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AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. GREEN OF TEXAS

Page 243, after line 17, insert the following new subparagraph:

(D) STATE PREFUNDED HEALTH BENEFIT TRUST FOR TEACHERS.—A prefunded health benefit trust established by a State for the benefit of retired teachers if—

(i) the trust offered health benefits as of September 1, 1993, and

(ii) as of both September 1, 1993, and January 1, 1996, has more than 5,000 retired teachers who are participants in the plan and entitled to health benefits under the plan.

Page 244, line 4, before the period, insert the following: ", other than a trust described in paragraph (1)(D)".

Page 245, after line 13, insert the following new paragraph (and redesignate the succeeding paragraph accordingly):

(4) PARTICIPANTS IN RETIRED TEACHER TRUSTS.—Each participant in a trust described in subsection (b)(1)(D) which has an election in effect

as a large group sponsor is eligible to enroll in an experience-rated plan offered by such sponsor.

Page 249, line 5, strike "AND RURAL COOPERATIVES" and ", RURAL COOPERATIVES, AND RETIRED TEACHER TRUSTS".

Page 249, line 7, strike "or (C)" and insert ", (C), or (D)".

[Conforming Amendments:]

Page 14, line 17, insert "or 1421(b)(1)(D)" after "1421(b)(1)(C)".

Page 268, line 18, strike "or (C)" and insert ", (C), or (D)".

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

[Increase eligibility to families with incomes below 200 percent of poverty] Page 173, line 21, page 174, line 8, and page 178, line 20, strike "150 percent" and insert "200 percent".

[Reduction of cost-sharing to zero] Page 173, line 17, strike "Subject to subsection (b), in" and insert "In".

Page 174, strike lines 1 through 11.

Page 175, strike line 1 and all that follows through page 176, line 12 and insert the following (and redesignate the succeeding subsections accordingly):

(b) AMOUNT OF COST SHARING REDUCTION.—The reduction in cost sharing under this section shall be the reduction of cost sharing to zero (other than with respect to hospital emergency room services for which there is no emergency condition, as defined in section 1867(e)(1) of the Social Security Act).

Page 176, line 17, strike "(other than cost sharing reductions under subsection (c)(2))".

[Extension of reduction to experience-rated individuals] Page 173, line 19, and page 176, line 16, insert "or experience-rated plan" after "community-rated plan".

Page 174, line 23, insert "or experience-rated plans" after "community-rated plans".

Page 177, line 11, insert "or experience-rated" after "community-rated".

[Funding through increase in catastrophic limit] Page 79, line 2, page 82, line 14, and page 84, line 2, strike "$1500" and insert "$2,500".

[Additional funding through 3% increase in premiums for unsubsidized individuals and employers] Page 169, at the end of line 23, add the following:

Each State, through such mechanism, also shall assure that payment is made to the Secretary of an amount equal to the additional payments received as a result of the following provisions:

(1) Section 6101(b)(2)(B)(iii).

(2) Section 6111(a)(2).

(3) The addition of the reference to 103 percent (instead of 100 percent) in section 6121(c)(1).

The cap amount provided under section 9102(e)(2) for a fiscal year is hereby increased by the aggregate amount paid to the Secretary by States under the preceding sentence in the fiscal year.

Page 275, after line 2, insert the following:

(c) LOW-INCOME ADD-ON.—Each large group sponsor shall make payment to the Secretary of an amount

equivalent to the additional amounts attributable to the addition of the reference to 103 percent (instead of 100 percent) in sections 6101(b)(3) and 6131(b). The cap amount provided under section 9102(e)(2) for a fiscal year is hereby increased by the aggregate amount paid to the Secretary by large group sponsors under the preceding sentence in the fiscal year.

Page 714, after line 13, insert the following:

(iii) ADD-ON FOR LOW-INCOME SUBSIDIES.—3 percent of the premium described in clause (i).

Page 715, after line 10, insert the following:

(vi) ADDITIONAL CREDIT FOR INDIVIDUALS RECEIVING DISCOUNTS.—In the case of a family entitled to any income-related discount under section 6104(a), the amount described in subparagraph (B)(iii).

Page 715, line 19, insert "103 percent of" after "is".

Page 716, after line 11, insert the following:

(iii) ADDITIONAL CREDIT FOR LOW-INCOME INDIVIDUALS.—In the case of a family that would be entitled to any income-related discount under section

6104(a) if the family were not enrolled in an experience-rated plan, 3 percent of the premium described in subparagraph (B).

