaucracies in the system. We need incentives for people--employers, individuals, doctors, hospitals, communities--to do better. People can make wise choices if they have information on how well health plans perform, what works and what doesn't.

Insurance reform is essential for health security and expanding choice.

There is consensus that we need to make major changes in the rules on which insurance companies operate. We will guarantee everyone a policy, and make sure it cannot be taken away.

Establishing standard benefit packages provides consumer protection and the ability to compare on the basis of price and quality. Health plans need to become accountable to the consumer.

Increase buying power for small business (under 100).

Small business and individuals can buy with the power of larger companies by grouping up. Adjusted community rating keeps prices fair and affordable.

Keep large businesses active in the marketplace.

Encourage large business (over 100) to demand value for their money. Businesses all over America are changing the way medicine is practiced. And expand the choices for employees to at least three health plans that offer the standard benefit package.

Uncontrolled increases in entitlement spending threaten the nation and future generations.

Spending on our public programs, Medicare and Medicaid, is increasing at an alarming rate. We cannot continue this trend. We have concluded that the best way to control these costs is to take advantage of the successes in the private sector.

We recognize that Americans do not want a wholesale, disruptive change in the way they get health care services. Rather than change everything overnight, we lay the groundwork for the transition. Beneficiaries of these programs will get more options to select private health coverage rather than government-run programs.

Encourage private plans for Medicaid.

States have labored hard to improve their Medicaid programs. We do not want to abruptly shift all low income people into the emerging health care markets. There are too many uncertainties and unintended consequences to communities.

We believe we must support states' efforts to expand managed care plans for low income individuals, and fully expect that when the medical markets are up and running in every community, a subsidy program that allows individuals to buy private health plans can be accomplished.

More choice for Medicare beneficiaries.

Our bill recognizes that senior citizens are concerned about disruptions to the Medicare program. But, the Medicare Trust Fund is nearly bankrupt. We offer seniors a choice of private health plans in addition to traditional Medicare. We change the current payment rules for health plans to encourage them to offer seniors the same benefits that those under 65 will enjoy.

Deep cuts in the programs are not the solution. They harm doctors and hospitals, particularly in rural areas, and force working people to pay more if government doesn't pay its fair share. We should strive to move out of a government-run health care system.

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Major Components of Mainstream Agreement

The Mainstream agreement dramatically reduces insecurity and price unpredictability for the 220 million Americans who are currently insured or underinsured. Additionally, the Mainstream Coalition is committed to expanding coverage to the majority of Americans who currently have no insurance. The agreement ensures that Congress will vote on recommendations to achieve universal coverage if we're not there by 2002.

The agreement reduces health care costs through market-based system reform, rather than a regulatory approach. The agreement also locks in deficit reduction. It changes the rules for buying and selling health insurance plans. Consumers will become better purchasers by being able to compare quality and price information. It combines national insurance reform, voluntary cooperatives for small businesses and individuals, adjusted community rating, low income subsidies, and expanded tax deductibility to expand access to coverage without mandates.

All individuals, including Medicaid and Medicare beneficiaries, will be able to purchase private health plans.

The agreement includes a provision which removes the uncertainty from CBO estimates about the cost of health reform by putting in place a fail-safe mechanism to ensure that deficit reduction and cost containment goals will be met. In addition, the phase in of subsidies will be based on actual market experience rather that CBO projections.

INSURANCE REFORMS

GUARANTEED ACCESS:

All qualified health plans must:

* Guarantee issue to all applicants;
* Guarantee availability through the entire community-rating coverage area;
* Guarantee portability and renewal to all;
* Not deny, limit or condition coverage based on health status;
* No pre-existing conditions in open enrollment period;
* Age-adjusted community rating for all small firms (under 100) individuals and self-employed buyers (states define community rating coverage areas).

BENEFIT PACKAGES:

Consumers need the ability to compare health plans on the basis of cost and quality. The bill offers two benefit options, a standard and a basic (alternative standard) plan. The standard plan will include the 12 benefit categories with an actuarial value equivalent to FEHBP's Blue Cross/Blue Shield standard option plan. The basic package will have a lower actuarial value, with fewer benefits and/or high deductibles.

Congress defines and sets forth the standards for determination of medical necessity or appropriateness. The plans must provide all medically necessary or appropriate care within the benefit categories.

The National Health Benefits Board, like the Office of Personnel Management at FEHBP, will design the packages based on criteria set in law. The Board does not have regulatory authority .

ADMINISTRATIVE SIMPLIFICATION:

Implements a national health information network to reduce the burden of administrative complexity, paper work, and cost on the health care system; to provide the information on cost and quality necessary for competition in health care; and to provide information tools that allow improved fraud detection, outcomes research, and quality of care.

QUALITY:

All health plans must comply with insurance reforms and quality standards to ensure:

* quality improvement and assurance
* fair utilization management
* consumer protection and consumer information
* equal access for all enrollees

HHS will be advised by a Quality Council. Regional quality improvement will be supported through a demonstration project.

NATIONAL RULES:

All anti-competitive state laws, including laws that limit managed care, restrict corporate practice of medicine or impose benefit mandates are preempted, except as modified by this Act.

EMPLOYERS' RESPONSIBILITY

All employers must distribute comparative information and offer their employees a choice of 3 qualified health plans, including a point-of-service (POS) option or fee-for-service if available. Employers must provide for payroll deduction at the employee's request, but are not required to pay a portion of the employees health insurance premiums. Employers with fewer than 100 employees may join a purchasing cooperative in lieu of offering three plans. All firms employing more than 100 employees may negotiate rates or may self-insure.

Association Health Plans:

Grandfathers certain association health plans. Qualified association plans (QAP) must have covered at least 500 covered lives as of date of enactment. QAPs may enroll association members only.

Multiple Employer Welfare Arrangements (MEWA):

A MEWA must meet the standards for either a qualified association plan or a purchasing cooperative.

Rural Cooperatives:

Rural Electric Cooperatives and Rural Telephone Cooperative Associations are treated as large employers.

PURCHASING COOPERATIVES

The Mainstream agreement gives individuals and small employers the same purchasing power and economies of scale as large companies by allowing them to buy health insurance through purchasing cooperatives at an adjusted community rate.

States must establish community rating areas and certify purchasing cooperatives. Cooperatives are voluntary and private. They may serve multiple community-rating areas and more than one state. States will continue to have flexibility in establishing the types of purchasing cooperative arrangements that may exist (e.g., negotiating, multiple, or single).

Cooperatives do not assume risk, and do not have any regulatory authority. They must accept all individuals and small businesses in the community rating area they serve. They must enroll and administer health plans for individuals and employees of small businesses who wish to join.

The Mainstream agreement also grandfathers existing association purchasing cooperatives. Association cooperatives may serve more than one state, and may enroll only members of their association.

SUBSIDIES

LOW-INCOME:

The government would provide subsidies for premiums for individuals and families with incomes of up to 200% of poverty. A full premium subsidy would be extended to persons with incomes below the poverty line; that premium subsidy would become available once the bill became effective. A partial premium subsidy (the amount of the subsidy would decline as income rose) for persons with incomes between 100% and 200% of poverty; that subsidy would be phased in between 1997 and 2004. Subsidies would be available for pregnant women and children up to 18 years with incomes up to 240% of the federal poverty level. [The final subsidy levels are subject to CBO estimates.]

MIDDLE - INCOME::

The proposal makes health insurance more affordable for individuals without employer-provided health insurance and the self-employed by phasing in a 100% deduction for their health insurance premiums. The amount that may be deducted is limited in the same manner as is employer-provided health care.

FEDERAL HEALTH PROGRAMS

MEDICARE:

The Medicare fee-for-service is not changed. In addition, Medicare beneficiaries have expanded choices. Seniors and the disabled may choose the same qualified basic benefit package, offered through their employer or purchasing cooperative. The Medicare managed care program is improved to encourage more plan participation, including revision of federal payment to health plans to reflect market costs. Provides easy access to compare information and allows all Medicare beneficiaries access to all Medicare choices during an open enrollment period, regardless of health status.

MEDICAID:

Allows states to enroll Medicaid patients into managed care plans without applying for a federal Medicaid waiver. The proposal sets standards by which states may enter into contracts with managed care plans.

