

Aug 13, 1994

4 pages

To: Ms. Jennifer Klein JD
West Wing - 2nd floor - 458-2599
202-456-2878
From: Linda Bergthold

Some data on covered
benefits. I have much more.
Let me know what you need

Table H-4

**Percent of Covered Workers with Selected Preventive Benefits, within Plan Funding Status
and Provider Fee Arrangement: Small and Large Establishments, 1990-1991**

	Establishments with Less than 100 Employees, 1990							Establishments with 100 Employees or More, 1991						
	Any	Routine Physical	Well Baby	Vaccina- tion	Mammo- graphy	Hearings	Value	Any	Routine Physical	Well Baby	Vaccina- tion	Mammo- graphy	Hearings	Value
Total	49.5	30.2	35.0	27.2	11.6	20.3	14.8	56.0	30.0	36.3	30.7	16.6	24.2	14.3
<i>Plan funding:</i>														
Self-insured	37.4	18.4	23.0	13.5	10.0	8.0	5.3	47.8	17.2	22.5	16.6	18.0	15.7	4.8
Commercially insured	47.0	26.9	27.7	21.0	11.7	13.8	6.7	51.1	25.0	32.0	27.0	16.9	13.7	8.9
Blue Cross/Blue Shield	43.4	17.6	28.7	18.4	15.6	10.5	8.3	51.7	19.9	33.1	24.2	19.6	14.3	10.9
Other ¹	94.8	91.8	91.5	89.9	5.7	83.5	67.8	96.4	92.5	91.6	90.1	7.4	83.0	58.5
<i>Provider fee arrangement:</i>														
Fee for service	34.8	15.0	17.6	9.7	11.7	6.6	3.0	43.3	13.3	17.6	13.1	18.2	10.0	2.6
PPO/EPO	60.9	24.3	46.8	30.2	12.5	7.6	4.4	63.0	29.0	48.8	34.5	19.1	13.2	8.7
Staff/group model HMO	99.7	98.7	98.7	98.5	12.8	95.8	78.0	99.3	96.8	96.7	98.2	6.5	91.9	62.3
IPA model HMO	99.8	97.2	93.7	93.6	8.0	79.3	66.0	99.0	95.4	97.5	93.8	9.2	88.1	68.2

Source: Tabulations of the 1990 and 1991 Employee Benefit Survey (U.S. Department of Labor, Bureau of Labor Statistics).

Note: Row detail adds to 100 percent within size groups. Details may not add to totals because of rounding. Tabulations include both full-time and part-time workers and may differ from DOL's published data describing plan features for full-time workers only.

¹ Principally includes independent HMOs.

Table II-2

**Percent of Covered Workers with Selected Benefits:
Small and Large Establishments, 1990-1991**

	Establishments with Less than 100 Employees, 1990		Establishments with 100 Employees or More, 1991	
	Percent with Benefit	Percent with Cumulative Benefit	Percent with Benefit	Percent with Cumulative Benefit
Hospital inpatient (1)	100.0	100.0	100.0	100.0
Physician - inpatient (2)	100.0	100.0	99.9	99.9
Surgery - inpatient (3)	100.0	100.0	99.9	99.9
Surgery - outpatient (4)	100.0	100.0	99.9	99.9
X-ray and laboratory (5)	100.0	100.0	99.9	99.9
Physician - outpatient (6)	99.9	99.9	98.3	98.3
Mental health - inpatient (7)	98.1	98.0	98.9	97.1
Alcohol detoxification (8)	97.5	95.7	97.6	94.8
Mental health - outpatient (9)	96.3	92.1	97.3	92.4
Drug detoxification (10)	95.4	90.2	96.5	91.3
Outpatient prescription drugs (11)	94.6	85.4	96.0	87.8
Extended care (12)	81.4	70.5	79.5	70.2
Home health care (13)	79.9	61.8	80.5	62.1
Alcohol rehabilitation - inpatient (14)	79.6	51.4	77.4	50.8
Alcohol rehabilitation - outpatient (15)	73.6	46.3	77.8	45.1
Drug rehabilitation - inpatient (16)	75.2	44.4	75.8	44.6
Drug rehabilitation - outpatient (17)	70.0	43.4	74.9	43.8
Hospice (18)	50.0	29.4	54.5	30.3

Source: Tabulations of the 1990 and 1991 Employee Benefit Survey (U.S. Department of Labor, Bureau of Labor Statistics).

Note: Tabulations include both full-time and part-time workers and may differ from DOL's published data describing plan features for full-time workers only.

TABLE II-1

**Common Health Benefit Mandates Affecting the Content of Health Insurance Plans:
Type of Mandate and Number of States that Require Coverage, as of August 1991**

Type of Mandate	Number of States that Require Coverage
Treatment Mandates	
Alcoholism	40
Mammography screening	39
Mental health	29
Drug abuse	27
Maternity	25
Home health	20
Ambulatory surgery	12
Temporomandibular joint disease	12
Breast reconstruction	11
Optional coverage for abortions	8
Pap tests	8
Hospice	7
In vitro fertilization	7
Cleft palate	7
Ambulance transportation	7
Orthoptic/prosthetic devices	6
Provider Mandates	
Optometrists	46
Chiropractors	45
Dentists	40
Podiatrists	37
Psychologists	36
Nurse midwives	24
Social workers	22
Osteopaths	20
Physical therapists	16
Nurse practitioners	15
Nurse anesthetists	11
Nurses	10
Psychiatric nurses	9
Speech therapists	8
Licensed health professionals	7
Professional counselors	7

Source: "New Study Shows 992 Mandated Benefits in the States, Health Benefits Letter 1 (Alexandria, VA: August 29, 1991). Based on data from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the Intergovernmental Health Policy Project (The George Washington University, Washington, DC).

FACSM1

Post-It™ brand fax transmittal memo 7671		# of pages ▶
To <i>Jennifer Klein</i>	From <i>Jim Mays</i>	
Co.	Co.	
Dept.	Phone # 703-941-7400	
Fax # 202-456-2777	Fax #	

Page 1

MEMORANDUM

To : Jennifer Klein

From : Jim Mays *Jm*

Subject : Cost-sharing Maximum versus Per Admission Deductible

Copy : Ken Thorpe

We worked out an approximate offset for adding a cost-sharing maximum to a Ways and Means-type policy (\$500/750 deductible) of \$3,000 per person/\$6,000 family maximum. Adding 20% coinsurance to SNF and home health but not regular inpatient services generates very little. Adding a per admission deductible of \$300 should bring the package back to its original value.

If the cost-sharing maximum itself adds about 5% (it would be a lot more if there were coinsurance on inpatient hospital services), then adding only a \$200 per admission deductible would leave a premium increase of about 2% from the original package. A \$100 per admission deductible would leave a premium increase of about 4% from the original package. Is there a CBO estimate available for any part of this? If so, we can calibrate - as is, this is our best guess as to where CBO would end up.

pacsm1
/a/w

CSEL1

Tuesday, July 26, 1994 9:18 am

Page 1

MEMORANDUM

To : Jennifer Klein
From : Jim Mays
Subject : Cost-sharing Maximum versus Zero Coinsurance on Inpatient Hospital Services
Copy : Ken Thorpe

We worked out rough equivalences of adding a cost-sharing maximum to a Ways and Means-type policy (\$500/750 deductible) while putting 20% coinsurance on inpatient hospital services. It looks like applying coinsurance would more than pay for the \$5,500/11,000 cost-sharing maximum - a limit as low as \$3,000/6,000 would appear to be feasible.

csell
/a/w

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To <i>Jennifer Klein</i>	From <i>Jim Mays</i>
Co.	Co.
Dept.	Phone # <i>703-941-7400</i>
Fax # <i>202-456-2878</i>	Fax #

No copay on home health in Part C.

OCOP1

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages >

Page 1

MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : Other Changes for Benefit Package to Offset Parity Costs

To	Jennifer Klein	From	Thorpe
Dept./Agency		Phone #	
Fax #	(ALL) (2)	Fax #	
NSN 7540-01-312-7368		5099-101 GENERAL SERVICES ADMINISTRATION	

Looking back at our earlier mental health estimates and considering what Mike O'Grady said, it looks to me like our best guess as to the cost-sharing changes needed to get 8% off of HSA while adding parity for mental services is the "HSA minus 15%" Option 1 from 5/24/94. The difference between that and the cost-sharing discussed yesterday is what you said - raising the comprehensive deductible from \$200/\$400 to \$400/\$800. Compared to HSA, the other changes are adding a \$250 per admission deductible, raising the coinsurance rate to .25 from .20, and raising the out-of-pocket limit from \$1,500 to \$2,500.

The implied cost of parity here is 7%. That is roughly consistent with Mike's estimate, with the mental health base adjusted for the higher proportion it represents in HCFA's premiums compared to CRS's premiums. The concern here is less with the absolute cost than with what trade-off is required to finance it. Given Mike's comments on the slower premium movement in his model than in some others, his lower cost for parity may match a lower savings estimate from raising the deductible farther.

ocopl
/a /s

6/29/94

TO: KEN

From: Sharman

SUBJECT: Request From Jennifer Regarding Senate Finance Benefit

(1) What reduction in actuarial value has the Senate Finance Committee achieved?

Response from Jim Mays - approximately 15%
and

(2) Is this sufficient to cover the cost of parity on mental health?

Response from Jim Mays - assuming that 7% is available it is sufficient. For purposes of discussion parity to other medical conditions refers to acute care. Thus long term care or custodial services are not covered. For example the HSA which sets 100 days on extended care services.

Jennifer described the major parameters as follows:

High Cost Plan

- o o-o-p max \$2500/\$3000
- o deductible \$400/\$800
- o 25% coins
- o \$250/admission hospital deductible
- o \$250 prescription drug deductible

Low Cost Plan

- o cost sharing to be specified by board for lower cost sharing

Mental Health

Secretary of HHS would be directed to define such services so as to achieve parity with services for other medical conditions and would develop standards for appropriate management of these benefits.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages 1

To <i>Jennifer Klein</i>	From <i>Sharman Stephens</i>
Dept./Agency	Phone #
Fax #	Fax #

Response to Senate Finance Committee Markup: Medical Malpractice

A. Fee shifting/Alternate Dispute Resolution

1. Both the Clinton bill and the bill reported by the Senate Labor Committee contemplate several possible forms of alternate dispute resolution as applicable to medical malpractice cases. The Clinton bill provides for ADR to be conducted by a health care plan before suit; the Kennedy bill provides for more flexible "state based" ADR mechanisms, with considerable uncertainty as to what kind of entity would conduct ADR (court-annexed or private) or whether it would occur before or after suit is filed. Such a flexible scheme is not well suited to punitive fee-shifting measures.
2. The purpose of ADR is to facilitate settlement, not to punish the litigants. Several of the forms of ADR permitted by the Kennedy bill -- mediation, early neutral evaluation, and the filing of a certificate of merit do not lend themselves to fee shifting arrangements, as those techniques do not produce a "decision" about the law or facts in a case which can then be appealed.
3. From the brief description of the fee shifting provision adopted by the Finance Committee, it seems to be one-sided; i.e., the sanctions would only apply against plaintiffs who recover less at trial than from an ADR procedure, such as arbitration. This is extremely unfair and is contrary to the harshest versions of fee shifting that have been proposed in other forms of civil justice reform.
4. Various proposals on fee shifting have been made to the Advisory Committee on the Federal Rules of Civil Procedure but have not advanced because they are too controversial and result in the denial of access to justice for many litigants. The fee shifting measure in the Finance Committee flies directly in the face of FRCP 68. A separate rule should not be carved out for medical malpractice cases in either state or federal courts, creating a confusion of procedural and substantive rules.

B. Limited Federal Preemption

The Clinton bill would preempt state law to the extent that such laws are inconsistent with proposed federal law or provide for defenses or limitations on liability which are less than those afforded by the Health Security Act. The Kennedy bill is silent as to preemption, rendering the proposed reforms virtually meaningless at the state level. The Finance Bill proposes some kind of federal preemption, but it is impossible to tell from the brief notes what is intended.

AMENDMENT TO THE CHAIRMAN'S MARK

I. INSURANCE REFORM STANDARDS

A. REQUIREMENTS FOR INSURED HEALTH PLANS

1. Item 1 (p. 1). Strike second paragraph relating to civil monetary penalties.

2. Replace Item 8.b. (p. 3) with the following:

8. Modified Community Rating

Less than b. The community-rated market would include all eligible individuals who are not (i) employees (and their dependents) of an employer with 100 or more employees (other than an employer whose primary business is employee leasing) or (ii) participants in a grandfathered Taft-Hartley plan, rural cooperative plan, or Qualified Association Plan.

B. REQUIREMENTS FOR SELF-INSURED HEALTH PLANS

1. Item 1.b. (p. 5). Strike second paragraph pertaining to civil monetary penalties.

2. New Item 9 (p.7). Insert the following new item:

9. Reinsurance Standards

Department of Labor will develop appropriate standards for reinsurance for self-insured plans.

Effective date.--The Secretary of Labor will promulgate regulations by July 1, 1995, which would be effective January 1, 1996.

C. REQUIREMENTS FOR EMPLOYERS

1. In Item 2.a. (p. 8), delete 500 and insert 100.

2. Amend Item 2.b. (p. 8) to read:

"(b) Grandfathered Taft-Hartley plans with 500 or more participants. These plans must meet the same requirements as large employers;"

3. In Item #2 strike (c) and all that follows to the end and replace with:

"(c) Grandfathered Qualified Association Plans meeting the following requirements:

1. Definition -- Association health plans that have been in existence for 3 years prior to the date of enactment.

2. Standards --

i. QAPs must meet strict solvency requirements which would be established by the Department of Labor.

ii. QAPs may only take any member in their designated association.

iii. QAPs must have covered at least 500 participants as of June 1, 1994.

iv. QAPs could not increase the number of participants covered under the plan by more than 10 percent in any year.

3. Requirements of Sponsoring Entity (Association):

i. Must be organized and maintained in good faith.

ii. Must have appropriate by-laws that specifically state the purpose as a trade association, industry association, professional association, chamber of commerce, religious organization, or public entity association.

iii. Must have been established and maintained for substantial purposes other than to provide the health care required under this section.

iv. Must be, and have been, in operation (together with its immediate predecessor, if any) for a continuous period of not less than 3 years.

v. Must receive the active support of its membership.