Page 734, line 22, insert "the sum of (1)" after "equal to".

Page 734, line 25, insert before the period the following ", and (2) for any individual not entitled to a reduction in liability under section 6113, 6114, or 6115, 3 percent of the amount of such base employment monthly premium".

Page 736, line 20, strike "6111" and insert "6111(a)(1)".

Page 748, line 12, insert "103 percent of" after "is".

Page 770, line 13, insert "103 percent of" after "is".

AMENDMENT TO COMMITTEE PRINT (H.R. 3600)

OFFERED BY MR. OWENS

Page 175, strike line 1 and all that follows through page 176, line 4, and insert the following:

(c) AMOUNT OF COST SHARING REDUCTION.—

(1) GENERAL REDUCTION.—

(A) IN GENERAL.—Subject to subparagraph (B), the reduction in cost sharing under this paragraph shall be such reduction as will reduce the cost sharing to the level of a lower or combination cost sharing plan, except that in no case shall the copayment exceed $2 per visit or $1 per prescription and such reduction shall not apply with respect to hospital emergency room services for which there is no emergency condition, as defined in section 1867(e)(1) of the Social Security Act.

(B) STATE OPTION TO LOWER COST SHARING.—A State may, at its option, lower cost sharing below the reduction provided under subparagraph (A) for some or all of the classes of individuals eligible for a reduction under such subparagraph but only if the State agrees to increase the total amount of its maintenance of effort payment under section 9001 by an

amount equal to the estimated total additional payments that results from such election, including any increase in the average premium that results directly from such election.

[Extension of reduction to experience-rated individuals] Page 173, line 19, and page 176, line 16, insert "or experience-rated plan" after "community-rated plan".

Page 174, line 23, insert "or experience-rated plans" after "community-rated plans".

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(1) Section 6101(b)(2)(B)(iii).

(2) Section 6111(a)(2).

(3) The addition of the reference to 101.5 percent (instead of 100 percent) in section 6121(c)(1). The cap amount provided under section 9102(e)(2) for a fiscal year is hereby increased by the aggregate amount paid to the Secretary by States under the preceding sentence in the fiscal year.

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(iii) ADD-ON FOR LOW-INCOME SUBSIDIES.—1.5 percent of the premium described in clause (i).

Page 715, after line 10, insert the following:

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Page 715, line 19, insert "101.5 percent of" after "is".

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Ed & Labor

PROPOSED AMENDMENT TO DME DEFINITION

(c) Durable Medical Equipment. -- For purposes of this subtitle, the term "durable medical equipment" includes the equipment described in section 1861(n) of the Social Security Act, except that such term also includes equipment that does not meet all of the criteria under such section when such equipment is functionally equivalent for a specific individual to equipment described in such section, and other items of durable equipment (such as bathtub lifts and grab bars) relating to bathing, toileting, or lifting which are essential to the prevention of complications of an existing illness, injury, disorder, or other health condition."

strike mobility canes.

MEMO FOR : LEN NICHOLS, L. BLUMBERG, J. LEW, J. KLEIN

FROM : KEN THORPE

RE : Benefit Package Estimates for E+L

DT : April 18, 1994

****

We have provided the following informal estimates, none on paper. Sections A + B are from the Actuarial Research Corp.

A. Women's Health Issues

a. Annual Pap Smears
b. Annual Clinical Breast Exam
A+B----- 1% premium increase

c. Annual screening for STDs for sexually active individuals at risk of infection---- +0.7%

call Jim Mays

d. annual mammograms for women over 40 +0.5% every other year .2490
e. annual mammograms for women 50+ +0.2% adding 1

f. annual osteoporosis screening for females +0.8%

B. Family Planning

a. No cost sharing for for planning services or contraceptive devices and drugs and clinician visits and associated services related to prenatal care or 1 post-partum visit ---- +1%

C. Medicaid Wrap (From John Klemm--see attached)

a. Restore all Medicaid services (restore noncash adult wrap) adds +$5.7 Billion over 5 years.

b. Provide Medicaid wrap services to all all kids under 23 and under 200% of poverty. (We estimated it for 18 and under). Adds $11 Billion over 96-00 with a state MOE, $13.6 B. without one. Clearly costs higher if want to add kids 19-22.

D. Cost Sharing Subsidies.

Jim Mays provided some ballparks concerning cost sharing. The numbers reflect increased premium costs when cost sharing is waived for selected populations enrolled in FFS plans. Note these differ from what previously was provided to Senate Labor--they examined changes in cost when reducing cost sharing among low-income non-cash assistance populations.