UNDERSERVED AREAS:

Competitive grants are authorized to develop community health groups, certified community health plans, community health networks, and provide capital assistance. The grants will help address geographic, financial and other barriers to health care services in underserved urban and rural areas. This section also authorizes rural health plan demonstrations to improve access to plans in rural areas, and a telemedicine program to assist rural providers with specialty consultation, continuing education, referrals, provider collaboration.

LONG TERM CARE

HOME AND COMMUNITY-BASED SERVICES

Establishes a new capped federal program for home- and community-based long term care services. This program will be administered by the states and will be limited to those with incomes below 150% of the federal poverty level. All persons with developmental disabilities are eligible for the benefit, however they will pay a sliding-scale cost-sharing up to 100% of costs for those with high incomes. The proposal also includes minor changes in the Medicaid home and community-based waivers to improve state administration. This proposal is paid for through an auto insurance offset.

TAX TREATMENT OF LONG-TERM CARE INSURANCE

The agreement makes it easier for individuals to deduct expenses for long term care and premiums for long term care insurance policies. In addition, employer-provided long term care is excluded from an employee's taxable income. Amounts paid out under a long term care insurance policy up to $150 per day would not be subject to federal income tax.

UNIVERSAL COVERAGE

The goal of the bill is that at least 95% of all Americans will have health care coverage by 2001. Every 2 years a Commission will issue a report that outlines who is uncovered and why, as well as how cost containment is working. If 95% coverage is not reached, the Commission must submit recommendations to Congress on how to achieve the goal. The Congress must vote on the recommendations, or propose alternatives, in an expedited legislative process that guarantees a Congressional vote.

FINANCING

The agreement raises additional revenues to finance health care reform by increasing tobacco taxes by $.45 a pack; extending the Medicare Hospital Insurance tax to all state and local employees; raising Medicare part B premiums for individuals with incomes over $75,000 and couples with incomes over $100,000; imposing a limitation on the deductibility of health insurance costs of high cost health plans; and other Medicare and Medicaid spending reductions.

COST CONTAINMENT

MARKET REFORMS:

Cost containment would be achieved through market reforms: changing the unfair insurance market; establishing adjusted community rating; establishing comparable benefit packages so consumers can compare price and quality; pre-empting anti-competitive state laws; reforming medical liability laws; and revising the tax code to promote cost-conscious buying of health care.

LIMIT ON DEDUCTIBILITY OF HEALTH CARE EXPENSES:

The agreement limits employer deductibility of standard or basic health insurance premium cost to 110% percent of the average in the community rated market. For experience rated plans, employers may choose to deduct the same amount as the community rated plans, or may deduct actual costs for 1997, and that amount is frozen in future years. This will create additional incentives for employers and employees to bring down the cost of their health plans through more efficient health care delivery. Beginning in the year 2000, supplemental insurance policies that cover copayments and deductibles under the standard or basic plans are non-deductible to the employer and taxable to the employee. All other supplementals are not subject to limits on deductibility and are excludable from income.

MALPRACTICE:

Limits non-economic damages in medical malpractice cases to $250,000. Within one year, an advisory committee will develop and recommend to Congress a sliding scale of limits for non-economic damages. In addition, requires non-binding ADR, with incentives to abide by ADR. Imposes limits on attorneys fees. 75% of punitive damages are deposited in a state fund for quality and discipline. Establishes several liability for non-economic and punitive damages. Does not preempt state laws to the extent such laws impose greater restrictions on attorneys fees or liability, or permit additional defenses to malpractice actions.

REMEDIES FOR CLAIMS DISPUTES:

All claims disputes are adjudicated by a neutral third-party, not affiliated with the health plan. Remedies are limited to the amount of the claim, and attorneys fees. In addition, health plans conducting preauthorization or utilization review are required to use reasonable care in making medical judgments.

A health plan that fails to use reasonable care may be liable for compensatory damages with a $250,000 cap on non-economic damages. A health plan is not liable if the claimant fails to use the third-party claims dispute process, or if the plan decision was upheld by a neutral third-party.

ANTI-FRAUD AND ABUSE CONTROL PROGRAM:

Requires the HHS Secretary and Attorney General to jointly establish and coordinate a national health care fraud program to combat fraud and abuse in government and private health plans. Monies from penalties, fines and damages assessed for health care fraud are dedicated to financing anti-fraud efforts. It also expands criminal and civil penalties for health care fraud to provide a stronger deterrent to the billing of fraudulent claims and to eliminate waste in our health care system resulting from such practices, and provides better guidance to health care providers (new safe harbors, interpretive rulings and special fraud alerts) to help them comply with fraud and abuse laws.

FAIL-SAFE:

The agreement protects against inaccurate cost estimates by adopting a "pay-as-you-go" mechanism. Automatic cuts in health care spending would be made if the expenditures otherwise authorized by the proposal exceeded projections. The automatic cuts would be targeted at new spending authorized by the bill--such as expanded subsidies and tax deductions--rather than existing health care programs. When savings from competition occur, they would be applied to the deficit.

It also requires the President to notify the country of the percentage of Federal taxes that are being spent -- each year -- on total Federal health care. For each year when total Federal health spending rises, Congress is required to report to the American people on the additional amount of Federal taxes that are attributable to Federal health care spending.

The agreement would achieve deficit reduction over the next ten years. The plan anticipates deficit reduction of $100 billion over this time frame. [The final deficit reduction amount is subject to CBO estimates.]

MAINSTREAM PLUS

SUMMARY

1. Overview:

No mandate

Phased-in individual based subsidies

tax on high cost health plans

Hard cap on Federal health spending

Pros
Starting small allows time to learn about how to manage insurance reforms
Solid fail-safe protection for the Federal budget
Subsidies are targeted very well to low income households
Minimizes job losses
Incentives are improved for insurers and patients

Cons
Will not achieve universal coverage
Very little private sector cost-containment
Medicare program savings and no expansion of benefits to the elderly
Limitation of Federal Medicaid payments could have adverse impacts on teaching hospitals
Premiums in the community rated pool are likely to be high due to adverse selection.

2. Coverage/Insurance Reforms:

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

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

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

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

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

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

Guaranteed renewability and limits on pre-existing condition exclusions.

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

3. **Subsidies:**

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

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

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

No cost-sharing subsidies.

4. **Benefit package:**

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

Under 200% of poverty cannot use subsidies for basic plan

5. **High cost plan assessment:**

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

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

6. Medicaid:

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

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

Growth in Federal payments is capped.

Disproportionate share payments are phased out by 2000.

7. Medicare:

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

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

No Medicare drug benefit or new long term care program.

8. Other Federal Programs

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

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

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

9. Tax incentives:

Phased in deduction of health insurance premium payments for individuals.

Deduction limited to average premium in each group.

10. Financing:

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

Medicaid and Medicare savings

Cigarette tax increased $1 per pack

Assessment on high cost plans

Postal Service savings

Medicare HI tax levied on State and local workers

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

Fiscal Summary

Changes from Baselines

($ Billions)

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

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

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

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

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

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline										
Medicaid	96.4	108.2	121.5	136.3	152.2	170.4	190.8	213.6	239.1	267.6
Medicare	158.1	176.0	194.0	213.1	235.5	260.8	289.1	321.1	357.0	397.9
Tax Expenditures	84.7	92.4	99.5	107.4	117.0	127.3	137.8	149.2	161.5	174.5
Baseline Total	339.2	376.6	415.0	456.8	504.7	558.5	617.7	683.9	757.6	840.0
Reform										
Low Income Voucher Program	0	0	30.2	49.5	62.4	75.2	87.0	96.3	103.2	109.9
Medicaid	96.4	105.6	114.0	123.0	132.0	141.6	155.2	170.0	186.0	203.4
Medicare	157.7	172.3	184.9	200.0	214.5	230.8	251.4	275.3	302.1	333.6
Tax expenditures	85.2	93.0	99.6	108.9	121.2	134.0	147.7	162.5	177.4	192.1
Reform Total	339.2	370.9	428.7	481.4	530.1	581.6	641.3	704.1	768.7	839.0
New Revenues										
Tobacco	-15.1	-14.1	-14.0	-13.9	-13.8	-13.7	-13.6	-13.5	-13.4	-13.3
High Cost Plans	0	0	- 1.1	- 1.7	- 1.9	- 2.1	- 2.3	- 2.6	- 2.7	- 2.9
Net Expected Surplus (-) or Shortfall (+)	-15.1	-19.8	- 1.4	+ 9.0	+ 9.7	+ 7.3	+ 7.7	+ 4.1	- 5.0	-17.2
Percent Insured	83-86%	82-87%	85-91%	86-92%	86-92%	86-92%	86-92%	86-92%	86-92%	86-92%

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

ISSUES AND POSSIBLE SOLUTIONS

1. Coverage:

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

2. Subsidies:

Issues	Possible Solutions
Subsidy schedule produces very high marginal tax rates.	Smooth it out by having the poor pay something.
Pegging the vouchers to the overall average (experience rated pool plus community rated pool) in a geographic area means that very low income individuals will have difficulty affording plans in the community rating area.	Tie the subsidies for each type of pool to the average premium in that type of pool. (We understand that this is now the policy. This implies that the subsidy estimates presented here are somewhat understated.)