4. Treatment of Multiple Employer Welfare Arrangements (MEWAs)

i. In general, upon enactment, a MEWA will meet the standards to become either a QAP or a purchasing cooperative.

ii. Any MEWA that has been in effect for not less than 18 months upon enactment and with respect to which there is application with the domicile state for certification as a QAP, shall be treated for purposes of this Part as Qualified Health Plan (if such plan otherwise meets the requirements of this Act);

iii. However, MEWAs will not be able to continue to operate if the domicile State can demonstrate that: the sponsor has made fraudulent or material misrepresentations in the application; the plan that is the subject of the application, on its face, fails to meet the requirements for a complete application; or a financial impairment exists with respect to the applicant that is sufficient to demonstrate the applicant's inability to continue its operation.

5. Treatment of Rural Electric Cooperatives (RECs) and Rural Telephone Cooperative Associations (RTCs) -- RECs and RTCs can continue to exist if they meet the same standards as QAPs; or if they meet the standards for a purchasing cooperative."

PART IV. BENEFITS AND THE NATIONAL HEALTH BENEFITS BOARD**SECTION A: VALUE AND STRUCTURE OF THE BENEFITS PACKAGE (page 18)**

Strike the two sentences beginning "Fee-for-service plans....fee-for-service levels." and replace with the following:

A relationship between the actuarial value and the types of delivery systems would be determined.

Strike Section IV A (1), (2), and (3) and the paragraph, "In addition.....employers." from the Chairman's Mark and replace with the following:

(1) Cost sharing arrangements would be specified by the National Health Benefits Board.

(2) There would be at least two options for certified standard health plans. Both would have the same categories of covered services, however one would contain higher cost sharing and/or fewer covered services.

SECTION B: COVERED SERVICES (page 19)

Strike Section IV B: Categories of covered services and equipment (1) through (16) from the Chairman's Mark and replace with the following:

(1) Inpatient and outpatient care, including hospital and health professional services;

(2) Emergency services, including appropriate transport services;

(3) Clinical preventive services, including services for high risk populations, immunizations, tests and clinician visits;

(4) Mental illness and substance abuse services;

(5) Family planning and services for pregnant women;

(6) Prescription drugs and biologicals;

(7) Hospice care services;

(8) Home health care services;

(9) Outpatient laboratory, radiology and diagnostic services; and medical equipment;

(10) Outpatient rehabilitation services;

(11) Vision care, hearing aids and dental care for individuals under the age of 22 years;

(12) Patient care costs associated with investigational treatments that are part of approved clinical trials.

SECTION C: THE NATIONAL HEALTH BENEFITS BOARD (page 21)

Substitute "refine the statutory definition of medically necessary or appropriateness" with the following:

Qualified health plans would provide coverage for categories of services that are medically necessary or appropriate for the enrollee. Criteria for determination of medically necessary or appropriate treatments would be set forth. The National Health Benefits Board would:

- (1) Develop interim coverage decisions in limited circumstances;
- (2) Design the benefits package to prevent adverse risk selection;
- (3) Not specify specific types of providers when clarifying covered services;
- (4) Not specify particular procedures or treatments or classes of procedures or treatments;
- (5) Consider the following priorities within the constraints of the actuarial limits set in this Act:
 - (a) Parity for mental health and substance abuse services with other medical services, using the standard of medical necessity or appropriateness for the enrollee, and using outpatient treatments to the greatest extent possible;
 - (b) Consideration for the needs of children and vulnerable populations (including rural and underserved individuals);
 - (c) Improving the health of individuals through prevention.

VI. COST CONTAINMENT

Strike the "description of proposal" for the "Budget Control: Pay-as-you-go Failsafe" in Part VI(B) (p. 27) and insert the following new proposal:

B. BUDGET CONTROL: PAY-AS-YOU-GO FAILSAFE

Description of Proposal

This proposal would establish a mechanism for delay in the phase-in of subsidies and delay in, or reduction of, tax deductions in the event of projected increases in the deficit attributable to health care reform.

1. Timetable for pay-as-you-go mechanism

January/February - In every January through 2003, CBO and OMB are required to submit to the Congress projections of whether health care reform will cause an increase in the deficit in the upcoming fiscal year. OMB's projections--which are to be included in the President's Budget--must explain any differences from CBO's preliminary determinations. If OMB projects a deficit increase due to health care reform, the President would be required to implement on September 20: (1) a delay in the subsidy

phase-in; and (2) a delay in the effective date of, or a reduction in, the tax deductions for purchase of individual health insurance policies.

June 1 - Deadline for the President to submit to the Congress an alternative deficit reduction resolution, which offsets the deficit increase attributable to health care reform.

June 10 - CBO to report to the Senate and House Budget Committees on whether the alternative deficit reduction resolution submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through the automatic delays/reductions. If the Chairmen of the Senate and House Budget Committees certify that the alternative deficit reduction resolution produces the required deficit reduction, it is protected by fast-track procedures, as follows.

June 15 - Deadline for the Majority Leaders of the House of Representatives and the Senate to introduce alternative deficit reduction legislation. Legislation to be referred to all relevant committees. Committees are to review the legislation, but no amendments are permitted.

June 25 - House committees discharged of alternative deficit reduction legislation if they have not reported.

July 10 - Deadline for House of Representatives to vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

July 20 - Senate committees discharged if they have not reported bill received from the House.

August 5 - Deadline for Senate vote on alternative deficit reduction legislation. Bill may not be amended; debate limited to 20 hours, equally divided.

September 20 - If OMB made a projection in the President's January Budget that the deficit will increase in the upcoming fiscal year due to health care reform, and if alternative deficit reduction legislation has not been enacted into law, then the President must implement, proportionally: (1) a delay in the subsidy phase-in; and (2) a delay in the effective date of, or a reduction in, the tax deductions for purchase of individual health insurance policies.

November 1 - GAO audit of automatic reductions, or implementation of alternative deficit reduction legislation, as the case may be.

January/February - CBO report to Congress on success of automatic reductions or alternative deficit reduction legislation in eliminating health care deficit.

2. Entitlement to subsidies and certain tax deductions made contingent on automatic deficit reduction

The legal entitlement to subsidies and the tax deduction for purchase of individual health insurance policies would be subject to the operation of the back-up deficit reduction mechanism explained below.

3. Preparation of "pre-health care reform baseline"

CBO and OMB would be required, within 60 days following enactment, to prepare a baseline for total Federal health care entitlement spending, projected for each fiscal year through 2004, as would have occurred without the enactment of health care reform. CBO shall transmit its estimates to the Congress and OMB within 30 days of enactment. Five days after CBO's transmittal, OMB shall transmit to the Congress its determinations, explaining in detail any differences from CBO's estimates.

4. Determination of deficit increase

In each year through 2003, five days prior to the President's budget submission, CBO is required to submit to the Congress and OMB estimates of whether health care reform will cause an increase in the deficit in the upcoming fiscal year. Five days later, the President's annual Budget for the upcoming fiscal year is to include OMB's determination of whether health care reform will cause a deficit increase in the upcoming fiscal year. OMB must explain any differences from CBO's estimates.

In determining whether health care reform will cause an increase in the deficit in the upcoming fiscal year, CBO and OMB shall proceed as follows:

a. Determine "total Federal health care entitlement spending for the upcoming fiscal year," including subsidies and all other new direct spending enacted in health care reform.

b. Adjust the "pre-health care reform baseline" for Federal health entitlements in the upcoming fiscal year to reflect all reasonably discrete and identifiable health care spending variables not attributable to health care reform.

c. Subtract pre-health care reform spending for the upcoming fiscal year (as adjusted) from total Federal health care

entitlement spending for the upcoming fiscal year--producing the "net increase in Federal health care entitlement spending for the upcoming fiscal year."

d. Subtract from the net increase in Federal health care entitlement spending, net revenues for the upcoming fiscal year projected to result from enactment of health care reform. If the "net increase in Federal health care spending" exceeds "net revenues," the difference shall be designated the projected deficit increase for the upcoming fiscal year resulting from health care reform legislation.

Example of calculation: In January of 1997, CBO and OMB will project how much total Federal health care entitlement spending will be in fiscal year 1998; they will subtract from that total, the amount of pre-health care reform spending which had been projected by OMB for FY 1998 (in the pre-health care reform baseline) as adjusted to exclude increases in entitlement spending unrelated to health care; the resulting number will reflect the net increase in Federal health care entitlement spending for FY 98 which is projected to result from health care reform; finally, the net revenues projected to be raised in FY 98 due to health care reform are offset against the net spending increase; this yields the projected FY 98 deficit increase, if any, resulting from health care reform.

5. President's Budget to specify required action

If OMB reports in the President's budget a projected deficit increase for the upcoming fiscal year, due to health care reform, the projection shall be accompanied by a determination of how the projected deficit may be fully offset, proportionally, through: (1) a delay in the subsidy phase-in and (2) a delay in the effective date of, or a reduction in, the tax deductions for purchase of individual health insurance policies. The proportional allocation of the deficit offset shall be determined using the total outlays attributable to projected subsidies for the fiscal year and total outlay equivalents attributable to projected tax deductions for the upcoming fiscal year. The required delay in subsidy phase-in, and the required delay in, or reduction of, tax deductions would take effect on September 20, unless alternative deficit reduction legislation is enacted in the interim.

6. Alternative Deficit Reduction Legislation

A procedure is established for fast-track consideration of a legislative alternative to the automatic reductions. If OMB projects a deficit increase attributable to health care reform

for the upcoming fiscal year, the President would be required to submit to Congress by June 1: (1) alternative deficit reduction legislation designed to achieve the required deficit reduction for the upcoming fiscal year; or (2) a report explaining why such alternative legislation is not being transmitted.

It is expected that the alternative deficit reduction legislation would be developed through a process similar to the trade fast-track process used for the implementing bills for the North American Free Trade Agreement and the Uruguay Round of the General Agreement on Tariffs and Trade. Those processes have involved extensive consultation among the Senate and House committees of jurisdiction through "mock mark-ups and conferences," as well as extensive consultation with the Executive Branch.

The alternative deficit reduction legislation is to be submitted as a joint resolution stating in the resolving clause that the "Congress has determined that it is necessary to avert automatic delays and reductions in Federal health care subsidies and tax deductions by enacting the following changes in law, which are estimated to eliminate projected deficit increases resulting from the enactment of health care reform."

If alternative deficit reduction legislation is transmitted to the Congress, CBO is to report to the Senate and House of Representatives by June 10, estimates of whether the alternative deficit reduction language submitted by the President will produce the same amount of deficit reduction in the upcoming fiscal year as is required to be achieved through automatic delays and reductions (as estimated by OMB). If the Chairmen of the Senate and House Budget Committees certify by June 13, that the alternative deficit reduction legislation produces the required amount of deficit reduction, it will proceed through the Congress under the following "fast-track" procedures.

7. Fast-Track Procedures

Introduction of Resolution.--Under the fast-track procedure, the Majority Leaders of the House of Representatives and the Senate are required, no later than June 15, to introduce the alternative deficit reduction legislation, transmitted by the President, on behalf of themselves and the respective Minority Leaders.

Referral.--The legislation is to be referred to all relevant committees. Committees are to review the legislation, but no committee amendments are permitted.

Discharge.--On June 25, House committees are to be discharged of alternative deficit reduction legislation if they

have not yet reported.

Vote by House of Representatives.--The House of Representatives must vote on the alternative deficit reduction legislation no later than July 10. During consideration by the House of Representatives, the bill may not be amended and debate is limited to 20 hours.

Discharge by Senate Committees.--If alternative deficit reduction legislation passes the House of Representatives, all Senate committees to which the legislation was referred are discharged no later than July 20 if they have not reported the legislation.

Vote by Senate.--The Senate must vote on the alternative deficit reduction legislation no later than August 5. During consideration by the Senate, the bill may not be amended and debate on the bill (and all motions and appeals) is limited to 20 hours, equally divided between the Majority and Minority Leaders or their designees. A motion to proceed to the alternative deficit reduction legislation is non-debatable. Motions to recommit the alternative deficit reduction legislation are not in order. Section 313 of the Congressional Budget and Impoundment Control Act of 1974, commonly known as the "Byrd Rule," would apply in the Senate so that any "non-budgetary" provisions included in the alternative deficit reduction legislation, as submitted by the President, could be stricken from the bill.

8. Implementation of Deficit Reduction

If alternative deficit reduction legislation has not been enacted by September 20 the President is required: (1) to order the delay in the phase-in of subsidies, as specified in the January Budget; and (2) to direct the Secretary of the Treasury to promulgate regulations delaying the effective date of, or reducing, tax deductions for purchase of individual health insurance policies, as specified in the January Budget.

9. Low-growth suspension; vote by Congress

CBO shall inform the Congress any time the Department of Commerce has reported two consecutive quarters of real economic growth of less than one percent. In the Senate and House of Representatives, the Majority Leaders must introduce a joint resolution suspending the enforcement of these deficit control procedures for the upcoming fiscal year, upon receipt of a CBO low-growth report and the Senate and House must vote on the resolution under expedited procedures (incorporated by reference from the Gramm-Rudman-Hollings Act).

10. GAO Audit of Reductions

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of the Treasury has issued regulations under these procedures, the General Accounting Office is required to report to Congress no later than November 1: (1) in the case of an executive order and Treasury regulations, an analysis of whether the delays and reductions have been implemented according to statutory requirements; or (2) if alternative deficit reduction legislation has been enacted, an analysis of whether the reductions have been implemented as required.

11. CBO Report

If alternative deficit reduction legislation has been enacted, or if the President has issued an executive order and the Secretary of Treasury has issued regulations making required reductions, the Congressional Budget Office must include in its January publication of the Economic and Budget Outlook, an analysis of whether the reductions are likely to be successful in eliminating the deficit overage.

Effective Date

Upon enactment.