Quick Analysis of Education & Labor Amendments

Topic Group: Benefits

Provision(s):

- [no author - from Members' staff]

  -- include pap smears and clinical breast exams as part of regular, i.e., at least annual, physical examinations for all women;

Approximate Cost:

- Compared to the HSA: Adding these services to the benefits package would result in an approximately 1% premium increase.

Quick Analysis of Education & Labor Amendments

Topic Group: Benefits

Provision(s):

- [no author - from Members' staff]

  -- cover annual screening for sexually transmitted diseases for sexually active individuals at risk for infection;

Approximate Cost:

- Compared to the HSA: Adding these services to the benefits package would result in an approximately .7% premium increase.

Quick Analysis of Education & Labor Amendments

Topic Group: Benefits

Provision(s):

- [no author - from Members' staff]

    -- cover biennial mammograms for women between 40 and 50 years of age, and annual mammograms for women over 50;

Approximate Cost:

- Compared to the HSA: Adding these services to the benefits package would result in an approximately .5% premium increase. Annual mammograms for women over fifty alone would add .24% to the premium.

Quick Analysis of Education & Labor Amendments

Topic Group: Benefits

Provision(s):

- [no author - from Members' staff]

  -- cover annual osteoporosis screening for women;

Approximate Cost:

- Compared to the HSA: Adding these services to the benefits package would result in an approximately .8% premium increase.

Quick Analysis of Education & Labor Amendments

Topic Group: Benefits

Provision(s):

- [no author - from Members' staff]

    -- eliminate cost-sharing for family planning services, contraceptive devices, drugs, and clinician visits and associated services related to prenatal care and 1 post-partum visit;

Approximate Cost:

- Compared to the HSA: Adding these services to the benefits package would result in an approximately 1% premium increase.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 1. Mr. Owens

  -- allow persons with disabilities to use specialists as gatekeepers
  -- establish "special characteristics rate modifier" for physician services for person with disabilities

Approximate Cost:

- Effect on private health insurance costs: This provision could potentially have no costs associated with it, compared to current law and the Health Security Act. This provision could be characterized as a "freedom of provider choice" provision that would allow disabled persons now using specialists as their primary care physicians to keep using them. It seems reasonable to assume that many disabled persons currently use a specialist as a primary care physician because of their special medical needs -- this provision would simply affirm that current practice.

  If there were increased private insurance costs involved -- under the assumption that this provision would encourage more disabled persons to use specialists -- these increased costs would be included in the premium for the guaranteed benefit package.

- Effect on Medicare costs: The Medicare physician fee schedule reimburses the same amounts for office visits regardless of the specialty of the physician providing the service -- the first provision would not affect Medicare outlays. A "special modifier" (i.e., per-service payment increase) also would not increase costs, because the law requires that such changes to the Medicare fee schedule be made in a budget-neutral manner. All other fees would be reduced.

Comments:

- The AMA figures on fee differentials are from a pre-reform world; comprehensive health reform may decrease the payment differences between generalists and specialists.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 2. Mr Engel and Mr. Becerra

  -- Adjustment of the GME Fund in the Health Security Act to project "safety net" providers in underserved areas

Approximate Cost:

- *Current Law.* The GME pool included in the Health Security Act used current Medicare spending as the basis for the Federal contribution to the GME pool. This proposal would add an unspecified amount to that pool; it is not clear whether this would be new Federal spending or a higher private sector contribution to the pool.

  The proposal could increase Federal outlays by several hundred million dollars annually, depending on the definition of 'safety net' and 'underserved.' Assuming a broad definition for each term, Federal spending could increase, with a rough mid-range estimate of new Federal spending of $500 million per year.

- *Health Security Act.* With respect to the Health Security Act and under the assumptions stated above, it could increase outlays associated with the HSA by $500 million annually. Federal GME spending assumes only a different allocation of the baseline amounts.

Comments:

- Inner-city hospitals and rural hospitals could qualify as 'safety net' providers in 'underserved' areas. If DSH payments are used as a proxy for underserved areas, then the number of hospitals that could receive these payments may very well increase.

  Moreover, this money could be either discretionary or mandatory, depending on the specifics of the actual legislation. If discretionary, additional offsets will be needed to accommodate the discretionary spending caps; if mandatory, then it would be useful to identify the offsetting cuts and/or receipts.