3. Benefit Package:

Issues	Possible Solutions
Offering a basic and a standard package will lead to adverse selection and uncompensated care.	Limit access to basic plan to those above specified income levels (250% of poverty, for example). We understand that the policy is now at 200% of poverty.

4. High Cost Plan Assessment

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

5. Medicaid:

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

6. Medicare:

Issues	Possible Solutions
Proposal includes Medicare program reductions, but no fee-for-service benefit expansions. Some benefit expansions are available through managed care option.	Phase-in Medicare drug benefit as savings allow.
Unclear if Medicare Choice Act provisions are included in the final proposal. If included, achieving a 7% growth target by the year 2000 could lead to across-the-board reductions. This could lead to increased cost-shifting to the private sector.	Develop specific policies for reduction in spending.

7. Tax Incentives:

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

8. Financing:

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

MAINSTREAM FILE

UPDATE ON NEGOTIATIONS WITH MAINSTREAM GROUP

Resolved Issues:

- **Individuals Deduction.** Mainstream has agreed to drop this proposal.

- **Risk Adjustment.** We agreed to the mainstream's original position to risk adjust between community-rated plans. We also agreed to the Mainstream's new proposal to risk adjust between the community-rated pool and association plans, as well as large public employee plans. (See Insurance Reform, below.)

- **Malpractice.** We agreed to drop objections to (1) mandatory fee shifting (English rule) in ADR cases and (2) limits on several liability. Mainstream has agreed to drop cap on damages. State caps would be retained.

- **Insurance Reform.** We agreed to the mainstream proposal which sets the community rated level at 100.

  We agreed to accept the mainstream's original position that allows association plans to continue selling experience-rated and self-insured plans to their members but does not allow new plans to develop. The mainstream staff agreed to (1) several substantial modifications to the criteria for determining which associations will be grandfathered and (2) risk adjust association plans with the community-rated pool. We agreed to leave in place the 20 percent association plan growth limit in the mainstream bill.

  We also agreed to the mainstream's original position allowing large purchasing groups that serve public employees to continue offering experience-rated plans. As with association plans, we also agreed to risk adjust these large, public employee purchasing groups with the community-rated pool.

- **Federal Employees Health Benefits Program (FEHBP).** The mainstream staff agreed to our proposal that working individuals in the community-rated pool be allowed to take their employer's contribution (if any) for health care to any FEHBP plan in the area. We agreed to their modification of our proposal that employers be allowed to charge a reasonable administrative fee if an employee chooses an FEHBP plan not offered by the employer.

- **Outcomes and Quality Research.** The mainstream group has agreed to a 0.1 percent set-aside (out of the 0.6 total set-aside) for the Agency for Health Care Policy and Research.

- **Plans and HIPCs.** We can accept the mainstream approach.

Outstanding Issues:

- **State Flexibility.** The mainstream group has proposed an option which would amend ERISA to allow states to tax the employer, but not the employer's health plan. This would clarify the uncertainty which exists today for states with regard to taxing authority. This option would allow states to impose taxes of general applicability (a broad based tax) to finance their state health reform programs - for example, an income, payroll, privilege or sales tax. However, states will continue to be prohibited from imposing direct taxes on self-funded health benefit plans, or taxing only self-funded plans.

  While this is a step forward by the mainstream group, we believe it still will not allow Washington State to implement its reform because it does not appear to grant a mandate authority, and prohibits a premium tax. We are attempting to get clarification of these issues with regard to Washington and other states that have implemented state wide reforms today.

- **Medicare Outpatient Prescription Drug Benefit.** We have agreed to drop this as part of a package with lower medicare cuts and a Long Term Care benefit closer to Mitchell. Our staff is working on an appropriate level of medicare cuts.

- **Home and Community-Based Long Term Care Benefit.** We are still negotiating the level of the program, but have gotten them to agree in principle to increase towards the Mitchell level. The issue of means testing remains unresolved with little flexibility on the part of the senior groups. Our staff is working on that issue today. AARP is opposed to means testing a program that is funded with Medicare cuts. It undermines the concept of social insurance and asks the upper income beneficiaries to pay more for Part B while precluding them from benefitting from the long term care benefit.

  On insurance standards, the mainstream group has made no significant movement toward the consumer protections included in the Mitchell provision.

- **Fail-Safe.** We continue to oppose sequester of low income subsidies to offset unanticipated cost increases in the Medicare program. As an alternative, the mainstream group has suggested that unanticipated increases in Medicare be offset through sequester of the Medicare program itself. This is not acceptable. While we support the concept of having this ***new*** program pay for itself, expanding the fail-safe to cap spending in the ***existing*** Medicare program goes well beyond that concept. Under the Mitchell bill, changes in Medicare spending which were related to health care reform were included in the calculation of an overage, but Medicare changes which were unrelated to health care reform were not included. This bill should not be used as an excuse to cap the Medicare program.

- **Limit on Tax Deductibility and Employer Deductions/Employee Exclusion for Cost-Sharing Supplemental.** No resolution has been reached on mainstream proposals to (1) limit employer deduction to plans that cost no more than 110 percent of average in community rated area; and (2) to deny deduction for employers and exclusion for employees in the case of supplemental cost sharing benefits.

- **Underserved/Public Health.** The mainstream group continues to oppose new mandatory spending. Senator Kennedy will meet with mainstream to discuss.

- **Benefit Package/Role of the Health Board.** We have agreed on three standardized benefit packages (Standard, Catastrophic and Basic) that will differ in actuarial value. A congressionally-appointed Benefit Commission will establish cost sharing schedules within each package and will decide which categories of services to offer in the Basic Package, which will be embodied in implementing legislation for Congressional action on a fast track. If Congress fails to pass the Commission's recommendations, health reform could not be carried out because there would be no standardized benefit packages.

  As a compromise, we recommend that: (1) Congressional implementing language be limited to change in benefit categories and actuarial value of the standard benefit package; (2) the Commission develop criteria for defining medical necessity or appropriateness, rather than defining these terms in legislation.

- **Workforce/Graduate Medical Education.** The Mainstream establishes a 0.6 percent premium assessment for graduate medical education and health research. It also creates a commission to make recommendations on workforce reform for fast-track Congressional approval. We have not resolved the issue of whether funds should be earmarked for primary care. Under the mainstream bill, expanded funding starts even if Congress does not approve the commission's workforce recommendations and there is no mention of a goal to increase primary care residencies to 55 percent.

  As a possible compromise, we recommend that: (1) Expanded all-payer funding for graduate medical education be contingent on Congressional passage of a health professions workforce policy developed by a congressionally-appointed Commission; and (2) the Commission be directed to consider steps to increase primary care physician residencies to 55 percent of federally supported positions, and to bring the overall number of residency positions closer to the number of American medical school graduates.

- **State Preemption of Insurance Reforms.** We will be discussing (and hopefully resolving) our differences with mainstream staff.

Cost containment Alt: Trigger

POSSIBLE REVERSE TRIGGER APPROACHES

Goals

- To avoid windfall payments to providers or insurers related to uncompensated care and Medicaid.
- To provide an opportunity for competitive forces to achieve cost containment goals.
- To minimize federal budgetary risk.

Determining "Competitive" and "Non-Competitive" Areas

- Prior to the beginning of the first year of reform, health plans provide community-rated premium bids for the guaranteed package of benefits.
- Based on these premium bids, geographic areas (e.g. alliance areas, or community rating areas) are classified as "competitive areas" or "non-competitive areas."
  - **"Competitive areas"** are those areas where the health plan premium bids demonstrate the area's ability to avoid windfall payments to providers or insurers through competitive forces alone.