D. ADMINISTRATIVE SIMPLIFICATION AND PAPERWORK REDUCTION

On p. 39, at the end of section 11, insert the following:

Direct Billing for Clinical Laboratory Services

Claims for clinical laboratory services would be required to be submitted directly by the person or entity that performed (or supervised the performance of) the tests to the plan in a manner consistent with the requirements for direct submission of such claims under the Medicare program.

VII. REVENUE PROVISIONS

A. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS

The tobacco tax increases proposed in the Chairman's Mark (p. 41) would be modified as follows:

(1) The tax rate on small cigarettes would be reduced from \$1.76 per pack of 20 cigarettes to \$1.00 per pack.

(2) The tax rate on other tobacco products (except snuff and chewing tobacco) would be computed using the methodology in the Chairman's Mark, but would be reduced to provide comparable increases to that proposed for small cigarettes.

(3) The tax rates on snuff and chewing tobacco would be increased by the following amounts:

Snuff -- \$13.33 per pound (\$1.00 per 1.2 oz. tin)

Chewing tobacco -- \$5.33 per pound (\$1.00 per 3 oz. pouch)

E. CREDIT FOR HEALTH INSURANCE COSTS OF INDIVIDUALS NOT ELIGIBLE FOR SUBSIDIZED EMPLOYER PROVIDED HEALTH CARE

Section VII.E. (p. 49) of the Chairman's Mark would be amended by replacing the 15 percent credit for certain health insurance expenses with a deduction for 100 percent of such health insurance expenses.

A conforming change would be made to section VII.F. (p. 50) to provide that the rule in the mark regarding prepayment of medical expenses applies to the 100 percent deduction.

G. DEFINITION OF EMPLOYEE

Section VII.G. (p. 51) of the Chairman's Mark would be deleted and replaced with the following:

The Department of the Treasury would be directed to submit a legislative proposal providing statutory standards for the classification of workers as employees or independent contractors to the House Committee on Ways and Means and the Senate Finance Committee by January 1, 1996.

K. TAX TREATMENT OF ORGANIZATIONS PROVIDING HEALTH CARE SERVICES AND RELATED ORGANIZATIONS

Section VII.K.8 (pages 65-66) of the Chairman's Mark would be amended by deleting the first paragraph (which proposes repeal of the special tax rules provided in section 833 to Blue Cross and Blue Shield organizations and other eligible organizations) and paragraphs 3 and 4 (concerning effective dates of repeal). The proposal extending the special rules to certain organizations to the same extent they have been provided to certain existing Blue Cross or Blue Shield organizations would be effective for taxable years beginning after December 31, 1986.

T. TAX TREATMENT OF VOLUNTARY EMPLOYER HEALTH CARE CONTRIBUTIONS

Section VII.T. (p.80) of the Chairman's Mark would be amended by

adding coverage under a certified very high deductible health plan to the definition of "permitted coverage". In addition, the Chairman's Mark would be amended to provide that employer contributions to an accident or health plan that would supplement the coverage or benefits provided under a certified very high deductible health plan would not be "permitted coverage".

U. ASSESSMENT ON LARGE EMPLOYERS

Section VII.U. (p. 82) of the Chairman's Mark would be amended to provide that the assessment on large employers would only apply to employers not in the community-rated market.

W. TAX TREATMENT OF LONG TERM CARE

Title VII of the Chairman's Mark would be amended by adding the following:

1. Amounts received under a long-term care insurance contract generally would not be includible in gross income, subject to a cap of \$150 per day (indexed).
2. Expenses for long-term care services and long-term care insurance premiums would be treated as medical expenses for purposes of the itemized deduction for medical expenses (Internal Revenue Code sec. 213).
3. Employer contributions for long-term care insurance would not be excludable from gross income. Long-term care insurance could not be offered through a cafeteria plan.
4. A long-term care insurance contract generally would be treated as an accident and health insurance contract, and a long-term care insurance rider to a life insurance contract generally would not disqualify the life insurance contract.

The proposal would generally be effective after January 1, 1996.

X. MEDICARE

Item D. 6. Improvements in Risk Contracts

on p. 114, after "(1) Section 1876 (f), which requires that at least 50 percent of enrolled membership consist of non-Medicare or Medicaid eligible individuals," insert the following:

The Secretary would be permitted to waive the 50/50 rule if a plan provides for an adequate quality of care for beneficiaries. The plan would be required to: (1) meet quality standards for Medicare risk contracts; (2) meet the fiscal soundness requirements under XIII of the Public Health Service

Act and Part XV of this bill for at least 3 years preceding an application for a waiver under this section; (3) demonstrate successful operational experience as a Medicare prepaid health plan for at least 3 years immediately preceding an application for a waiver; (4) the number of individuals enrolled in the plan or its parent organization is at least 50,000; and (5) in reviewing a plan's quality performance, the Secretary would be permitted to accept quality performance standards as measured by private organizations acceptable to the Secretary or organizations defined by the Secretary, including peer review organizations.

The Secretary would be permitted to terminate the 50/50 requirement at the point at which the Secretary determines that health plans have alternative quality assurance mechanisms in place that effectively provide sufficient quality safeguards.

On p. 115, following the last sentence on risk contracts, insert the following:

Such marketing information would include information about fee-for-service plans.

Employer plans would be permitted to offer Medicare health plans to former or current employees.

Medicare health plans would be required to offer a health plan consisting of benefits to which Medicare beneficiaries are legally entitled. Alternatively, such plans could offer a package of benefits, as defined by the Secretary, that include the same services but with cost-sharing provisions consistent with managed care practices. These benefit packages could not exceed the actuarial value of fee-for-service plans.

The Secretary would be permitted to administer a coordinated open enrollment period during which Medicare beneficiaries would have an opportunity to choose among all plans (including Medigap insurers) offering health plans to Medicare beneficiaries. The Secretary would be permitted to authorize variations in the enrollment process.

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

In cases where the premium of a Medicare risk contract is less than the federal Medicare contribution, enrolled Medicare beneficiaries are entitled to a rebate. The plan could choose to receive a rebate or apply the difference toward the purchase of a

supplemental health benefits plan. If a beneficiary receives a rebate, it would be considered non-taxable income.

The Secretary would be authorized to provide for coordination of Medicare and supplemental insurance claims processing. The Secretary would also be permitted to develop a standardized, paperless process for claims forms.

The Social Health Maintenance Organization (SHMO) demonstration would be continued for an additional two years.

The Prospective Payment Assessment Commission (ProPAC) would be directed to study and make recommendations to Congress regarding ways to slow the rate of growth in Medicare spending in community rating areas. ProPAC would be directed to study ways to set local expenditure targets and monitor whether they are successful in controlling the rate of growth in spending.

The Secretary would be authorized to conduct demonstration projects using provider-group or State level volume performance standards. These demonstration projects could include hospital or physician services.

The Physician Payment Review Commission and the Prospective Payment Assessment Commission would each be required to conduct an evaluation of the Medicare risk contracting program and report to Congress.

XV. HEALTH PLAN STANDARDS

A. STANDARDS FOR ALL HEALTH PLANS

1. Strike 3.a. -- Guaranty Funds (p. 130)

2. The section on Additional Standards for Integrated Health Plans is moved into the section on Standards for All Health Plans, striking the word integrated. The section on Additional Standards for Fee-For-Service Health Plans is deleted and Balance Billing is moved to the section on Standards for all Health Plans. Under the Quality, Patient Protection, and Access Standards sections is added: The Secretary has discretion to adopt these standards so that they are appropriate for a variety of organizational forms.

3. (B.1.b., p. 131) The first, second, and fourth paragraphs under Utilization Management are changed to read as follows:

Health plans would be required to use licensed or certified health professionals with appropriate clinical training in making review determinations.

Health plans would be required to base utilization management on current scientific knowledge, stress the efficient delivery of health care and outcomes, rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review, and be consistent and timely in application.

Upon request, each health plan would be required to provide a description to a participating or prospective provider, enrollee or prospective enrollee, of utilization review protocols. The standards would address the need to protect proprietary business information.

4. Medical Recordkeeping (B.1.d., p. 132) is changed to read as follows:

Health plans would be required to assure that pertinent information is readily available to appropriate professionals.

5. The second paragraph of Consumer Protection is changed as follows:

In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, an health plan may not engage in any practice that discriminates against a provider based on the health status, of a patient of the provider.

6. Physician Participation (B.2.h., p. 133) is changed to read as follows:

Health plans would be required to establish a mechanism through which physicians have input into matters affecting patient care, and that patients would be able to choose their primary care physician from available practitioners.

Health plans would be required to provide reasonable (at least 30 days) notification to physicians of decisions to cancel or deny renewal of contracts and establish an informal, non-binding and advisory review process for appeals.

7. Enrollment (B.2.j, p. 133) is changed to read as follows:

An health plan may not knowingly enroll an individual who is currently enrolled in another health plan.

8. The first paragraph of Accreditation and Certification (D.1., p. 136) is changed to read as follows:

The Secretary would be required to develop guidelines for Accreditation, Certification, Enforcement, and Information (ACEI) programs, and approve ACEI programs as meeting Federal guidelines.

9. The first three paragraphs of Enforcement (D.2., p. 136) are changed to read as follows:

State ACEI programs, in conjunction with private accreditation agencies where appropriate, would be required to determine a process for imposing sanctions including prohibiting new member enrollment, allowing existing members to leave with no penalties, operating a health plan to provide transitional access, developing a correction program for the plan, or decertificating the health plan after the plan has been given a reasonable opportunity to make corrections.

10. The first paragraph of Funding (D.3., p. 137) is changed to read as follows:

The Secretary would be required to distribute funds to States from the Health Security Trust Fund in the amounts of \$100,000,000 in 1995, and \$300,000,000 in each of 1996-2004, for State ACEI programs.

11. The following is added to the section on Preemption of Certain State Laws (F., p. 138):

State laws requiring health plans to cover certain items and services in a health benefit plan would be preempted.

State laws affecting utilization management and review programs of a health plan would be preempted.

12. The first paragraph of the Essential Community Provider provision (B.3.a) on page 134 is as follows:

All health plans, including self-insured plans would be required to offer a contract with at least one of each category of Essential Community Providers in State-defined service areas. The Secretary would be required to develop guidelines for the definition of State-defined health plan service areas. The State-defined service area could be smaller than a community-rated area, but could not divide cities or towns and would, at a minimum, include any adjacent designated urban and rural underserved areas. The Secretary may make exceptions and require contracts to be offered to more than one Essential Community Provider if the Secretary determines extra capacity is required to serve the needs of enrollees.

XVI. QUALITY, CONSUMER INFORMATION, AND HEALTH SERVICES RESEARCH

Amend pages 140 to 142 as follows:

B. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH

The funding mechanism in this section is changed to:

In addition to monies appropriated for these purposes, twenty percent of the .25 percent portion of the 1.75 percent assessment on premiums for certified health plans would be available from the Health Research Trust Fund for health services and quality improvement research.

C. IMPLEMENTATION OF QUALITY IMPROVEMENT RESEARCH

This section is replaced with the following:

The Secretary would be required to establish demonstration projects and grants to test and evaluate mechanisms to provide technical assistance to health plans for the purpose of implementing quality improvement research into medical practice.

The Health Research Trust Fund monies would be available for these purposes and there would be authorized to be appropriated \$50,000,000 for fiscal years 1996-2004 for implementation of quality improvement research.

D. CONSUMER INFORMATION

The first three paragraphs of this section (P. 141) would be replaced with the following:

In addition to certifying that health plans meet the Federal Standard for reporting a standard set of data, the State Accreditation, Certification, Enforcement, and Information (ACEI) programs would produce annual, standardized comparative value information on the performance of all health plans in each community rating area, develop distribution mechanisms for the comparative value information, educate and provide outreach for consumers on comparative value information, and receive and seek to resolve complaints.

The funding portion of this section is removed (p. 142).

DEFINITIONS

Amendment: References to certified very high deductible health plans (as defined in the Chairman's mark)

All references in the Chairman's Mark to "certified very high deductible health plans" will be amended to read "Basic Benefit Package".

Jen

Health Reform Issues

LABOR

FINANCE

ISSUE: Benefits

I.12-27; I.28.

1. Lists 19 categories of services and defines scope and duration for many of these services. In particular, limits mental health benefits, such as inpatient treatment, to 34 days/year.
2. Describes explicit cost-sharing arrangements: high, low and combined.
3. No definition of medical necessity or appropriateness. National Board defines services that are not medically necessary.

p18-21; amended p.3.

1. Defines levels of benefits as equal to the actuarial value of the standard benefit package of the BC/BS Standard Option in FEHB.
2. Lists 12 categories of services: differs from labor, in that, some categories are collapsed into others; the only missing benefits are: extended care; and health education classes.
3. Cost sharing definitions are left to the National Benefits Board. Two standard plans offered with same categories of benefits; differ only in amount of cost sharing.
4. Criteria for the determination of medical necessary or appropriate treatments would be developed by the National Health Benefits Board, which would use the following guidelines:
 - a. design benefits package to prevent adverse risk selection;
 - b. not specify specific types of providers when clarifying covered services;
 - c. not specify particular procedures or treatments;
 - d. consider following priorities:
 1. parity for mental health and SA services;
 2. Consideration of needs of children and vulnerable pops
 3. improving health through prevention.
 - e. develop interim coverage decisions in limited circumstances.

Health Reform Issues

LABOR

FINANCE

Options

1. Compromise on benefits probably needs to be closer to Finance than Labor. This gives Benefits Board more authority in determining benefits package under guidelines to keep mental health parity, emphasize prevention and have preferences for children and vulnerable populations.

Tenklein

Health Reform Issues

LABOR

FINANCE

Issue: Malpractice

V59-66

1. No right to action in federal courts V60.
2. Alternative Dispute Resolution Procedures V61.
3. Limitation on Attorney Fees - 33%, 25% V62.
4. Collateral Sources V62.
5. Periodic Payment of Awards V63.
6. Malpractice Reform Demos (no fault, enterprise liability, practice guidelines V63.

- p.34, amended
same as in Kennedy, except:
1. imposes penalty if court action results in an award of one-third below that awarded by ADR. Penalty=court costs and attorney fees of the other party.
 2. damage caps: \$250,000 for noneconomic losses.
 3. punitive damage reform: 75% of punitive damage awards allocated to the State for quality improvement: 1. licensing; 2. Q/A programs; 3. public education; 4. reducing malpractice costs for providers in medically underserved areas.
 4. Limited federal preemption.

Options

1. Take Finance penalty if court action results in an award below the ADR award.
2. Do not impose damage caps.
3. Do not reform allocation of punitive damage awards.
4. Otherwise take Kennedy and Moynihan approaches.

Comment: Danforth amendment in Finance narrowly passed, with 10 yeas; 9 neas; 1 pass.

Issue: Antitrust

V-77
repeals McCarran-Ferguson with
respect to Health Insurance

p.8
same

Options

No major difference between Kennedy and Moynihan; use Kennedy language.

Comment: Senator Hatch appears to be main proponent of broadening antitrust exemptions for hospitals and doctors. Did not introduce changes in Finance.

(13)

SENATE FINANCE COMMITTEE MARK UP

Date: JULY 1, 1994

Amendment: MALPRACTICE

Sponsor: DANFORTH

Result: AGREED TO: 10-9-12-8

MEMBER	YES	NO	YES/PROXY	NO/PROXY
Moynihan		✓		
Baucus	✓✓			
Boren	✓✓			
Bradley		? ← ✓		
Mitchell		✓		
Pryor		✓		
Riegle		✓		
Rockefeller		✓		
Daschle		✓		
Breaux	✓✓			
Conrad	✓✓	WMM		
Packwood PASS	RABBIT			
Dole	✓✓	?		
Roth	✓ WMM →	?		
Danforth	✓✓			
Chafee	✓✓			
Durenberger	✓✓			
Grassley	✓✓			
Hatch	✓✓			
Wallop	✓✓			
TOTALS	12	WMM		

Swila-
Initially
Packwood-
passed
Laguardia
POM Δ pass to
year

MALPRACTICE REFORMS**Present Law**

No Provision.

Description of Proposal

Strike Title VI C, the malpractice reforms in the Chairman's mark, and insert in its place the following:

1. Alternative Dispute Resolution (ADR) Procedures

a. No health care malpractice action may be brought in court until final resolution of the claim under an alternative dispute resolution (ADR) method adopted by the state from models developed by the Secretary of HHS, or developed by the state and approved by the Secretary of HHS.

b. After final resolution of claim under the required ADR procedure, a party dissatisfied with the resolution would be permitted to bring a cause of action to seek damages or other redress with respect to that claim, to the extent permitted under State law. Yet, if the party initiating court action following ADR receives a worse result with respect to liability or a level of damages 33 1/3% below that awarded in the ADR, that party must pay the costs and attorneys fees of the other party incurred subsequent to the ADR.

2. Damage Caps

With respect to a health care malpractice claim or action brought in any forum, the total amount of damages that may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury alleged under such claim or action may not exceed \$250,000, indexed annually by the consumer price index.

3. Several Liability for Noneconomic and Punitive Damages

With respect to a health care malpractice claim or action, the liability of each defendant for noneconomic and punitive damages, shall be several only, and shall not be joint. Each defendant shall be liable only for the amount of noneconomic and punitive damages allocated to such defendant in direct proportion to such defendant's percentage of responsibility.

4. Punitive Damage Reform

Seventy-five percent of punitive damage awards in medical malpractice liability actions shall be paid to the State in which the action is brought, and such funds shall be used to assure the safety and quality of health care services provided in the State. The resources should be expended on

such things as 1. licensing and certifying health care professionals in the state; 2. implementing health care quality assurance programs; 3. carrying out public education programs to increase awareness of the availability of comparative quality information on accountable health plans; and 4. carrying out programs to reduce malpractice related costs for providers volunteering to provide services in medically underserved areas.

5. Fee Reform

Contingency fees paid to attorneys would be limited to a sliding-scale schedule. An attorney who represents a plaintiff in a medical malpractice action on a contingency fee basis would not be permitted to charge, demand, receive or collect more than the following percentages of the plaintiff's award, based on after tax amounts: 33 1/3% of the first \$150,000 of the award and 25% of amounts in excess of \$150,000.

6. Limited Preemption

Federal malpractice laws would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney fees, non-economic damages or punitive damages, or permitted additional defenses to health care malpractice actions.

8. No Right to Action in Federal Court

The Federal malpractice provisions would govern actions in State courts and would not establish a basis for bringing malpractice actions in federal court.

Effective Date

Effective for causes of action arising after January 1, 1995.

Issues to consider with Finance approach to Benefits

1. Use of the BC/BS-SO actuarial value - adequate level of coverage, comprehensive set of benefits, however includes cost sharing on prevention when go to non preferred providers.
2. Categories of service - very important to keep list of categories of service; not clear why extended care services were excluded - should be kept in. What happened to adult dental care? What about outpatient ambulatory or surgical services [i.e. the freestanding centers]
3. Cost sharing - okay to establish by Board, except that MUST preserve NO cost sharing on prevention, including prenatal care, associated services and one post partum visit. In defining cost sharing, Board should not have option of offering fewer covered services [see mainstream mark, last line before Section B], otherwise this could lead to risk selection. Cost sharing levels should not only preserve market viability of HMO's, but promote the use of integrated delivery system.
4. Medical Necessity Criteria - Do the specifications in the amendment replace the language at the top of page 19 as well? In specifying the guidelines for establishment of medical necessity the Board should:
 - have permissive consultation authority with experts;
 - assure that [not design] the benefits package application by health plans does not result in adverse risk selection;
 - modify (c) to "improving the health of individuals through prevention and maximizing functioning and quality of life"
5. Other comments:
 - Do these specifications give the Board adequate authority to EXCLUDE services that they deem to be NOT medically necessary or appropriate?
 - In allowing the Board to establish cost sharing schedules, should purpose/guidelines for these be given, e.g. "assure access to preventive services" or "promote the use of cost-effective service delivery settings and modalities".

7/6/94

Health Reform Issues

1. Benefits

Corrections:

- Labor
 - Mental health inpatient is ~~30~~³⁴ days per year.
- Finance
 - Also omitted adult dental.
 - Mainstream amendment would allow one benefit plan to have fewer services -- you say only cost sharing.

Policy:

- BC/BS Standard (out of network) has an actuarial value that is 8% lower than the HSA. According to Jim Mays, it "costs" 7% to achieve parity for mental health services. Therefore, this option will reduce the HSA benefit package by only 1%.
- Why has extended care been eliminated? Durable medical equipment (actually lumped with diagnostic??)? What about ambulatory medical or surgical services (i.e. freestanding centers) -- is this intended to be included within outpatient care? I assume adult dental has been omitted intentionally.
- Cost sharing
 - It should be specified that there is no cost sharing on prevention and prenatal care. BC/BS includes cost sharing on prevention when go to non-preferred providers.
 - Is cost sharing determined by the Board so as to make package actuarially equivalent to BC/BS? Is that the "check" that the standard package is affordable? Still a worry that without defined benefits and cost sharing, people are not guaranteed anything.
 - There may be risk selection problems by allowing two standard plans -- somewhat alleviated by fact that benefits are the same, but still could be a

Why comp?
Why specifying
cost sh.



even in higher
cost sharing
plan

problem given likelihood that younger, healthier people will choose plan with higher cost sharing.
ASK GARY.

- Criteria for medically necessary or appropriate treatments
 - What does it mean to "design" package to prevent adverse risk selection? Does this mean to make sure that it is applied so as to prevent adverse risk selection?
 - What does it mean to "develop interim coverage decisions in limited circumstances"? As science and medical practice advance?
 - Specify that Board consult with experts in developing benefit package.

2. Antitrust

- Kennedy language for repeal of McCarran-Ferguson for the business of insurance is fine (same as the original Health Security Act).

3. Malpractice

WAITING FOR CINDY LEBOW.

- Penalty provision

This is a significant bar to suit since only those who can afford costs and attorneys fees can bring suit. Certificate of Merit provisions missing and penalty added -- is this because certificate is not seen as a sufficient check on the merit, reasonableness of the case?
- Access to National Practitioner Databank missing?

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U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
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ALAN J. ROTH, STAFF DIRECTOR AND CHIEF COUNSEL
DENNIS S. FITZGIBBONS, DEPUTY STAFF DIRECTOR

FAX COVER SHEET

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FROM: NANCY DELEW
FAX NUMBER 456-2878
NUMBER OF PAGES
(INCLUDING COVER) 10
COMMENTS: _____

If there are any problems with the transmission, please
call (202) 225-9037.



May 4, 1994

TO : House Energy and Commerce Committee
Attention: Nancy DeLew

FROM : Michael J. O'Grady
Specialist in Social Legislation
Education and Public Welfare Division

SUBJECT : Varying the Benefits in the Health Security Act, H.R. 3600--
Premium Effects

In response to our meeting and subsequent phone conversations, I have prepared the following memorandum analyzing the effect of various benefit changes on health insurance premiums. Using the benefit package specified in H.R. 3600 as a basis for comparison, our consulting actuaries at Hay/Huggins Co., Inc. have estimated the actuarial value of the benefits changes you specified in your fax dated April 21, 1994. With the Hay/Huggins estimates of actuarial value, I have used the Census Bureau's March 1993 Current Population Survey (CPS) to model the distribution of the U.S. population¹ into the four types of coverage set specified in H.R. 3600: self only, two adults, single-parent families and two-parent families.

Table 1 details the effects of the benefit changes on the four premium types specified in H.R. 3600. Many of the changes have minimal effect on premiums. Taken as a whole, the effect may be pronounced.

There are a few items where we are still awaiting data. I will forward those estimates as soon as they are available. Our analysis of the premium effect of changing the mental health benefits is ongoing, but should be complete within another day. If you have any questions about our interpretation of the proposed changes or modifications in the proposed changes please let me know.

The methodology and assumptions underlying the estimates have been coordinated with the Budget Analysis Division of the Congressional Budget Office to ensure that they are consistent with estimates you may receive from them later.

If you have any questions or we can be of further assistance, I can be reached at 7-7347.

¹Except those people who primarily rely on Medicare for their health insurance.

TABLE 1. Modifications to Health Security Act and Their Effect on Premiums

Potential Benefit Changes	Estimated Price Changes for High Cost Sharing Plan			
	Self-only	Two Adults	Single Parent Family	Two Parent Family
1. Illness and injury Coverage to include congenital conditions for home health, extended care facilities and rehabilitation coverage. HSA restricts coverage to conditions that were a result of an illness or injury. 2. Outpatient Rehabilitation Replaces the "maintained" or "preventing deterioration" to include coverage with a condition that is improving. (The available data was not rigorous enough to separate the costs between items 1 & 2)	0.9%	0.9%	0.8%	0.8%
3. Colorectal screening a. Occult blood every year and sigmoidoscopy every 3 years after 3 annual for adults aged 50 -64	0.6%	0.6%	0.3%	0.4%
4. Mammogram and pap smears - Augments the benefit under HSA a. Biannual mammogram women age 40-49	0.3%	0.3%	0.2%	0.2%
b. Annual mammogram women age 50-64 rather than biannually.	0.6%	0.6%	0.3%	0.3%
c. Added benefit to HSA to cover pap smears annually unless individual has three years of negative pap smears and no risk factors for STDs or cervical cancer.	0.3%	0.3%	0.2%	0.2%
5. Family Planning Services a. Clinical services with no cost sharing	0.0%	0.0%	0.0%	0.0%
b. Family planning supplies & drugs as clinical preventive services	0.9%	0.9%	0.5%	0.6%

75%
15%
Medicare conforming

TABLE 1. Modifications to Health Security Act and Their Effect on Premiums				
Potential Benefit Changes	Estimated Price Changes for High Cost Sharing Plan			
	Self-only	Two Adults	Single Parent Family	Two Parent Family
6. Limited dental care essential to medical care a. For emergency treatment of infections	0.4%	0.4%	0.4%	0.4%
b. For adults if they are essential to the successful medical treatment for another condition and are ancillary to a covered benefit (e.g., cancer chemotherapy and AIDS patients should be covered for treatment of oral infections).	waiting for data			
7. Genetic screening, counseling, and treatment (MAPK, PKU, T4, sickle cell, galactosemia) a. Medical foods for people with PKU are covered as drugs	0.0%	0.0%	0.0%	0.0%
b. Genetic counseling and screening, including newborn screening and treatment of PKU, would be covered as a clinical preventive service (waiver of 20% coinsurance)	0.0%	0.0%	0.0%	0.0%
8. In vitro fertilization - benefit added under family planning services.	0.0%	0.6%	0.3%	0.4%
9. Prostate cancer screening for men (Additional for PSA; Digital Rectal Already included)	0.1%	0.1%	0.0%	0.1%
10. Hearing Aids for children under age 18	0.0%	0.0%	0.1%	0.0%
11. Investigational Treatment a. Health plan must cover routine medical costs and hospitalization associated with clinical trial (not to include the cost of new drugs or devices still being tested). HSA provides this coverage as an option.	waiting for data			
b. Cost of experimental treatment not part of a clinical trial when the treatment is available under FDA expanded access protocol for life-threatening diseases.	waiting for data			
12. Recreational therapy services included with other outpatient therapy.	indeterminant, likely to be quite expensive			

TABLE 1. Modifications to Health Security Act and Their Effect on Premiums

Potential Benefit Changes	Estimated Price Changes for High Cost Sharing Plan			
	Self-only	Two Adults	Single Parent Family	Two Parent Family
13. National board would have to cover services for which no evidence exists that it is not safe and effective.	indeterminant, likely to be quite expensive			
14. TB screening for children and on a risk basis for adults	0.1%	0.1%	0.1%	0.1%
15. Abortion services available as a separate optional benefit (not included with the mandatory benefits package).	26.4%	9.7%	12.1%	7.8%
18. Pro-rate out-of-pocket catastrophic cap over a year. Health plans would pro-rate the \$2,500 individual out-of-pocket cap over a 12 month period, so that if they have \$2,500 in cost-sharing in January they pay 1/12 of the cap in January.	0.4%	0.4%	0.4%	0.4%
19. Home health care covered as an alternative to hospitalization or as a cost-effective alternative.	0.0%	0.0%	0.0%	0.0%
Other benefits provided				
1. Immunization coverage for children through age 6, not to age 6.	0.0%	0.0%	0.0%	0.0%
2. Coverage for new vaccines when recommended in the future by ACIP.	0.0%	0.0%	0.0%	0.0%
3. Screening for STD expanded to include men (same benefit in HSA as for women).	0.0%	0.0%	0.0%	0.0%
NOTE: Items 16 and 17 were deleted from the list of benefit variations.				
No current cost impact. As with all medical services, future technology improvements will affect cost-frequently upward.				
Source: Congressional Research Service, Education and Public Welfare Division.				