    Specifically, a competitive area is one where the weighted average premium bid (based on projected enrollment) is less than the pre-established premium target for the area (or possibly within a small corridor above the target).
  - **"Non-competitive areas"** are those areas where the health plan premium bids *do not* demonstrate the area's ability to avoid windfall payments to providers or insurers through competitive forces alone.

    Specifically, a non-competitive area is one where the weighted average premium bid (based on projected enrollment) is *greater* than the pre-established premium target for the area (or possibly greater than the target plus a small corridor).

"Reverse Trigger"

- **Non-competitive areas.** A "reverse trigger" mechanism applies in non-competitive

areas. In these areas, a back-up mechanism is necessary to avoid windfall payments. In these areas, premiums caps would apply beginning in the first year of reform. Caps would sunset after three years (a "reverse trigger"), when a "retrospective trigger" mechanism would apply (see below).[1]

- **Competitive areas.** Premium caps do not apply at all in competitive areas. Since competitive areas demonstrated ability to avoid windfall payments, caps are not necessary in these areas. However, a "retrospective trigger" mechanism applies after the first year of reform to ensure appropriate growth in federal subsidy payments (see below).

<u>"Retrospective Trigger"</u>

- A "retrospective trigger" mechanism applies in competitive areas, and in non-competitive areas after the three year sunset of premium caps.

- The retrospective trigger would not seek to constrain premium increases. Its only goal is to ensure that federal payments for subsidies grow at an appropriate rate.

- There are a number of ways to structure a retrospective trigger. One approach is as follows:

  - If the average premium in an area exceeds the premium target for that area, it means that federal payments for subsidies are also higher. The excess federal subsidy payments are recouped in the following year.

  - In the following year, the federal government reduces the subsidy payments to the area (e.g. to the alliance, the state, or the "clearinghouse) by any excess payments from the previous year due to higher than targeted premium levels.

  - The reduced federal payments for subsidies are compensated for by reducing overall payments to health plans.

    The reduced payments to plans could be targeted at: (1) High cost plans (i.e. a payment reduction equal to a percentage of the difference between a plan's prior year premium and the premium target for that year); (2) High growth plans (i.e. a payment reduction equal to a percentage of the

[1]There are alternative ways of describing premium caps that may be more consistent with the approach described here. For example, the mechanism could be described as a bidding process where plans whose bids are excessive are accepted only if they lower their bids.

difference between a plan's premium *increase* and the targeted increase for the area); or (3) Some combination of the two.

- For health plans subject to payment reductions, payments to providers would, in turn, be reduced through a process similar to the Health Security Act.

- Under this approach, employers and families pay based on unconstrained premium bids. However, federal subsidy payments to an area (and, ultimately, to plans) are based on constrained levels.

- A state could be permitted (at its option) to make up the higher subsidy costs instead of triggering health plan payment reductions.

- A retrospective trigger mechanism could be somewhat disruptive if very large payment reductions are necessary. This could be addressed by automatically activating premium caps in an area if large payment reductions are necessary under the retrospective trigger.

LONG-TERM CARE

POLITICAL CONTEXT

- ACHIEVING FINANCIAL PROTECTION AGAINST THE COSTS OF LONG-TERM CARE IS THE TOP PRIORITY FOR SOME OF THE MOST INFLUENTIAL ADVOCATES FOR HEALTH REFORM -- OLDER AMERICANS AND PERSONS WHO ARE DISABLED.

- OVERALL PROMISE OF "SECURITY" CANNOT BE MET FOR THESE GROUPS WITHOUT SIGNIFICANT LONG-TERM CARE PROTECTION AND THEY WILL VOICE THEIR DISPLEASURE IF IT IS NOT INCLUDED.

- DURING THE CAMPAIGN, THE PRESIDENT PROMISED BOTH THE SENIOR POPULATION AND WORKING-AGED PEOPLE WITH DISABILITIES ESSENTIALLY A SOCIAL INSURANCE APPROACH TO LONG-TERM CARE -- THAT IS, THE GRADUAL EXPANSION OF MEDICARE.

- SENIOR AND DISABILITY ORGANIZATIONS SEE HEALTH REFORM AS THE "WINDOW" FOR ATTAINING LONG-TERM CARE; IT'S VIEWED AS A "NOW OR NEVER" PROPOSITION.

- WITHOUT ADEQUATE LONG-TERM CARE BENEFITS, THE REFORM PROPOSAL WILL NOT GET SUPPORT (AND MAY GET OPPOSITION) FROM SENIOR OR DISABILITY GROUPS; LOSING THAT SUPPORT PUTS OUR ENTIRE GRASS ROOTS EFFORT IN JEOPARDY.

LONG TERM CARE

POLICY RESPONSE

- LONG-TERM CARE IS BADLY NEEDED BUT VERY EXPENSIVE. A FULL SOCIAL INSURANCE BENEFIT FOR CARE AT HOME AND IN NURSING HOMES IS ESTIMATED TO COST $60 BILLION A YEAR IN 1994 DOLLARS.

- A COMMITMENT TO FULL SOCIAL INSURANCE EXCEEDS OUR WILLINGNESS AND CAPACITY TO SPEND. HOWEVER, A SIGNIFICANT AND AFFORDABLE START CAN BE MADE WITHOUT CREATING AN OPEN-ENDED ENTITLEMENT.

- PRIMARY ATTENTION SHOULD GO TO CARE AT HOME AND IN THE COMMUNITY -- WHERE MOST DISABLED LIVE AND WANT TO STAY.

- PRIVATE INSURANCE, ALONGSIDE PUBLIC PROGRAMS, HAS A SIGNIFICANT ROLE TO PLAY IN PROVIDING ADEQUATE PROTECTION.

LONG-TERM CARE POLICY OPTIONS
OVERVIEW

- TWO OPTIONS FOR A LONG-TERM CARE INITIATIVE WERE INCLUDED IN THE COST ESTIMATES PRESENTED WITH BENEFIT PLANS A AND B. THE PRIMARY DIFFERENCE BETWEEN THEM IS THE **SCOPE OF FINANCIAL ELIGIBILITY** FOR THE HOME CARE BENEFIT. (OTHER ELEMENTS OF THE TWO OPTIONS ARE THE SAME.)

OPTION A WOULD PROVIDE HOME CARE BENEFITS ONLY TO PEOPLE **UNDER POVERTY** WITH SEVERE DISABILITIES. (NET FEDERAL COST IN 2,000: $9.3 BILLION IN CONSTANT 1994 DOLLARS, INCLUDING PARALLEL PROGRAM FOR THE DISABLED POPULATION -- MR/DD).

- A MEANS-TESTED BENEFIT SUCH AS THIS WILL NOT BE ACCEPTED BY SENIOR AND DISABILITY GROUPS AS THE COMMITMENT AND SECURITY THEY EXPECT AND DEMAND FROM HEALTH REFORM.

- THIS OPTION WOULD LOSE THE SUPPORT OF THESE GROUPS AND QUITE POSSIBLY FORCDE THEM TO OPPOSE HEALTH REFORM.

OPTION B WOULD PROVIDE HOME CARE BENEFITS TO **ALL** PERSONS WITH SEVERE DISABILITIES **WITHOUT REGARD TO INCOME** (NET FEDERAL COST IN 2000: $21.1 BILLION IN CONSTANT 1994 DOLLARS)

- THIS APPROACH, THOUGH STILL SHORT OF THE FULL-SCALE SOCIAL INSURANCE SENIORS ARE SEEKING AND SCALED IN AT A SLOWER RATE THAN THEY WANT, REPRESENTS A SIGNIFICANT START ON LONG-TERM CARE.

- CONSULTATIONS WITH AARP INDICATE THAT ANYTHING MUCH LESS THAN THIS OPTION WILL MAKE IT IMPOSSIBLE TO GARNER GRASS ROOTS OR ORGANIZATIONAL SUPPORT.

- UNFORTUNATELY, EVEN WITH THE TOBACCO TAX ON TOP OF OUR ASSUMED MEDICARE SAVINGS, IT IS NOT COST NEUTRAL TO THE MEDICARE PROGRAM.

LESS COSTLY ALTERNATIVES TO OPTION B

- THE CHALLENGE IS TO DELIVER ON A PACKAGE OF LONG-TERM CARE AND PRESCRIPTION DRUG BENEFITS THAT ARE MINIMALLY ACCEPTABLE TO AGING ADVOCATES AND THAT CAN BE PAID FOR BY MEDICARE SAVINGS AND A TOBACCO TAX.