Fax Message From CRS/EPW

May 5, 1994 - 8:42am

TO : House Energy and Commerce Committee
Attention: Nancy DeLew
Fax # : 5-5288
FROM : Michael J. O'Grady 7-7347
Specialist in Social Legislation
Education and Public Welfare Division
Fax # : 7-7338
SUBJECT: Benefit Variations

In light of conversation yesterday, I'm sending along some estimates we did on how the low cost sharing plan premium might be pared down a little. They haven't been converted into the four premiums types, but if you're interested we certainly can do that.

Low Cost Sharing			
		Price Change	
Benefit	Proposed Benefit Changes	Individual	Family
Hospital Deductible	Increase from \$0 to \$250	-1.6%	-1.5%
Prescription Drug	Increase copayment from \$5 to \$10	-2.0%	-1.9%
Out-of-Pocket Limits	Individual: Increase from \$1,500 to \$2,500 Family: Increase from \$3,000 to \$5,000	0%	0%

I want to apologize for any misunderstanding about what you needed for your analysis. Almost all of the analysis of benefit variations we have done has been variations on the high cost sharing plan. The memo I sent you yesterday estimated the effects on high cost sharing premiums. We will begin work on showing the effect of your proposed changes on the low cost sharing plan this morning.

The following benefit changes occur on January 1, 2001:

1. Mental Illness

All day and visit limits as well as higher cost sharing are eliminated. Before January 1, 2001, the following limits apply:

Inpatient and residential - Before January 1, 2001, 30 day annual limit with an additional 30 days available under certain circumstances.

Intensive non-residential - Before January 1, 2001, two to one substitution for inpatient and residential treatment with a maximum of 60 additional days available at the discretion of the health plan. Before January 1, 2001, higher cost sharing applies to the additional 60 days. In addition, expenses for substance abuse treatment and for the additional 60 days of treatment do not apply to the out-of-pocket maximum.

Outpatient - Before January 1, 2001, 30 visit limit on psychotherapy, 30 group therapy visits for substance abuse counseling and relapse prevention, and four to one substitution at the discretion of the health plan for psychotherapy and substance abuse counseling and relapse prevention. Before January 1, 2001, higher cost sharing for psychotherapy. In addition, expenses for outpatient services do not apply to the out-of-pocket maximum.

2. Dental

Before January 1, 2001, prevention and diagnosis and treatment for dental disease are covered only for individuals under 18 years of age. After January 1, 2001, prevention and diagnosis and treatment of dental disease are covered for individuals 18 years of age and over. Even after January 1, 2001, however, dental sealants and endodontic services are not covered for individuals 18 years or older.

Before January 1, 2001, interceptive orthodontic treatments are not covered. After January 1, 2001, interceptive orthodontic treatments are covered for individuals 6 to 11 years old to prevent severe malocclusion.

ADVERSE SELECTION:

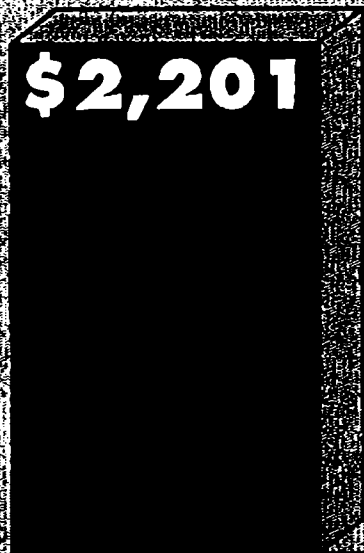
Lack of Standardized Benefits Makes Insurance Unaffordable

**Actuarial
Value
(1993)**

**Annual
Premiums
(1993)**



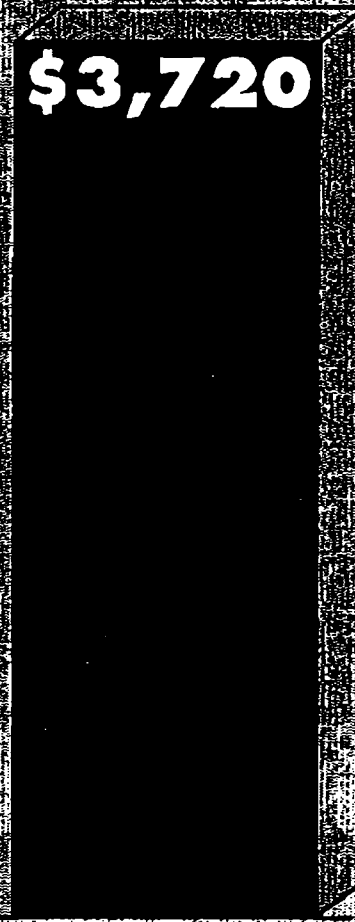
**Blue Cross
Standard
Option**



**Blue Cross
High Option**



**Blue Cross
Standard
Option**



**Blue Cross
High Option**

Source: OPM

AdverseSelection.LHR

To: Tricia Neuman
From: Alan Lopatin, Jon Weintraub, and Susie Ringel
Date: July 19, 1994
Re: Proposed Benefits Changes to be Costed

- ✓ 1. Lower deductibles and out-of-pocket expenses for those under 65 to those in the Education and Labor bill (out-of-pocket limits: \$2,500 indiv./\$3,000 family; deductibles: lower deductibles to those in Ed & Labor bill (where the general deductibles are zero in lower cost-sharing plans and \$200 indiv./\$400 family in higher cost-sharing plans) or to some other reasonable amounts.
2. Add "or appropriate" to "medically necessary" standard:
 - everywhere
 - ✓ - for clinical preventive services
 - for provision concerning revision of/additions to benefit package
 - for provision relating to pregnancy-related services
- ✓ 3. Include "disorder or other health condition" after all "illness or injury" language, especially for outpatient rehabilitation services. Also, include language concerning minimization of limitations (per Ed. & Labor outpatient rehab. language attached).
- ✓ 4. Remove cost-effectiveness list of criteria for revisions/additions to package. (Ed. & Labor language re: preventive benefits revision attached)
- ✓ 5. Add coverage for regular clinician visits for adults at the periodicity levels in the Education and Labor bill. In the Education and Labor bill we have a periodicity schedule covering visits every 3 years for those 20-39, every 2 years for those 40-65, and annually for those over 65.
- ✓ 6. Expand wrap-around benefits for pregnant women to include 2 months post-partum.
- ✓ 7. Raise age limit for children's wrap-around program to 22.
- ✓ 8. Eliminate cost-sharing for family planning services, including contraceptive drugs & devices.
- ✓ 9. Expand STD screening to all STDs and to men.

10. Expand durable medical equipment coverage to include coverage of bathing, toileting, lifting, and respiratory support at levels in the Ed & Labor bill (language attached).
11. Expand dental coverage to include preventive services for adults, dental services for those with seizure disorders, and other provisions in the Ed & Labor bill. (language attached)

- also, cost seizure disorder language separately
12. Include outpatient vision-related rehab. as in Ed & Labor bill (language attached).
13. Provide a special periodicity schedule for preventive services for high-risk individuals.
14. Provide vision care as in the Ed & Labor bill (language attached).
15. Include services provided at free-standing birth centers in family planning services/services for pregnant women.
16. Include broader coverage for medical foods (as in the Ed. & Labor bill - language attached).
17. Include extended care services as in the Ed. & Labor bill (language attached).
18. Include transportation services as in the Ed. & Labor bill (language attached).

OUTPATIENT REHABILITATION SERVICES.

(a) Covered outpatient rehabilitation services include occupational and physical therapy, speech-language pathology services and audiology, and vision-related rehabilitation services.

(b) Coverage for these services is subject to the following limitations:

(1) Subsection (a) includes only items or services used to maintain, restore, or prevent deterioration of, functional capacity or minimize limitations on physical and cognitive functions as a result of an illness, injury, disorder, or other health condition.

(2) Vision-related rehabilitation services include only items or services used to restore, or prevent deterioration in, independent functioning.

(3) To the extent that occupational therapy, physical therapy, or speech-language pathology services and audiology are provided to an individual to maintain, or prevent or minimize deterioration of, functional capacity, such services shall be limited to:

(A) initial evaluation and periodic oversight of the patient's needs by a qualified rehabilitation health professional;

(B) designing by such professional of a maintenance or prevention program appropriate to the capacity and tolerance of the patient and the treatment objectives;

(C) instruction of the patient, family members, and any personnel providing rehabilitation-related assistance to the individual, in carrying out such program; and

(D) reevaluations of such program.

(4) At the end of each 60-day period of outpatient rehabilitation services (other than services described in paragraph (3)), the need for continued services shall be reevaluated by the person with primary responsibility for providing the services. Additional periods of services are covered only if such person determines that the requirement in paragraph (1) is satisfied.

Outpatient rehabilitation services described in paragraph (3) shall periodically be reevaluated by a qualified rehabilitation health professional.

*Idolite
June 11, 2000*

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC DEVICES.

(a) The items and services covered under this section are:

(1) durable medical equipment (as defined in section 1861(n) of the Social Security Act) and other items of such equipment relating to respiratory support, bathing, toileting, or lifting (such as bathtub lifts and grab bars) which are essential to the prevention of complications of an existing illness, injury, disorder, or other health condition.

(2) prosthetic devices (other than dental devices) which replace all or part of the function of an internal body organ, including devices that are surgically inserted, devices that are physically attached to the body (such as colostomy bags), and external devices;

(3) leg, arm, back, and neck braces;

(4) artificial legs, arms, and eyes;

(5) accessories and supplies that are used directly with equipment or devices described in paragraphs (1) through (4) to achieve the therapeutic benefits of such equipment or devices or to assure the proper functioning of such equipment or devices;

(6) replacements of equipment and devices described in paragraphs (1) through (4) when required in cases of loss, irreparable damage, or wear; or because of a change in the patient's physical condition;

(7) repair and maintenance of equipment and devices described in paragraphs (1) through (4); and

(8) fitting (including adjustments) and training for use of equipment and devices described in paragraphs (1) through (4).

(b) An item or service described in this section is covered only if it improves functional ability or prevents, minimizes, or stabilizes further deterioration in function.

VISION CARE.

This section provides coverage for routine eye examinations, diagnosis, and treatment for defects in vision.

Hearing aids are covered, but only upon a determination of a certified audiologist or physician that the patient's hearing problem can be corrected by use of a hearing aid.

(b) Eyeglasses and contact lenses are covered only for individuals under 18 years old, according to a periodicity schedule established by the Board.

DENTAL CARE.

a) The dental care covered under this section is the following:

(1) Emergency dental treatment, including extractions, for bleeding, pain, acute infections, and injuries to the maxillofacial region.

(2) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(3) Treatment of dental disease, including non-cast fillings, periodontal maintenance services, and endodontic services.

(4) Space maintenance procedures to prevent orthodontic complications.

(5) Orthodontic treatment to prevent severe malocclusions.

(6) Full dentures.

(7) Medically necessary oral health care.

(8) Any items and services for special needs patients that are not described in paragraphs (1) through (7) and that:

(A) are required to provide such patients the items and services described in paragraphs (1) through (7);

(B) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(C) consist of orthodontic care for severe dentofacial abnormalities; or

(D) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(9) Any dental care for individuals with a seizure disorder that is not described in paragraphs (1) through (8) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

(b) Limitations on dental care coverage are:

(1) The examinations and prophylaxis described in subsection (a)(2) are covered only annually, except for those under 18 years of age and special needs patients. Dental sealants are not covered for individuals 18 years of age or older. These sealants are covered for individuals under 10 years of age for protection of the 1st permanent molars, and for individuals 10 years of age or older for protection of the 2nd permanent molars.

(2) Before January 1, 2001, the items and services described in subsection (a)(3) are covered only for individuals under 18 years of age and special needs patients. From that date on, these items and services are covered for all eligible individuals, except that endodontic services are not covered for individuals 18 years of age or older.

(3) The items and services described in subsection (a)(4) are covered only for individuals at least 3 years of age, but less than 13 years of age and

(A) are limited to posterior teeth;

(B) involve space maintenance for permanent posterior teeth

that would otherwise be prevented from normal eruption; and (C) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(4) Before January 1, 2001, the items and services described in subsection (a)(5) are covered only for individuals at least 6 years of age, but less than 12 years of age, who have severe dentofacial abnormalities. On or after such date, such items and services are covered only for all individuals in that age range.

(5) Before January 1, 2001, the dentures described in subsection (a)(6) are not covered, except for special needs patients. On or after such date, 1 set of such dentures are covered for an individual every 8 years, but this limitation does not apply to special needs patients.

(c) For purposes of this subtitle:

(1) "Medically necessary oral health care" means oral health care required as a direct result of, or that would have a direct impact on, an underlying medical condition. The term includes oral health care directed towards control or elimination of pain, infection, or reestablishment of oral function.

(2) "Special needs patient" includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

HEALTH EDUCATION PROGRAMS.

(a)&(b) Health education programs in smoking cessation, nutrition counseling, stress management, support groups, physical training, or programs that are otherwise intended to encourage reduction of behavioral risk factors and promote healthy activities are covered if a health plan chooses to offer such classes, except that the plan must offer smoking cessation programs to pregnant women enrolled in the plan.

(c) Programs offered under this section do not include or limit education or training provided as part of health professional services, as defined in section 1112(c).

(d) A health plan shall assess the availability of health education programs in the community that have demonstrated effectiveness in changing health behaviors, and provide enrollees with information about them.

MEDICAL FOODS.

Medical foods (as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)) prescribed by a physician that comply with the requirements of the Federal Food, Drug, and Cosmetic Act and that treat:

(A) an inborn error of metabolism identified by the Secretary as rendering a person unable to sustain life or avoid morbidity (such as mental retardation) without significant impairment by the ingestion of conventional foods; or

(B) an illness, injury, disorder, or other health condition identified by the Secretary as one for which coverage of such foods under this subtitle is medically necessary or appropriate and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation and will not result in an increase in any premium paid for the comprehensive benefit package.

PREVENTIVE SERVICES.**(a) Clinical Preventive Services.**

(1) The National Health Board, based on recommendations of the expert panel described in paragraph (2), must define clinical preventive items and services and a periodicity schedule for high risk populations. The Board is also required to update the periodicity schedule for immunizations, tests and clinician visits provided at periods other than the periodic age ranges. Finally, the Board may modify the clinical preventive services package but may not modify the cost sharing requirements.

(2) The Board shall establish an expert panel on clinical preventive services, including experts on those services, to advise the Board on functions under paragraph (1). The panel shall be responsible for reviewing scientific evidence on clinical effectiveness and cost-effectiveness of clinical preventive services, taking into account variations among individuals in health status and risk, and may submit recommendations to the Board about the matters in paragraph (1).

(b) (1) The Board shall establish an expert panel on community-based prevention to advise the Board on community-based prevention activities, including workplace-based prevention activities and core public health functions and other activities conducted under subtitle D of title III. Such panel shall include experts in public health and preventive medicine. The panel shall be responsible for the review of evidence on the effectiveness and cost-effectiveness of community-based approaches (including activities of State and local health departments) for health promotion and disease prevention for adults and children and the impact of this title on community-based prevention activities, and must submit periodic reports to the Board on its reviews, including recommendations regarding community-based approaches that should receive support under subtitle D of title III.

(c) The Board shall establish an expert panel on social and economic policy for prevention to advise the Board on the impact of social and economic policies on health and health status. The panel shall review relevant scientific and other evidence and submit analyses to the Board that may help them formulate recommendations under subsection (d)(2).

(d) The Board shall submit a report biennially to the Congress on approaches that have been, and may be, taken to improve health status and prevent disease. Each report shall include information on changes in clinical preventive services made under subsection (a) and on community-based prevention activities being undertaken under subtitle D of title III or otherwise and any recommendations on changes in social and economic policies that would promote health and prevent disease as the Board finds appropriate.

EXTENDED CARE SERVICES.

(a) Extended care services consist of items and services described in section 1861(h) of the Social Security Act.

(b) Coverage is limited to 100 days per year and is limited to cases in which care is furnished as an alternative to hospitalization as a result of an illness, injury, disorder, or other health condition.

(c) The term "rehabilitation facility" means an institution (or a distinct part of an institution) devoted to providing services to individuals for rehabilitation from illness, injury, disorder, or other health condition. Such term shall include a unit of a hospital (as defined in section 1111(c)(1)); "skilled nursing facility" means an institution (or a distinct part) that primarily provides skilled nursing care or services for rehabilitation from illness, injury, disorder, or other health condition.

TRANSPORTATION SERVICES.

(a) Transportation services include:

(1) Ambulance services consisting of ground transportation by ambulance, or air or water transportation by aircraft or vessels that are equipped for transporting ill or injured persons.

(2) Inter-island, intrastate air transportation (consisting of one round-trip for one complete series of treatments) where there is no other reasonable method of transportation available for an individual to receive an item or service covered under this subtitle not available on the island where the individual resides.

(3) Inter-island, intrastate air transportation necessary for one companion to accompany an individual described in paragraph (2) if the individual is under 18 years old or otherwise incapable of traveling alone.

(b) Ambulance services described in subsection (a)(1) are covered only if a patient's condition indicates that there is no alternative to such transportation or the alternative is contra-indicated.

**COMMITTEE ON EDUCATION AND LABOR****Subcommittee on Labor-Management Relations****U.S. House of Representatives****320 Cannon House Office Building****Washington, DC 20515****phone: (202) 225-5768****fax: (202) 225-3614*****FACSIMILE TRANSMISSION SHEET*****DATE:** 7/20/94**TO:** TRICIA NEUMAN**FROM:** Jon Weintraub___ Phyllis Borzi___ Rick Jerue___ Gail Brown___Susie Ringel ☒ Allison Hogue___ Tony Guiles___ Corinne Huddleston___**NUMBER OF PAGES TO FOLLOW:** 9**MESSAGE:** Hopefully this will work!



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

June 10, 1994

Honorable Sam M. Gibbons
Acting Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

At the request of your staff, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared the enclosed estimate of your health care reform mark, as released today. Although CBO and JCT have worked closely with the staff of the committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore be regarded as preliminary. Also, we have not had time to analyze the proposal's impact on employment or the economy or to review other considerations affecting the proposal's design and implementation.

Sincerely,

Robert D. Reischauer

Enclosure

cc: Honorable Bill Archer
Ranking Minority Member

benefit pkg. than
w + m 7% less generous HSA
- so premium in HSA would be 7% less with
w + m pkg.
2000
+ 50 B increase in per national health spending w + m
- 30 B decrease in HSA

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

Estimated On-Budget Effects

By fiscal year, in billions of dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0.0	0.0	0.0	-56.8	-84.4	-84.2	-105.0	-116.3	-128.8	-141.9
2 State Maintenance-of-Effort Payments	0.0	0.0	0.0	-39.1	-58.1	-80.1	-61.1	-65.4	-62.6	-66.9
3 Administrative Savings	0.0	0.0	0.0	-0.5	-0.7	-0.8	-0.9	-1.0	-1.1	-1.2
Total - Medicaid	0.0	0.0	0.0	-96.4	-141.2	-165.1	-167.0	-182.7	-192.6	-210.0
Medicare Parts A and B										
4 Drug Benefit (Net of Premiums and Rebate)	0.0	0.0	0.0	5.4	13.1	14.3	15.7	17.4	19.2	21.2
5 Out of Pocket Cap	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.4	15.4
6 Other New Benefits (Well-baby, Preventive, Mental Health, EACHRPCH)	*	0.1	0.1	0.3	0.5	0.4	0.4	0.3	0.4	0.4
7 Additional Medicare Savings										
Indirect Medical Education	0.0	0.0	0.0	-0.3	-1.0	-1.7	-2.0	-2.2	-2.4	-2.7
Disproportionate Share Adjustment	0.0	0.0	0.0	-0.9	-2.2	-2.5	-2.8	-3.1	-3.4	-3.7
Inpatient Hospital Capital	0.0	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2
Pilot for Phys Svcs in Certain Hospitals	0.0	0.0	0.0	-0.5	-0.8	-0.8	-0.8	-0.8	-1.0	-1.0
Home Health Services Coinsurance	0.0	0.0	0.0	-3.0	-4.7	-5.3	-5.8	-6.2	-6.8	-7.3
Home Health Cost Limits	0.0	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7
Medicare Secondary Payer	0.0	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
8 Minor and Technical Amendments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9 Part B Premium Offsets	0.0	0.3	0.7	1.5	1.8	1.8	1.9	2.0	2.0	2.2
10 Effect of Growth Limits a/	0.0	-2.7	-7.4	-14.5	-24.5	-35.2	-48.0	-63.5	-81.9	-103.6
Total - Medicare Parts A and B	0.0	0.0	0.0	13.1	25.4	32.2	44.2	58.9	76.3	93.3
11 Federal Employees Health Benefits										
Total - FEHB	0.0	1.1	1.5	1.2	1.0	0.8	0.7	1.0	1.3	0.9
Other Health Programs										
12 Long Term Care Program	0.0	0.0	3.2	4.5	5.4	8.3	10.0	11.0	12.1	13.1
13 Academic Health Centers	0.0	1.3	2.0	1.9	2.0	0.6	0.0	0.0	0.0	0.0
14 Essential Health Facilities (Loans) b/	0.0	0.5	0.7	0.8	0.9	0.5	0.3	0.1	*	0.0
15 Federal Grants for Managed Care Plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total - Other Health Programs	0.0	1.8	5.9	7.2	8.3	13.4	18.3	22.1	24.1	26.1

Part C wrap (line 18) [Medicaid + other low-income]
kids - EPSDT
adults - hearing & vision

Residual Medicaid optional benefits that states currently provide

1994 premiums

39
2,100 single premium Part C
4,785 family

+ 10% lower rates in Part C under Medicare w/les - this offsets 10% adverse selection compared to private sector
+ 12% to draw Medicare rates for Medicaid

06/10/94 09:10 AM

artificially lowers premium in first 5 yrs. to attract outside enrollers

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

Estimated On-Budget Effects		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicare Part C											
16 Medicare Part C Start-up Premium Offset c/		0.0	0.0	0.0	6.4	9.5	8.3	5.7	1.6	0.0	0.0
17 Additional Costs of the Disabled		0.0	0.0	0.0	4.6	7.3	8.7	10.3	12.2	14.2	16.5
18 Low-Income Wrap-Around Benefits		0.0	0.0	0.0	7.7	11.2	12.1	13.1	14.1	15.2	16.4
Total - Medicare Part C		0.0	0.0	0.0	18.7	28.0	29.1	29.1	27.9	29.4	32.9
Subsidies											
Premium Subsidies:											
19 For Medicare Beneficiaries below 120% of Poverty		0.0	0.0	0.0	4.3	6.0	6.3	6.6	6.9	7.2	7.6
20 For Persons b/w 0-240% of Poverty d/		0.0	0.0	0.0	73.5	104.5	113.0	124.5	133.6	145.8	155.6
Cost-Sharing Subsidies:											
21 For Medicare Beneficiaries below Poverty		0.0	0.0	0.0	10.6	17.5	18.7	20.0	21.3	22.3	23.6
22 For Certain Low Income Beneficiaries		0.0	0.0	0.0	13.5	22.3	24.1	26.0	27.9	29.8	31.6
Total - Subsidies		0.0	0.0	0.0	102.0	150.3	162.2	171.0	189.7	205.1	218.4
TOTAL MANDATORY OUTLAY CHANGES		0.0	-0.1	-0.2	18.6	28.5	15.0	6.3	-12.3	-12.8	-26.0
DISCRETIONARY OUTLAYS											
23 Administrative and Start-Up Costs	*	*	0.5	2.6	9.3	11.3	11.8	12.7	13.4	14.1	14.8
Total Administrative and Start-Up Costs	*	*	0.5	2.6	9.3	11.3	11.8	12.7	13.4	14.1	14.8
TOTAL OUTLAY CHANGES		0.0	0.4	2.4	28.9	37.8	26.8	18.0	1.1	1.3	-13.2
RECEIPTS											
24 Income and Payroll Tax Effects		0.0	-6.1	-8.1	-19.5	-25.5	-26.6	-26.4	-22.6	-21.6	-20.8
25 Net Medicare Part C Premium Payments from Non-enrolling Employers		0.0	0.0	0.0	24.0	34.2	31.3	23.8	5.4	0.0	0.0
26 Extend Medicare Cov of, & Extend Phase in HI Tax to All State & Local Govt Employees		0.0	0.0	0.3	0.7	1.0	1.3	1.4	1.3	1.2	1.2
27 Health Benefits may not be Provided under Cafeteria Plans		2.3	3.8	5.4	5.0	5.3	6.1	6.9	7.7	8.5	9.1
28 Modification of COBRA continuation care rules											
29 Limitation on Prepaid of Medical Expenses											
30 Trust of Nonprofit Health Care Organizations											

- premium for Part C = Medicaid spread over everyone in Part C pool with exception of SSI disabled
 - disabled per capita less Part C premium = additional federal subsidy for Part C disabled

line 24 every \$1 in wages that goes to health spending, lose .30 of it. taxes

H.R. 3600 - HEALTH SECURITY ACT AS AMENDED BY THE COMMITTEE ON WAYS AND MEANS - PRELIMINARY

CHAIRMAN'S MARK, JUNE 10, 1994

By fiscal year, in billions of dollars.

Estimated On-Budget Effects	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
31 Increase Rpt Penalties for Nonemployees	0.0	*	*	*	*	*	*	*	*	*
32 Tax Treatment of Accelerated Death Benefits under Life Insurance Contracts	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
33 Post-retirement Med & Life Insurance Reserves					Negligible Revenue Effects					
34 Increase in Tax on Tobacco Products	0.7	2.7	5.1	7.6	7.1	9.5	8.5	8.1	8.0	7.8
35 2% Excise Tax on Pvt Health Ins Premiums through 1999 and 1% thereafter	0.0	2.7	4.0	4.4	4.7	3.2	2.6	2.7	2.9	3.1
36 Self-employed Health Ins Deduction	-0.5	-0.4	-0.5	-1.3	-2.7	-2.9	-3.2	-3.4	-3.7	-3.9
37 Small Business Credit	0.0	0.0	0.0	-3.7	-5.9	-6.5	-7.0	-7.6	-6.9	-4.6
TOTAL RECEIPT CHANGES	2.5	2.7	6.1	17.1	18.1	15.3	6.5	-8.5	-11.7	-8.2
DEFICIT - MANDATORY CHANGES	-2.5	-2.8	-6.3	2.5	8.5	-0.3	-0.2	-3.8	-1.1	-19.8
DEFICIT - TOTAL CHANGES	-2.5	-2.3	-3.7	11.8	19.8	11.5	12.5	9.8	13.0	-5.0

39.6 increase in deficit

SOURCES: Congressional Budget Office, Joint Committee on Taxation

* Less than \$50 million.

NOTES:

a/ The estimate assumes that the expenditure limits would be less than fully effective.

75% effective in A+B (C gets to 75% after several years)

b/ Medicare spending in this section included in line 7.

c/ The estimate assumes that benefit outlays and premium receipts from the Medicare Part C program would balance, except for the start-up premium offset.

d/ The benefit package is assumed to be 7 percent less generous than the Administration's plan. The mental health benefit is assumed to be tightly managed.

e/ The estimate assumes that the small business credit has no effect on the distribution of the size of firms.