- THE ATTACHED TABLES ILLUSTRATE TWO OPTIONS THAT BRING THE COST OF THE LONG-TERM CARE AND PRESCRIPTION DRUG BENEFIT PACKAGES TO A LEVEL THAT IS, OR IS VERY CLOSE TO, COST NEUTRAL. (TABLE 1 DOCUMENTS THE COSTS OF THE OPTION B PACKAGE, WITHOUT ANY MODIFICATIONS TO THE LONG-TERM CARE PACKAGE THAT WAS PRESENTED LAST WEEK).

- THE BENEFITS BECOME MORE AFFORDABLE AS A RESULT OF:

  -- A 5-YEAR PHASE-IN (THE PREVIOUS ESTIMATE STARTED AT A HIGHER LEVEL AND PHASED IN OVER 3 YEARS);

  -- THE COUPLING OF THE MODIFIED LONG-TERM CARE WITH A LESS GENEROUS PRESCRIPTION DRUG BENEFIT THAN OTHERWISE PROPOSED; AND

  -- DEDICATING REVENUES FROM A CIGARETTE TAX TO COVER THE REMAINING LONG-TERM CARE COSTS.

- THE ONLY DIFFERENCE BETWEEN TABLE 2 AND TABLE 3 IS:

  -- TABLE 2 HAS THE MODIFIED LONG-TERM CARE BENEFIT OUTLINED ABOVE AND A PRESCRIPTION DRUG BENEFIT WITH A $250 DEDUCTIBLE AND A 20 PERCENT COPAYMENT WITH A $1,000 CAP. (THIS IS LESS GENEROUS THAN THE BENEFIT ASSUMED IN TABLE 1)

  -- TABLE 3 HAS THE SAME MODIGIED LONG-TERM CARE BENEFIT WITH A DRUG BENEFIT WITH A $250 DEDUCTIBLE AND A 40 PERCENT COPAYMENT UNTIL AN $800 DEDUCTIBLE IS REACHED. AT THAT TIME, A 20 PERCENT COPAYMENT REPLACES THE 40 PERCENT COPAYMENT. AND, AS WITH TABLE 2, THERE IS A $1,000 OUT OF POCKET CAP.

Table 1. MEDICARE SAVINGS AND NEW PROGRAM COSTS, BILLIONS OF DOLLARS ORIGINAL BUDGET ESTIMATES

	94	95	96	97	98	99	00
Medicare Savings without short-term private cost controls*	0	-6	-10	-12	-14	-20	-26
Medicare Savings with short-term cost controls**	-3	-2	-4	-6	0	0	0
Medicare Drug Package	0	0	16	17	19	21	23
LTC Package	0	0	11	16	20	20	21
Net without controls	0	-6	17	21	25	21	18
Net with controls	-3	-8	13	15	25	21	18

* Options provided by HHS

** Assumes 6% growth in costs per enrollee through 1997. These savings are in addition to the ones without short-term controls.

Medicare drug benefit assumes $50 deductible, 40% copayment, $1000 out of pocket cap, without Medicaid drug pricing policy. Costs grow at private sector baseline.

Table 2. MEDICARE SAVINGS AND NEW PROGRAM COSTS, OPTION 2, BILLIONS OF DOLLARS

	1994	1995	1996	1997	1998	1999	2000
Medicare Savings without short-term private cost controls*	0	-6	-10	-12	-14	-20	-26
Medicare Savings with short-term private cost controls**	-3	-2	-4	-6	0	0	0
Modified Medicare Drug Package	0	0	13	14	15	16	17
Modified LTC Package	0	0	5	9	14	18	23
Net without controls***	0	-6	8	11	15	14	14
Net with controls	-3	-8	4	5	15	14	14

* Options provided by HHS

**Assumes 6% per enrollee costs through 1997. These savings are in addition to those without short-term cost controls.

***Net Medicare spending would be zero, or contribute to deficit reduction in 1996, if accompanied by a cigarette tax. Out year deficit impact is dependent upon outyear growth in revenue

Medicare drug benefit includes $250 deductible, with 20% coinsurance and $1000 out of pocket cap.

Table 3. MEDICARE SAVINGS AND NEW PROGRAM COSTS, OPTION 3, BILLIONS OF DOLLARS

	94	95	96	97	98	99	00
Medicare Savings without short-term private cost controls*	0	-6	-10	-12	-14	-20	-26
Medicare Savings with short-term cost controls**	-3	-2	-4	-6	0	0	0
Modified Medicare Drug Package 3	0	0	8	9	10	11	11
Modified LTC Package	0	0	5	9	14	18	23
Net without controls***	0	-6	3	6	10	9	8
Net with controls	-3	-8	-1	0	10	9	8

*Options provided by HHS

**Assumes 6% growth in per enrollee costs through 1997. These savings are in addition to those without short-term cost control.

***Net Medicare spending would be zero, or contribute to deficit reduction if accompanied by cigarette tax in 1996.

Modified drug package assumes $250 deductible, with 40% coinsurance; once copayments reach $800, coinsurance rate falls to 20%. Out of pocket cap set at $1000.

HOME AND COMMUNITY-BASED CARE
OPTION A

THIS PROGRAM PROVIDES FEDERAL LONG-TERM CARE/PERSONAL ASSISTANCE FINANCING, TARGETED ON DISABLED PERSONS WITH LOW INCOMES. ITS COMPONENTS:

- NEW CLOSED-ENDED PROGRAM OF HOME AND COMMUNITY-BASED PERSONAL ASSISTANCE SERVICES **FOR SEVERELY DISABLED PEOPLE OF ALL AGES WITH INCOMES BELOW 100% POVERTY**

  --STATE FLEXIBILITY IN DESIGNING AND ADMINISTERING BENEFITS

  --BUDGET BASED ON ESTIMATED ELIGIBLES AND INCREASED ANNUALLY BASED ON INFLATION AND GROWTH IN DISABLED POPULATION

  --FEDERALLY FUNDED, WITH MATCH BASED ON STATE MAINTENANCE OF EFFORT

  --RESIDUAL MEDICAID FOR PERSONS WITH LESS SEVERE DISABILITIES

- NEW CLOSED-ENDED PROGRAM FOR INSTITUTIONAL AND COMMUNITY-BASED SERVICES FOR PEOPLE WITH MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES (MR/DD)

HOME AND COMMUNITY-BASED CARE
OPTION B

THIS PROGRAM EXPANDS PUBLIC COVERAGE FOR HOME AND COMMUNITY-BASED CARE WITHOUT REGARD TO FINANCIAL STATUS.

- NEW CLOSED-ENDED PROGRAM OF HOME AND COMMUNITY-BASED AND PERSONAL ASSISTANCE SERVICES **FOR SEVERELY DISABLED PERSONS OF ALL AGES, WITHOUT REGARD TO INCOME**.

  --STATE FLEXIBILITY IN DESIGNING AND ADMINISTERING BENEFITS

  --BUDGET BASED ON ESTIMATED ELIGIBLES AND INCREASED ANNUALLY BASED ON INFLATION AND GROWTH IN DISABLED POPULATION

  --INCLUDES MR/DD POPULATION (WHO PREFER EQUAL TREATMENT IN NON-MEANS-TESTED PROGRAM)

- TO PROVIDE SOME LEVEL OF ENTITLEMENT WITHIN CAPPED PROGRAM:

  --ALL ELIGIBLES ENTITLED TO CORE BENEFIT OF $500 PER MONTH IN SERVICES

  --ADDITIONAL SERVICES ALLOCATED AS NEEDED, ON FUNDS-AVAILABLE BASIS

- 20% COPAYMENT REQUIRED FOR BENEFICIARIES WITH INCOMES ABOVE 150% POVERTY

- $20 MONTHLY PREMIUM FOR SENIORS WITH INCOMES ABOVE 150% POVERTY

ADDITIONAL BENEFITS

IN BOTH OPTIONS 1 AND 2

ENHANCED MEDICAID NURSING HOME PROTECTION:

- INCREASED MEDICAID ASSET PROTECTION FOR SINGLE PEOPLE FROM $2,000 TO $12,000

- INCREASED MONTHLY PERSONAL INCOME ALLOWANCE FORM $30 TO $100

- REQUIREMENT THAT ALL STATES ALLOW PERSONS WITH INCOMES GREATER THAN ELIGIBILITY STANDARDS TO "SPEND DOWN"
  (13 STATES NOW PROHIBIT THIS)