- law-income in firms above \$0 can opt into Part C

- assume 2/3 of those eligible for Part C will take it

- \$0 million in Part C in 1994 years

87 " in 2000

(40 m bought in by employers)

↑ about 50% opt into Part C

of those eligible employers

6/22/94

NOTE TO: Ken
THROUGH: Cheryl
FROM: Gordon, Jim, Sharman
SUBJECT: FFS & HMO Reductions

Attached is a table which cross walks some of the FFS reduction options with the HMO options that Gordon has developed. In comparison to previous work please note that:

- o the FFS 5% are the same as we have shown previously;
- o in the case of the FFS 10% Options #1, 4, and 5 are new variations which we needed to develop to stay consistent to the HMO options, with FFS #2 and 3 being the same as #1 and 2 in the 6/6/94 document developed for Senate Finance;
- o the FFS 15% options are somewhat different than developed for Senate Finance in the 5/25/94 document. The 5/25/94 options were based on the thinking related to Jim's May 3 memo doing 5%, 10%, 20%, and 30%. When we lined those up with Gordon's HMO options we had to modify somewhat.
- o the FFS 20% options except for #5 are new, again to develop options consistent with the HMO tables.

On Gordon's HMO options Table 1 was developed to be for the most part consistent with Gordon and Jim's earlier work which was included in the 5/25/94 package. Tables 2, 3, & 4 were developed as other approaches which focus on using per day cost sharing on inpatient rather than just an inpatient deductible scheme, cost sharing on adult prevention, and modification or elimination of dental and vision.

Revised HMO Tables attached 6/22/94

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL# of pages **8**

To Jennifer Klein	From Sharman Stephens
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368

5099-101

GENERAL SERVICES ADMINISTRATION

6/22/94 3:30PM

HSA BASE

	FPS	HMO CONSISTENT COLUMN
5%	1. Coinsurance to .25 2. O-O-P \$2500/\$3000 3. Deductible to \$325	Tables 2, 3, 4 5% column
10% Option 1	1. O-O-P \$2500/\$3000; .25 coins.; deductible \$325/\$650; add cost sharing to adult prev., except prenatal;	Table 2 10% column
10% Option 2 & 3	2. O-O-P \$2500/\$3000; .25 coins., \$250 hospital deductible 3. O-O-P \$2500/\$3000; .25 coins.; deductible \$350/\$700	Table 3 10% column
10% Option 4 & 5	4. O-O-P \$2500/\$3000; .25 coins.; deductible \$260/\$520; add cost sharing to adult prev., except prenatal; eliminate dental and vision 5. O-O-P \$2500/\$3000; deductible \$475/\$950; add cost sharing to adult prev., except prenatal; eliminate dental and vision	Table 4 10% column

07/01/94 16:24

202 401 7321

HHS ASPE/HP

002/008

	FFS	HMO CONSISTENT COLUMN
15% Options ¹ 1, 2 &3	1. O-O-P \$2500/\$3000; .25 coins.; deductible \$375/\$750; add cost sharing to adult prev. except prenatal; increase prescr. drug coins. to .5 2. O-O-P \$2500/\$3000; .25 coins.; deductible \$500/\$1000; add cost sharing to adult prev. except prenatal 3. O-O-P \$2500/\$3000; .25 coins.; deductible \$240/\$480; add cost sharing to adult prev. except prenatal; mental health through a gatekeeper or central intake	Table 2 15% column
15% Option 4	4. O-O-P \$2500/\$3000; .25 coins.; deductible \$425/\$850; add cost sharing to preventive adult except prenatal; eliminate dental and vision	Table 4 15% column
15% Option 5	5. O-O-P \$2500/\$3000; .25 coins.; deductible \$230/\$460; mental health through a gatekeeper or central intake; partial elimination dental (diagnosis and prevention retained, treatment excluded)	Table 3 15% column

¹ The 15% options in this table are somewhat different than 5/25/94 list in order to be comparable to HMO changes.

	PFS	HMO CONSISTENT COLUMN
20% Option 1	1. O-O-P \$3000/\$3000; .25 coins.; deductible \$600/\$1200; add cost sharing to adult prev. except prenatal; increase prescr. drug coins. to .5.; eliminate dental and vision	Tables 2 & 4 20% Column
20% Option 2	2. O-O-P \$3000/\$3000; .25 coins.; deductible \$510/\$1020; mental health through a gatekeeper or central intake; partial elimination dental (diagnosis and prevention retained, treatment excluded)	Table 3 20% Column
20% Option 3	3. O-O-P \$3,000/\$3,000; .25 coins.; deductible \$675/\$1,350; add cost sharing to adult prev. except prenatal;	Table 1 20% Column
20% Option 4	4. O-O-P \$3000/\$3000; .25 coins.; deductible \$525/\$1050; mental health through a gatekeeper or central intake; add cost sharing to adult prev. except prenatal;	Table 1 20% Column
20% Option 5	5. O-O-P \$3,000/\$3,000; .25 coins.; deductible \$700/\$1,400	
20% Option 6	6. O-O-P \$3000/\$3000; .25 coins.; deductible \$550/\$1100; mental health through a gatekeeper or central intake;	

Table 1
Additional Cost Sharing to Reduce Premiums for "Low" Cost Sharing Plans
(All copayments assumed to be indexed from 1986 to applicable year by increase in premium rates)

ITEM	H.R. 2000	Save 5%	Save 10%	Save 15%	Save 20%	Save 26%
<u>FACILITY CHARGES</u>						
Admissions to hospitals or specialized facilities (1)	0	250	250	400	500	600
Medical/Surgical						
Maternity						
Alcohol/Drug/Mental						
Hospital confinement	0	0	0	0	0	0
SNF or hospice	0	0	0	0	0	0
ADM partial confinement	0	0	35	45	80	75
<u>Outpatient facilities (2)</u>						
ER-Emergencies	0	0	05	100	100	100
ER-Non-Emergencies	25	25	65	100	125	150
O.P. dept surgery	0	0	0	0	0	0
O.P. dept visit	0	0	0	0	0	0
Urgi-Center (3)	10	10	15	20	25	35
Radiology (4)(5)	0	0	0	0	15	20
Pathology (4)(5)	0	0	0	0	7.5	10
<u>PROFESSIONAL SERVICES</u>						
<u>Inpatient services (6)</u>						
Primary surgeon and obstetrics (5)	10	10	100	150	200	250
Organ transplant	10	10	200	300	400	500
Anesthesiologist	0	0	0	0	0	0
Attending physician visits	10	10	15	20	25	35
Inpatient professional radiology (4)(5)	0	0	0	0	15	20
Inpatient professional pathology (4)(5)	0	0	0	0	7.5	10
<u>Outpatient hospital (pro/feesional)</u>						
ER-Emergencies	0	5	35	50	60	50
ER-Non-Emergency visits	10	10	35	50	60	30
Other hospital outpatient or clinical services	10	10	15	20	25	35
<u>Outpatient surgery</u>						
OP dept	10	10	50	75	100	125
Urgi-Center	10	10	25	35	75	100
Office	10	10	15	20	25	35
<u>Primary care</u>						
Prenatal, well child, immunizations	0	0	0	0	0	0
Other preventive care	0	0	15	20	25	35
Family planning	10	10	15	20	25	35
Acute primary care (7)	10	10	15	20	25	35
Referral visits	10	10	15	20	25	35
<u>Other Practitioners</u>						
Rehabilitation	10	10	15	20	25	35
Phys extenders	10	10	15	20	25	35
Other professionals (podiatrist/chiropractor)	10	10	15	20	25	35
<u>Dental Care (8)</u>						
Diagnosis and Prevention	10	10	15	20	25	35
Treatment	10	10	15	20	25	35
Vision Care	10	10	25	35	35	35
<u>OUTPATIENT ADM</u>						
Diagnosis & medical management	10	10	35	45	60	75
Psychotherapy & counseling	25	25	35	45	60	75
<u>OTHER SERVICES</u>						
Home health care	0	0	15	20	35	35
Ambulance	0	0	30	75	100	125
DME, prosthetics, orthotics, contraceptive devices	0	0	0.3	0.7	0.7	0.7
Prescriptions	5	10	10	18	10 (10)	10 (10)

(1) Applied for first admission in any calendar year
(2) Includes freestanding radiology facilities and laboratories
(3) Includes professional components
(4) Single copayment per procedure, as defined by Health Care Board
(5) In addition to hospital deductible and copayments

(6) Reduced by net, if non-delivery
(7) Other than prevention, ADM, and vision
(8) Copayments are doubled for covered orthodonture
(9) Not Covered
(10) After \$200 deductible

Table 2
Additional Cost Sharing to Reduce Premiums for "Low" Cost Sharing Plans
(All copayments assumed to be reduced from 1994 to applicable year by (increase in premium costs)

ITEM	N.A. 3500	Save 5%	Save 10%	Save 15%	Save 20%	Save 25%
<u>FACILITY CHARGES</u>						
Admissions to hospitals or specialized facilities (1)	0	250	250	400	500	550
Medical/Surgical						
Maternity						
Alcohol/Drug/Mental						
Hospital confinement	0	0	0	0	0	0
SNF or hospice	0	0	0	0	0	0
ADM partial confinement	0	0	35	45	60	75
Outpatient facilities (2)						
ER-Emergencies	0	0	65	100	125	150
ER-Non-Emergencies	25	25	65	100	125	150
O.P. dept surgery	0	0	0	0	0	0
O.P. dept visit	0	0	0	0	0	0
Urgi-Center (3)	10	10	15	20	25	35
Radiology (3)(4)	0	0	0	0	5	10
Pathology (3)(4)	0	0	0	0	5	10
<u>PROFESSIONAL SERVICES</u>						
Inpatient services (5)						
Primary surgeon and obstetrics (5)	10	10	100	150	200	250
Organ transplant	10	10	200	300	400	500
Anesthesiologist	0	0	0	0	0	0
Attending physician visits	10	10	15	20	25	35
Inpatient professional radiology (3)(4)	0	0	0	5	5	10
Inpatient professional pathology (3)(4)	0	0	0	5	5	10
Outpatient hospital (professional)						
ER-Emergencies	0	5	25	35	35	25
ER-Non-Emergency visits	10	10	35	35	35	35
Other hospital outpatient or clinical services	10	10	15	20	25	35
Outpatient surgery						
O.P. dept	10	10	50	75	100	125
Surg-Center	10	10	50	75	100	125
Office	10	10	15	20	25	35
Primary care						
Prenatal, well child, immunizations	0	0	0	0	0	0
Other preventive care	0	0	15	20	25	35
Family planning	10	10	15	20	25	35
Acute primary care (7)	10	10	15	20	25	35
Referral visits	10	10	15	20	25	35
Other Practitioners						
Rehabilitation	10	10	15	20	25	35
Phy extenders	10	10	15	20	25	35
Other professionals (podiatrist/chiropractor)	10	10	15	20	25	35
Dental Care (8)						
Diagnosis and Prevention	10	10	15	20	(9)	(9)
Treatment	10	10	15	20	(9)	(9)
Vision Care	10	10	25	35	(9)	(9)
<u>OUTPATIENT ADM</u>						
Diagnosis & medical management	10	10	15	20	25	35
Psychotherapy & counseling	25	25	35	45	50	75
<u>OTHER SERVICES</u>						
Home health care	0	0	15	20	25	35
Antidotes	0	0	50	75	100	125
DME, prosthetics, orthotics, contraceptive devices	0	0	0.8	0.75	0.75	0.75
Prosthetics	5	10	15	15	10 (10)	10 (10)

- (1) Applied for first admission in any calendar year
(2) Includes transferring radiology facilities and laboratories
(3) Includes professional components
(4) Single copayment per procedure, as defined by Health Care Board
(5) In addition to hospital deductible and copayments

- (6) Reduced by half, if non-delivery
(7) Other than prevention, ADM, and vision
(8) Copayments are doubled for covered orthodonture
(9) Not Covered
(10) After \$250 deductible

Table 3
Additional Cost Sharing to Reduce Premiums for 'Low' Cost Sharing Plans
 (All copayments assumed to be reduced from 1994 to applicable year by increase in premium rates)

ITEM	N.A. 3800	Save 5%	Save 10%	Save 15%	Save 20%	Save 25%
<u>FACILITY CHARGES</u>						
Admissions to hospitals or specialized facilities (1)	0	0	0	0	0	0
Medical/Surgical						
Maternity						
Alcohol/Drug/Mental						
Hospital confinement	0	25	50	75	110	125
SNF or hospice	0	12.5	25	37.5	55	62.5
ADM partial confinement	0	12.5	25	37.5	55	62.5
Outpatient facilities (2)						
ER-Emergencies	0	50	60	75	75	100
ER-Non-Emergencies	25	50	50	75	75	100
O.P., dept surgery	0	60	50	60	75	100
O.P., dept visit	0	50	50	60	75	100
Urgi-Center (3)	10	10	12.5	15	20	25
Radiology (3)(4)	0	10	12.5	15	20	25
Pathology (3)(4)	0	6.5	11	12	18.5	15
<u>PROFESSIONAL SERVICES</u>						
Inpatient services (5)						
Primary surgeon and obstetric (6)	10	80	100	180	200	300
Organ transplant	10	100	250	500	1000	2500
Anesthesiologist	0	0	0	0	0	0
Attending physician visits	10	10	12.5	15	20	25
Inpatient professional radiology (3)(4)	0	10	12.5	15	20	25
Inpatient professional pathology (3)(4)	0	6.5	11	12	12.5	15
Outpatient hospital (professional)						
ER-Emergencies	0	10	35	35	35	35
ER-Non-Emergency visits	10	10	25	35	35	35
Other hospital outpatient or clinical services	10	10	12.5	15	20	25
Outpatient surgery						
OP dept	10	25	50	75	100	100
Surgi-Center	10	25	50	75	100	150
Office	10	10	12.5	15	20	25
Primary care						
Prenatal, well child, immunizations	0	0	0	0	0	0
Other preventive care	0	0	0	0	0	0
Family planning	10	10	12.5	15	20	25
Acute primary care (7)	10	10	12.5	15	20	25
Referral visits	10	10	12.5	15	20	25
Other Practitioners						
Rehabilitation	10	10	12.5	15	20	25
Physicians	10	10	12.5	15	20	25
Other professionals (podiatrist, chiropractor)	10	10	12.5	15	20	25
Dental Care (8)						
Diagnosis and Prevention	10	10	12.5	15	20	25
Treatment	10	10	12.5	15	20	25
Vision Care	10	10	12.5	15	20	25
<u>OUTPATIENT ADM</u>						
Diagnosis & medical management	10	10	12.5	15	20	25
Psychotherapy & counseling	25	25	30	30	40	50
<u>OTHER SERVICES</u>						
Home health care	0	10	12.5	15	20	25
Ambulance	0	50	50	65	75	100
DME, prosthetics, orthotics, contraceptive devices	0	0.5	0.75	0.75	0.75	0.75
Prescriptions	5	6.5	11	12	13.5	15