- STATE OPTION TO PROVIDE ADDITIONAL MEDICAID ASSET PROTECTION TO PERSONS WHO HAVE PURCHASED A QUALIFIED LONG-TERM CARE INSURANCE POLICY

INCENTIVES TO ALLOW WORKING-AGED DISABLED TO ENTER OR REMAIN IN THE WORK FORCE:

- TAX CREDIT FOR PERSONAL ASSISTANCE EXPENSES EQUAL (50% UP TO $7,500)

ENCOURAGEMENT OF PRIVATE LONG-TERM CARE INSURANCE:

- PREFERRED TAX TREATMENT FOR PREMIUMS AND SPENDING ON LONG-TERM CARE, AS FOR MEDICAL SERVICES

- CONSUMER PROTECTION STANDARDS FOR INSURANCE MARKETING PRACTICES AND POLICY CONTENT

OFFER LIMITED PUBLIC LONG-TERM CARE INSURANCE POLICY ($30,000) FOR PEOPLE OF MODEST MEANS:

- ONE-TIME OPTION TO PURCHASE AT AGE 65

- 3-YEAR WAITING PERIOD TO AVOID ADVERSE SELECTION

- ESTIMATED PREMIUM: $60-$70 PER MONTH (NO FEDERAL SUBSIDIES)

AARP

Bringing lifetimes of experience and leadership to serve all generations

Mitchel Levitas, Op-Ed Page Editor
New York Times
229 West 43rd Street
New York, NY 10036

Dear Mr. Levitas:

When it comes to deciding whether to purchase a private long-term care insurance policy: Buyer beware. Despite recent improvements in policies and new plans in Connecticut and New York that sound good at first glance, we remain concerned that "the large print giveth and the small print taketh away."

We were disappointed by the inaccuracies in your recent editorial regarding the admittedly very complex and confusing New York long-term care insurance plan. [March 1 -- "Shielding the Elderly From Bankruptcy"]. For example, it is simply not true that "premiums won't change as long as the policyholder retains the policy." Premiums can increase, especially if less than the estimated number of policyholders end up dropping the policy. According to the U.S. General Accounting Office, insurance companies assume when pricing their policies that, on average, about 60 percent of the policies sold will be dropped within ten years after purchase. If significantly less than 60 percent drop their policy, companies are likely to increase premiums on those who keep their policy. If a policy is dropped, companies generally keep all the premiums that had been paid in while the policyholder would receive nothing for his investment.

In addition, it is misleading to state that "If the customer should later enter a nursing home and stay beyond three years, Medicaid will pick up the tab..." Since the plan does nothing to make it easier to meet Medicaid's stringent income eligibility test, benefits of a waived asset test may be largely illusory. Protecting assets which generate income for several additional years could, ironically, make it even more difficult to qualify for Medicaid.

Your editorial properly points out that the asset protection feature is not portable and that the plan may not save money (some experts believe that over the long run it will cause Medicaid expenditures to increase). One should also keep in mind that, on average, a 65-year-old purchaser will not need long-term care services for almost 20 years. Given the prospects for comprehensive health care reform at the national level, together

with New York's continuing proposals to cut Medicaid, particularly in the home care area, the Medicaid program is likely to look very different in 20 years, if it exists at all.

These and other concerns lead us to conclude that for many Americans these long-term care asset protection policies are not a good buy. For those who want the insurance protection, we urge extreme caution -- read the fine print and be sure that you understand what you are buying before spending several thousand dollars on a policy that may not deliver on what it promises.

Ultimately, AARP believes that a social insurance program, like Medicare and Social Security, where everyone is protected is a far better way to address the need to make long-term care available and affordable to those who need it. Meaningful private insurance protection is simply unaffordable to the vast majority of Americans. We continue to hope that the President's health care reform proposal will provide true peace of mind for all Americans that a family member's need for long-term care will not wipe out their life savings.

Sincerely,

Horace B. Deets

Managed Competition

H.R. 5936 "Managed Competition Act of 1992"
Introduced by Reps. Cooper (TN), Andrews (TX) and Stenholm (TX)

Overview: This bill would guarantee universal access to affordable health care coverage, relying on a system of managed competition. Through tax incentives, providers and insurance companies would be encouraged to form health partnerships to deliver quality, cost-effective health care. Each State would be required to have at least one Health Plan Purchasing Cooperative (HPPC) which would enter into agreements with Accountable Health Plans to offer a uniform benefit package. A uniform package of effective benefits would be offered to small employers and individuals through HPPCs. Unlike other managed competition models, there is no employer or individual mandate.

Coverage: Universal access to affordable health care coverage would be attained by allowing small employers and individuals to purchase a health care policy through a HPPC. The Medicaid program would be repealed. All individuals below 200% of poverty would be enrolled in a HPPC. Premiums, copayments and deductibles would be paid for under the new federal program for all individuals below 100% of poverty. A Federal subsidy would be provided to individuals between 100% and 200% of poverty to help pay their premiums and copayments.

Benefits: The National Health Board would develop a uniform set of effective treatment benefits, including preventive services which must be approved by Congress. The Board could exclude treatments that have not been proven effective. An enhanced benefit package including prescription drugs, eyeglasses and hearing aids would be available for low-income individuals. Copayments and deductibles would be required.

Quality: The National Board would be required to establish minimum quality standards. Providers would be required to report medical outcomes and consumers would be provided information on the quality of care provided in a plan.

Cost Containment: Cost restraint is built into the system through cost conscious consumer choice, competition between health plans, reduced administrative overhead, limitations imposed on the tax treatment of employer provided health benefits, and specification of effective treatment benefits.

Financing: The bill would eliminate the limit on income which is subject to the Medicare HI tax, cap deductibility of health plan expenses at the price of the lowest health plan, impose a 34% excise tax on employers or individuals who purchase an enhanced benefit package and redirect Federal Medicaid spending.

Status: HR 5936 was introduced in the 102nd Congress and had 19 cosponsors. It has not been reintroduced in this Congress. Blue Cross/Blue Shield, the American Hospital Association and American Healthcare Systems were strong supporters of Mr. Cooper's bill.

	Clinton	HR 5936 Cooper
1. Goals/Coverage	Universal access achieved through expanded employer-based insurance and state administered regional health alliances.	Access improved through State Health Purchasing Cooperatives, but universal access not guaranteed.
	Medicare remains in place and expanded.	Similar
	Medicaid incorporation phased-in;	Similar
	FEHB incorporated;	No provision
	VA incorporated for vets;	No Provision
	CHAMPUS /DOD study;	No Provision
	IHS remains in place and expanded.	No Provision
2. Benefits	Three (3) options available: fee-for-service, network & HMO.	Similar
	Guaranteed benefits package include: hospital and physician services; preventive care services; mental health (w/ limits phased-in; vision and hearing for kids; preventive dental for kids (phased-in for adults); Rx drugs w/ separate cost-sharing; limited long-term home care services through separate program (with phase-in expansion).	Benefit package to be determined by Natl.Health Bd. to include at min. hospital, physician and prevention services
	Fee for service cost sharing incl. $250 deductible & 20% copay, $3000 out-of-pocket limit; No cost sharing for preventive services. Lower cost-sharing in managed care plans.	Cost sharing required of all individuals. Natl. Bd. determines copays and deductibles. No cost sharing for individuals under 100% of poverty; 100%-200% of poverty cost sharing subsidized.
3. State Role	Federal program administered by States. States given flexibility to meet Federal requirements. State option includes establishment of a single payer system, an alternative delivery system w/ multiple plans or an all payer system w/ multiple plans.	Federal program administered by States. States have no authority to set rates or adopt a single payer system.
	Within Federal guidelines States must:	
	▸ establish alliances;	same
	▸ assure enrollment & access to care for its residents;	same
	▸ regulate plans, incl. financial standards, risk adjustment system, & quality standards;	similar requirement for Natl.Bd.
	▸ provide for data/information systems;	same
	▸enforce budgets after a transition.	No provision

	Clinton	HR 5936 Cooper
4. Cost Containment	The national health board will set a national per capita budget target for health care based on current health care spending.	No provision
	The Board will set annual allowable premium increases equal to GDP -1%.	No provision
	The allowable increase will be adjusted for each alliance to reflect any changes in the demographics of the alliance during the previous year.	No provision
	State budgets allocated according to geographic adjustment factors. Federal funds to States for low-income subsidies.	No provision
	Payments to providers are negotiated by plans, except that provider payment limits are one tool available to States/Feds to enforce budget.	Payments to providers are negotiated by plans.
	During years 1-3 the federal government assumes responsibility for enforcement of alliance budgets, thereafter the states will enforce the budgets.	No provision
	Tax deductibility for basic benefit plan.	Limits tax deductibility for employers and individuals to 100% of lowest cost plan.
5. Employer Financing	Employer must contribute 80% of the cost of employees coverage (contribution not to exceed 7.6% of employee wages).	No provision
	Small low-wage firms employer contribution capped at 3.2% (depending on size and average wage level).	No provision
6. Other Financing	Employees pay up to 20% of avg. premium in regional health alliance	Individuals pay full premium with subsidy for low-income.
		No provision
		No provision
		No provision
	Cigarette tax.	No provision
	No Provision	Eliminates limit on income subject to Medicare HI tax; caps employer, employee deductibility to 100% of lowest health plan; imposes 34% excise tax for excessive benefit pkg; redirects Medicaid spending

Managed Competition FH

LET COMPETITION WORK TO BRING UNIVERSAL COVERAGE

MANAGED COMPETITION THEORY NEVER ASSUMED THAT UNIVERSAL COVERAGE COULD BE ACHIEVED THROUGH MARKET MECHANISMS. THE JACKSON HOLE GROUP ADVOCATED EMPLOYER MANDATES TO ACCOMPLISH THIS GOAL.

MANAGED COMPETITION IS DESIGNED TO HOLD DOWN THE GROWTH IN HEALTH CARE COSTS THROUGH A RESTRUCTURING OF THE MARKET WHICH HAS THE FOLLOWING CHARACTERISTICS.

- STANDARDIZES THE BENEFIT PACKAGE SO THAT INSURANCE BUYERS CAN COMPARISON SHOP

- REPLACES FEE-FOR-SERVICE MEDICINE WITH INTEGRATED HEALTH PLANS BIDDING A YEARLY PREMIUM TO PROVIDE THE STANDARD BENEFITS PACKAGE TO FAMILIES

- REMOVES THE TAX DEDUCTIBILITY OF HEALTH INSURANCE FOR PURCHASES MADE ABOVE THE LOW COST PLAN IN AN AREA TO PROVIDE INCENTIVES FOR PURCHASERS TO BUY THE LOW COST PLAN

- FORMS HEALTH PURCHASING COOPERATIVES BY REQUIRING ALL SMALL EMPLOYERS (UNDER 1,000 WITH STATE OPTION FOR 10,000 IN THE ORIGINAL COOPER BILL - 100 IN THE NEW BILL), GOVERNMENT WORKERS, SELF EMPLOYED PEOPLE AND NON-WORKERS TO JOIN A LARGE COMMUNITY POOL

LET COMPETITION WORK TO BRING UNIVERSAL COVERAGE (CONT'D.)

- COMMUNITY RATES THE POOL AND DISSEMINATES REPORTS ON HEALTH PLAN QUALITY SO THAT COMPETITION WOULD OCCUR AMONG PLANS BASED ON QUALITY AND PRICE NOT ON RISK SELECTION AS IS THE CASE TODAY

- PROVIDES SUBSIDIES TO LOW-INCOME PEOPLE TO MAKE INSURANCE AFFORDABLE

FEW REALLY BELIEVE THAT COMPETITION WILL BRING INCREASED COVERAGE

THE COOPER/BREAUX BILL CONTENDS THAT REFORMS THAT RESTRUCTURE THE HEALTH CARE MARKET WILL MAKE INSURANCE MORE AFFORDABLE AND THEREFORE, INCREASE COVERAGE.

NEITHER CBO NOR LEWIN NOR THE ADMINISTRATION HEALTH POLICY TEAM BELIEVE THAT COMPETITION AND INSURANCE REFORMS WILL INCREASE COVERAGE SIGNIFICANTLY. THE GENEROUS SUBSIDIES PROVIDED TO LOW-INCOME PEOPLE, WE ALL AGREE, WILL ENCOURAGE MANY TO BUY INSURANCE.

CBO AND LEWIN ESTIMATE THAT UNDER COOPER/BREAUX, THE NUMBER OF PEOPLE WHO AT SOME TIME DURING THE YEAR WILL BE UNINSURED WILL DROP FROM 58 MILLION TO 35-40 MILLION.

- ALMOST ALL OF THE NEWLY INSURED WILL BE UNDER THE POVERTY LEVEL DUE TO SUBSIDIES THAT COVER ALMOST THEIR ENTIRE PREMIUM

- VERY FEW PEOPLE ABOVE 150% OF POVERTY WILL GAIN INSURANCE. IN FACT, 8 MILLION PEOPLE, PRIMARILY WORKING MIDDLE CLASS PEOPLE, WHO NOW HAVE INSURANCE WILL BE DROPPED.

TO ACHIEVE THIS MODEST INCREASE IN COVERAGE HAS A HUGE PRICE TAG. CBO ESTIMATES THAT THE COOPER/BREAUX APPROACH IS SHORT BY OVER $200 BILLION OVER THE NEXT 5 YEARS AND OVER $300 BILLION OVER THE NEXT 10 YEARS.

FEW REALLY BELIEVE THAT COMPETITION WILL BRING INCREASED COVERAGE (CONT'D.)

IF THE PROPOSAL DID NOT INCLUDE A TAX ON BENEFITS ABOVE THE LOW-COST PLAN, THE SHORTFALL WOULD BE EVEN HIGHER -- OVER $400 BILLION OVER 10 YEARS.

TRIGGER PROPOSALS

SOME HAVE PROPOSED TRIGGERS TO LET COMPETITION WORK AND THEN ENFORCE A MANDATE IF COMPETITION FAILS. "TRIGGER" PROPOSALS, HOWEVER, RUN THE RISK OF INCREASING THE NUMBER OF THE UNINSURED, DIMINISHING COVERAGE FOR THE CURRENTLY INSURED, AND INCREASING THE AMOUNT SOME PEOPLE PAY FOR HEALTH CARE.

TO MINIMIZE THESE RISKS REQUIRES POLICIES THAT DILUTE COMPETITION:

- REPLACING ONE STANDARD BENEFIT PACKAGE WITH AT LEAST TWO. ONE STANDARD BENEFIT PACKAGE WOULD RAISE THE COST FOR BUSINESSES THAT CURRENTLY INSURE BUT OFFER A LESS COMPREHENSIVE PACKAGE. IN A WORLD WITH NO REQUIRED EMPLOYER CONTRIBUTIONS THIS WOULD LIKELY LEAD SOME EMPLOYERS TO DROP COVERAGE AND BLAME THE PRESIDENT'S PLAN

- DILUTING INSURANCE REFORMS. WE MUST MODIFY COMMUNITY RATING TO INCLUDE AGE RATING AND PRE-EXISTING CONDITION WAITING PERIODS. WITH PRICE COMMUNITY RATING IN A WORLD WITH NO REQUIRED EMPLOYER CONTRIBUTIONS, HEALTH INSURANCE COSTS FOR COMPANIES WITH YOUNG HEALTHY WORKERS WOULD INCREASE AND MANY WOULD DROP COVERAGE AS HAS OCCURRED IN NEW YORK LAST YEAR

- WE WILL NOT TAX BENEFITS ABOVE THE LOW COST PLAN, SO THIS INCENTIVE TO LOWER COST WILL BE GONE

COMPETITION AND THE TRIGGER LETTING COMPETITION WORK? (CONT'D.)

- WE WILL LIKELY HAVE TO REDUCE THE SIZE OF THE POOL OF INDIVIDUALS UNDER THE COMMUNITY RATE TO AVOID DISRUPTING THE CURRENT MARKET

- WE MAY NOT BE ABLE TO AFFORD TO PROVIDE SUBSIDIES AS GENEROUS AS PROPOSED IN THE COOPER/BREAUX BILL AND THEREFORE, MAY NOT ENCOURAGE PEOPLE TO ENROLL.