- (1) Applied for first admission in any calendar year
 (2) Includes freestanding radiology facilities and laboratories
 (3) Includes professional component
 (4) Single copayment per procedure, as defined by Health Care Board
 (5) In addition to hospital deductible and copayments

- (6) Reduced by half, if non-delivery
 (7) Other than prevention, ADM, and vision
 (8) Copayments are doubled for covered orthodonture
 (9) Not Covered
 (10) After \$250 deductible

Table 4
Additional Cost Sharing to Reduce Premiums for "Low" Cost Sharing Plans
(All copayments assumed to be indexed from 1984 to applicable year by increase in premium rates)

ITEM	M.R. 3000	Save 5%	Save 10%	Save 15%	Save 20%	Save 25%
FACILITY CHARGES						
Admissions to hospitals or specialized facilities (1)	0	250	250	400	250	280
Medical/Surgical						
Maternity						
Alcohol/Drug/Mental						
Hospital confinement	0	0	8	10	25	50
SNF or hospice	0	0	8	5	12.5	25
ADM partial confinement	0	0	25	45	80	75
Outpatient facilities (2)						
ER-Emergencies	0	0	0	50	100	100
ER-Non-Emergencies	25	25	30	65	125	150
O.P. dept surgery	0	0	0	0	0	0
O.P. dept visit	0	0	0	0	0	0
Urgi-Center (3)	10	10	15	20	25	35
Radiology (3)(4)	0	0	0	0	10	15
Pathology (3)(4)	0	0	0	0	5	10
PROFESSIONAL SERVICES						
Inpatient services (5)						
Primary surgeon and obstetrics (5)	10	10	100	150	250	250
Organ transplant	10	10	200	300	400	500
Anesthesiologist	0	0	0	0	0	0
Attending physician visits	10	10	15	20	25	35
Inpatient professional radiology (3)(4)	0	0	0	0	10	15
Inpatient professional pathology (3)(4)	0	0	0	0	5	10
Outpatient hospital (professional)						
ER-Emergencies	0	5	25	35	60	80
ER-Non-Emergency visits	10	10	25	35	50	50
Other hospital outpatient or clinical services	10	10	15	20	25	35
Outpatient surgery						
OP dept	10	10	50	75	100	125
Surgi-Center	10	10	50	75	100	125
Office	10	10	15	20	25	35
Primary care						
Prenatal, well child, immunizations	0	0	0	0	0	0
Other preventive care	0	0	15	20	25	35
Family planning	10	10	15	20	25	35
Acute primary care (7)	10	10	15	20	25	35
Referral visits	10	10	15	20	25	35
Other Professionals						
Rehabilitation	10	10	15	20	25	35
Physicians	10	10	15	20	25	35
Other professionals (podiatrist, chiropractor)	10	10	15	20	25	35
Dental Care (8)						
Diagnosis and Prevention	10	10	(9)	(9)	(9)	(9)
Treatment	10	10	(9)	(9)	(9)	(9)
Vision Care	10	10	(9)	(9)	(9)	(9)
OUTPATIENT ADM						
Diagnosis & medical management	10	10	15	20	25	35
Psychotherapy & counseling	25	25	25	45	60	75
OTHER SERVICES						
Home health care	0	0	15	20	25	35
Ambulance	0	0	80	75	100	125
DME, prosthetics, orthotics, contraceptive devices	0	0	0.3	0.75	0.75	0.75
Prescriptions	5	10	10	10	10 (10)	10 (10)

(1) Applied for first admission in any calendar year
(2) Includes freestanding radiology facilities and laboratories
(3) Includes professional component
(4) Single copayment per procedure, as defined by Health Care Board
(5) In addition to hospital deductible and copayments

(6) Reduced by half, if nondelivery
(7) Other than prevention, ADM, and vision
(8) Copayments are doubled for covered orthodonture
(9) Not Covered
(10) After \$250 deductible

6/6/94

NOTE TO: Len Nichols, Chris Jennings

From: Ken Thorpe

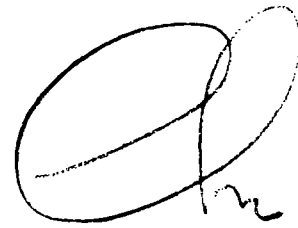
Subject: REQUEST FROM KAREN HEIN - Options For 5% and 10%
Reductions in FFS Off of a HSA Base

Karen Hein contacted my office because she could not reach Chris. She has requested options for a 5% and 10% reduction in FFS. Attached is a table showing option packages for achieving these levels of reduction in fee-for-service. The base used for the reductions was HSA.

cc. Jennifer Klein

Jim - done

auths?



6/6/94

TABLE 2
OPTION PACKAGES FOR 5% and 10% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE

5% Reduction

- Option 1: Raise coinsurance from .2 to .25
- Option 2: Raise cost-sharing maximum from \$1,500 per person to \$2,500
- Option 3: Raise deductible from \$200 per person to \$325

10% Reduction

- Option 1: Out-of-pocket maximum \$2,500/\$3,000, .25 coinsurance; \$250 hospital deductible
- Option 2: Out-of-pocket maximum \$2,500/\$3,000, .25 coinsurance; deductible \$350/\$700
- Option 3: Out-of-pocket maximum \$2,500/\$3,000, .25 coinsurance; deductible \$275/\$550; eliminate dental and vision
- Option 4: Out-of-pocket maximum \$2,500/\$3,000; deductible \$500/\$1000; eliminate dental and vision
- Option 5: Raise out-of-pocket maximum \$2,000/\$3000, raise deductible to \$325, and cut mental health benefit to Blue Cross Standard Option level.
- Option 6: Raise out-of-pocket maximum to \$2,000/\$3000, raise deductible to \$325, eliminate special preventive services package
- Option 7: Eliminate prescription drug coverage.
- Option 8: Eliminate mental health coverage.

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

(703) 941-7400
FAX (703) 941-3951

Date: 26 May 94

-----Please Deliver Immediately-----

To: Jennifer Klein

From: Jim Mays

Re: _____

Memo: HSA min 5 min 10, 15, 20%

Gordon is working on HMO's - 20% more may
not be practical in a reasonable manner.

We are transmitting 2 pages (including this transmittal sheet).

CCSOL

Thursday, May 26, 1994 5:17 pm

Page

MEMORANDUM

To : Jennifer Klein
From : Jim Mays
Subject : More Cost-sharing Variations - (Fee-for-service only)
Copy : Ken Thorpe

Following up on your request for options to cut 10%, 15%, and 20% off the "HSA-5%" level, here are cost-sharing changes which should generate approximately these additional savings.

Additional 10% cut:

deductible = \$500/\$1,000
coinsurance = 25%
cost-sharing maximum = \$2,500/\$3,000

Additional 15% cut:

deductible = \$700/\$1,400
coinsurance = 25%
cost-sharing maximum = \$3,000/\$3,000

Additional 20% cut:

deductible = \$1000/\$2,000
coinsurance = 25%
cost-sharing maximum = \$3,000/\$3,000

ccsol
/a /s

5/25/94

TABLE 2
OPTION PACKAGE FOR 10% and 15% HMO REDUCTIONS (HSA BASE)

In order to get a 10% or 15% reduction all of the following would be needed:

<u>Change</u>	<u>HSA</u>	<u>-10%</u>	<u>-15%</u>
Hospital or specialized facilities admission deductible	0	\$250	\$400
Emergency Room Use (includes physician charges)	\$10	\$100	\$150
Inpatient Surgery (in addition to hospital deductible)	\$10	\$100	\$150
Delivery (in addition to hospital deductible)	\$10	\$100	\$150
Outpatient Surgery (includes facility charge):			
Outpatient hospital	\$10	\$50	\$75
Freestanding facility	\$10	\$25	\$35
Office Surgery	\$10	\$15	\$20
Physician, dental visits, Other practitioners (other than prevention, ADM, and vision)	\$10	\$15	\$20
ADM residential or outpatient	\$25	\$35	\$45
Routine vision exams	\$10	\$25	\$35
Home Health Care	\$10	\$15	\$20
Ambulance	0	\$50	\$75
DME	0	20%	30%
Prescription Drugs	\$5	\$10	\$15

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL# of pages **2**

To **Ken Thorpe**
Dept./Agency

From **Sharman Stephens**
Phone #

Fax #

Fax #

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



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

From: Seanne

Date: _____

To: JENNIFER
KLEIN

Phone: (202) 690-_____
(202) 690-6870

Phone: _____

FAX: (202) 401-7321

Fax: _____

Number of Pages (Including Cover): _____

Comments: You probably have this;
I would follow
through w/ Gordon.

~~11/11/94~~
Add to #28

5/25/94

TABLE 1
OPTION PACKAGES FOR 15% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE*

Each option contains a set of changes all of which must be done to obtain 15%.

Option I

Raise Cost Sharing .20 to .25
Raise Out of Pocket \$1500 to \$2500
Raise deductible to \$400
Add a \$250 per hospital admission deductible

Option II

Raise Cost Sharing .20 to .25
Raise Out of Pocket \$1500 to \$3000
Cut Mental Health benefit to Blue Cross Standard
Change Prescription Drug cost sharing (.2 to .6 in higher)

Option III

Raise Out of Pocket \$1500 to \$2500
Eliminate Prescription Drug or Mental Health

Option IV

Raise Out of Pocket \$1500 to \$2,000
Raise deductible to \$250
Eliminate preventive services package
Cut mental health benefit to Blue Cross Standard

*To get full 15% will need comparable reductions in HMO benefits.
See Table 2 for HMO package.

5/25/94

TABLE 2
OPTION PACKAGE FOR 10% and 15% HMO REDUCTIONS (HSA BASE)

In order to get a 10% or 15% reduction all of the following would be needed:

<u>Change</u>	<u>HSA</u>	<u>-10%</u>	<u>-15%</u>
Hospital or specialized facilities admission deductible	0	\$250	\$400
Emergency Room Use (includes physician charges)	\$10	\$100	\$150
Inpatient Surgery (in addition to hospital deductible)	\$10	\$100	\$150
Delivery (in addition to hospital deductible)	\$10	\$100	\$150
Outpatient Surgery (includes facility charge):			
Outpatient hospital	\$10	\$50	\$75
Freestanding facility	\$10	\$25	\$35
Office Surgery	\$10	\$15	\$20
Physician, dental visits, Other practitioners (other than prevention, ADM, and vision)	\$10	\$15	\$20
ADM residential or outpatient	\$25	\$35	\$45
Routine vision exams	\$10	\$25	\$35
Home Health Care	\$10	\$15	\$20
Ambulance	0	\$50	\$75
DME	0	20%	30%
Prescription Drugs	\$5	\$10	\$15

Memorandum

To: Gary Claxton, Larry Levit

From: Gordon R. Trapnell

Date: February 22, 1994

Re: Cost Sharing to Reduce HMO Premiums 10%

A. Objective

The purpose of this note is to present a schedule of copayments that will reduce the premium rates for HMOs (and the cost of the network services in a POS plan) offered through the alliances by 10% compared to H.R. 3600.

B. Coverage in H.R. 3600

I tried the set of copayments set forth below for plans with the distributions of expenses anticipated for HMOs of four prototypes:

- o A staff model plan (or one organized like Kaiser that does not serve fee for service patients).
- o A group model based on multispecialty clinics that serve both fee for service and HMO patients.
- o A "FFS-IPA" HMO, i.e. that utilizes physicians in their own offices and the primary payment is on the bases of a fee schedule (perhaps with a withhold and through a capitated intermediary IPA) with relatively diffuse incentives to constrain specialty referrals and hospital confinements.
- o A "capitated IPA" HMO, i.e. that makes extensive use of capitation to providers, including both primary and specialty care, and with focused financial incentives to reduce hospital utilization.

The H.R. 3600 and alternative schedules of copayments are as follows.

	<u>H.R. 3600</u>	<u>Revised</u>	
o Admissions to hospitals or specialized facilities	0	\$250	4
o Emergency room use (includes physician charges)	\$10	100	1

2

o Inpatient surgery (in addition to hospital deductible)	10	100	150
o Delivery (in addition to hospital deductible)	10	100	150
o Outpatient Surgery (includes facility charge):			
Outpatient hospital	10	50	75
Freestanding surgical facility	10	25	35
Office surgery	10	15	20
o Preventive care	0	0	
o Physician and dental visits (other than prevention, ADM and vision)	10	15	20
o ADM residential or outpatient	25	35	45
o Routine vision exams	10	25	35
o Other practitioners	10	15	20
o Home health care	10	15	20
o Ambulance	0	50	75
o DME, prosthetics, orthotics, contraceptive devices	0	20%	30%
o Prescriptions	5	10	15

CCSOL

Thursday, May 26, 1994 5:17 pm

MEMORANDUM

To : Jennifer Klein
From : Jim Mays
Subject : More Cost-sharing Variations - (Fee-for-service only)
Copy : Ken Thorpe

Following up on your request for options to cut 10%, 15%, and 20% off the "HSA-5%" level, here are cost-sharing changes which should generate approximately these additional savings.

Additional 10% cut:

deductible = \$500/\$1,000
coinsurance = 25%
cost-sharing maximum = \$2,500/\$3,000

Additional 15% cut:

deductible = \$700/\$1,400
coinsurance = 25%
cost-sharing maximum = \$3,000/\$3,000

Additional 20% cut:

deductible = \$1000/\$2,000
coinsurance = 25%
cost-sharing maximum = \$3,000/\$3,000

ccsol
/a /s

Post-it [®] brand fax transmittal memo 7671		# of pages •
To <i>Ken Thorpe</i>	From <i>Jim Mays</i>	
Co.	Co.	
Dept.	Phone # <i>707-941-7400</i>	
Fax # <i>202-401-7321</i>	Fax #	