TRIGGERS

WHETHER THE TRIGGER ACTUALLY GETS PULLED AND UNIVERSAL COVERAGE IS ACHIEVED RESTS ON THREE CONDITIONS:

- WILL COSTS BE CONTAINED DURING THIS PERIOD? NATIONAL HEALTH CARE SPENDING IS PROJECTED TO GO FROM $980 BILLION IN 1994 TO $1.6 TRILLION BY 2000 UNDER THE STATUS QUO. IF COSTS INCREASE TO THIS LEVEL, UNIVERSAL COVERAGE WILL BE TOO EXPENSIVE

- WILL THE REFORMS PEOPLE GAIN/MAINTAIN CURRENT LEVELS OF COVERAGE AND WILL QUALITY BE MAINTAINED? IF PEOPLE LOSE COVERAGE DURING THE TRANSITION PERIOD OR IF QUALITY SUFFERS, THE PRESIDENT MAY BE BLAMED AND THE CONGRESS MAY NOT ACT.

- WILL THE 1998 CONGRESS BE ANY MORE INCLINED THAN THE 1994 CONGRESS TO MAKE THE HARD DECISIONS?

TRIGGERS WITHOUT PREMIUM CAPS

SOME BELIEVE THAT COSTS CAN BE CONTROLLED THROUGH TAX CAPS AND COMPETITION. SOME BELIEVE THAT GOVERNMENT CONTROLS -- EITHER PRICE CONTROLS OR PREMIUM CAPS -- ARE NECESSARY. SOME BELIEVE THAT A COMBINATION OF THE TWO WILL CONTROL COSTS.

FEW BELIEVE THAT THE CURRENT MARKETPLACE WILL BRING DOWN THE RATE AT WHICH COSTS ARE INCREASING WITHOUT LEADING TO A DECREASE IN BENEFITS AND SERVICES OR AN INCREASE IN THE NUMBER OF THE UNINSURED.

REFORMS THAT DO NOT INCLUDE A TAX CAP, A STANDARD BENEFITS PACKAGE, FULL COMMUNITY RATING AND MANDATORY ALLIANCES WILL DIMINISH THE POTENTIAL FOR COST REDUCTION THROUGH COMPETITION.

WE FACE A TRADEOFF: EITHER PUT THE FEDERAL BUDGET AT RISK FOR INCREASED COSTS OR PUT THE PRIVATE SECTOR AT RISK.

EITHER DECISION MAKES PULLING THE TRIGGER UNLIKELY. IF COSTS GO UP SIGNIFICANTLY, EITHER THE GOVERNMENT WON'T BE ABLE TO AFFORD IT, OR BUSINESSES WON'T.

- accurately.
  - I'm making this up. – Len
  - Assumptions. Cost of plans
  - Levels of Uncertainty
- ✓ Preliminary alternatives
  - most [illegible] [illegible] — 1 slate
- Medicare cuts – Total –

Pat [illegible] [illegible]

George Lloyd [illegible]

[illegible] [illegible]

Roger Altman

[illegible]

H.C.R

MALPRACTICE REFORM

REDUCE CIGARETTE TAX TO 75 CENTS IF AT ALL POSSIBLE. IF TOBACCO LOBBY WANTS OTHERS, THEY SHOULD PUSH FOR IT THROUGH THE CONGRESS; THE REDUCTION IN THEIR PERCEPTION OF THE DOLLARS WE ARE NOW ASSUMING SHOULD BE WELCOME NEWS AND, FOR THE MOMENT, I BELIEVE SHOULD SUFFICE.

MEDICARE CUTS. MUST BE REALISTIC AND LEAVE ROOM FOR POPULATION (BOTH IN TERMS OF NUMBERS AND SICKNESS) differences.

FUTA OUT

UNEARNED INCOME TAX IN TO MAKE SYSTEM LESS COMPLEX

ENFORCEMENT THROUGH TAX CODE TO SAY WE ARE GIVING FINANCE AND WAYS AND MEANS A BIG STICK

DO COMMUNITY CONTRIBTION ASSESSMENT FOR CORPORATE ALLIANCES

PREMIUM

LTC AND DRUGS. need BOTH, BUT TALK IT UP AS AN ENTITLEMENT.

we share a commitment to comprehensively reforming the the belief in the need for and a commitment for achieving reform of the nation's ailing health care system.

During the past several months, we have not found a great deal of commonground for discussion about the. We both agree, however, on the desperate need for a comprehensive reform of the nation's health care system.

Briefing on Malpractice Reform Options
prepared by Bob Berenson

Goals of a malpractice system:
1. promote health care quality
2. provide remedies for negligently injured patients
3. provide prompt resolution of disputes
4. adequately and equitably compensate injured patients
5. operate efficiently and economically

Many find that the current tort-based system does not satisfy these goals:

o Two studies a decade apart find that roughly 1 percent of hospitalizations result in medically induced adverse outcomes. Yet, only a small fraction of these ever enter the tort system and only about a half of claimants receive any compensation.

o Only 30-40% of costs of the tort system actually goes to claimants. The rest supports legal fees, court costs, etc.

o There is little evidence that the tort system deters poor medical care.

o In some states, e.g., Florida, that have not enacted some limits on damages and other tort reforms, malpractice premiums are such that certain high risk specialties, such as obstetricians, go bare.

Despite these manifest problems, there has been no consensus on reform. Physicians seek limits on damages, which do limit premium increases but do nothing to increase patient access to remedies for negligence. Others recommend removing disputes from the tort system altogether, but numerous state demonstrations with various forms of alternative dispute resolution mechanisms have been inconclusive. Practice guidelines offer promise for a subset of malpractice claims (estimated to be about 30%), but they have not yet been developed broadly or adequately tested.

The managed competition model offers some new possibilities for reform. Responsibility for injury resolution could be integrated with responsibility for quality assurance and monitoring under the umbrella of health plans or other responsible entity, e.g., hospitals. Even more important, responsibility could go well beyond the small share of cases found by the current liability system. This would provide appropriate incentives for monitoring injuries and taking cost-effective steps to reduce the risk of injury during medical care.

The workgroup is looking at a range of options, some of which could be adopted in the short term, whereas others need further demonstration and would be more appropriate in a reformed health care system. For the long term, either legislative or monitored private contracts could lodge responsibility for quality

assurance and redress of injuries with plans rather than individual providers. **Formal approaches to do so include proposals for "enterprise liability," "quasi-no-fault compensation" and "monitored private alternatives" offered by health plans during the open enrollment process.** The workgroup is examining these options.

The short term options include:

1. Statutory reform of tort litigation rules. The federal government would require states to meet a set of minimum reforms. The most prominent ones are capping liability for non-pecuniary losses such as pain and suffering, collateral source offsets, modifying contingency fees, periodic payment of awards. These come from the California-model of tort reform enacted in 1975.

Pros

o Limits provider exposure, reduces size of awards, may have a marginal positive effect on "defensive medicine."

Cons

o Decreases access for injured patients, does nothing to promote quality, prompt resolution of disputes or efficiency of the tort system.

2. ADR methods. ADRs change the process by which disputes are solved, not the substantive rules of fault, causation, or damages. ADR can involve a full-blown system that formally weighs all evidence and comes to conclusions on all issues, as arbitration does. Or it can involve less formal facilitation techniques, such as mediation or pre-trial screening.

Pros

o Potentially faster, less expensive, less adversarial than traditional litigation.

Cons

o Their promise has not been realized in the medical malpractice arena. Some "voluntary" approaches create duplicative layers of discovery and delay. Yet "mandatory" techniques are relatively untested and may take away rights.

3. Inducement of voluntary "early offers" of settlement. To bring more negligent injuries to light and provide faster compensation, medical providers would be encouraged to make voluntary offers to settle out of court for objectively determined reasonable amounts. In exchange, any person rejecting such an offer could not sue for non-pecuniary losses. Offers would be made within a short period of time, e.g., 120 days from an adverse event or reasonable discovery of the event.

Pros

o Potentially many more patients would be compensated, faster and with more predictable outcomes. The tort system "lottery" would be replaced. Transaction costs may be less.

Cons

o Virtually untested. May shift too much power to providers. (But HIPCs or other program oversight could monitor that offers were being made when they should.)

4. Practice Guidelines. They are systematic, scientifically derived statements of appropriate measures to be taken by health professionals in the diagnosis and treatment of disease. Guidelines will be of forensic use only in those cases in which the physician allegedly chose the wrong course of treatment or should have gone further to diagnose or treat. However, most malpractice claims involve errors of performance. While perhaps not directly applicable in many particular cases, practice guidelines, have the potential of alleviating the perception of physicians that their practice will be retrospectively judged according to arbitrary and ill-founded standards determined by a lay jury.