Finally, the Health Security Act creates a Vulnerable Population Adjustment to ensure that hospitals serving in underserved areas will be able to remain financially viable.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 3. Mr. Kildee

  -- Creation of a graduate medical loan program funded through the IME pool to encourage individuals to go into primary care and to serve in underserved areas.

Approximate Cost:

- *Current Law.* The language does not mention changing the amount of money spent on IME, but a *loan program* indicates that current IME funds would be used to guarantee new loans. If that is the sole purpose of IME spending, then it is possible that the Federal government will save money if not all IME funds are disbursed as payments for defaults. This is likely not the case, however, and it is very possible that IME funding would be used for scholarships as well. Since the language does not mention changing the amount of IME spending, **the net effect on current Federal spending is likely zero.**

  If the loan program is *in addition* to the IME/AHC pool included in the HSA, then new spending would occur, depending on whether the proposal would create a direct loan program or a loan guarantee program.

- With respect to the Health Security Act, current IME spending is reduced and then supplemented by private funds to pay for training provided at academic health centers. If the current IME rate is not adjusted by this proposal, then **roughly $18 billion in five-year savings under the HSA could be lost.**

Comments:

- Under this proposal, teaching hospitals would not appear to receive *any* payments for the indirect costs of training residents; all spending would appear to flow to students and residents, bypassing the hospitals.

  The Federal government already operates a loan guarantee program -- the HEAL program -- which guaranteed about $375 million in private loans this year. This proposal could duplicate those efforts and result in redundant efforts to increase primary care providers in underserved areas.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 4. Ms. Woolsey

  -- designate OB/GYNs as primary care physicians
  -- require all plans to reimburse licensed non-physician practitioners

Approximate Cost:

- Effect on private health insurance costs: The first provision could potentially have no costs associated with it, compared to current law and the Health Security Act. This provision could be characterized as a "freedom of provider choice" provision that would allow women now using specialists as their primary care physicians to keep using them. It seems reasonable to assume that many women currently use an OB/Gyn as a primary care physician -- this provision would simply affirm that current practice.

  If there were increased private insurance costs involved -- under the assumption that this provision would encourage more women to use specialists -- these increased costs would be included in the premium for the guaranteed benefit package.

  Effect on Medicare costs: The first provision would not affect Medicare outlays. The Medicare physician fee schedule reimburses the same amounts for office visits regardless of the specialty of the physician providing the service. A "special modifier" (i.e., per-service payment increase) also would not increase costs, because the law requires that such changes to the Medicare fee schedule be made in a budget-neutral manner. All other fees would be reduced.

- Effect on private health insurance costs: The costs of the second provision would presumably be included in the premium for the guaranteed benefit package. Reimbursing non-physician practitioners would result in additional costs (due to increased access) and savings (from substitution). Costs would depend on the scope of services allowed for reimbursement. This provision could cost anywhere from a hundred million dollars to billions of dollars, compared to both current law and the HSA, depending on how the provision is structured, i.e., will plans be required to reimburse all licensed practitioners or only those in areas not served by a licensed physician.

Under Medicare, there would presumably be some substitution of physician services with lower-cost non-physician practitioner services, but net costs would likely increase. For example, the HCFA actuary priced the HSA's expanded coverage of advanced practice nurses' services at $2.5 billion over FY 1995-2000. HCFA actuaries assumed that practioners could only be reimbursed in areas not served by a licensed physician. Absent this limitation, the cost of this proposal could be as low as $100 million. Medicare already covers some other non-physician practitioners, but the scope of services is quite narrow -- any provision that expanded those scopes could increase costs substantially.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

5. Mr. Becerra

   -- Modify the risk adjustment provision to insure that the adjusted payments are passed on to providers that directly serve high-risk patients.

   -- Ensure that the NHSC is more reflective of current demographics.

Approximate Cost:

- It is not clear exactly how the risk adjustment mechanism would be altered, but this provision seems likely to change who gets paid rather than the overall cost.

- Making the NHSC more reflective of current demographics appears merely to change the mix of the NHSC, and thus is probably a non-cost item.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

6. Mrs. Mink

   -- Proposes that Native Hawaiian health centers be established as "essential community providers."

   -- She also wants to ensure that states have the flexibility to accommodate state health care systems other than the single-payer opt out.

Approximate Cost:

- Most likely a small cost item since there are a relatively limited number of Native Hawaiian health centers (probably under $10 million vs. both current law and HSA).

- Aside from the single-payer waiver, the HSA also allows states significant flexibility in design and configuration of the alliances.

- State flexibility could be a problem if it impaired cost containment.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 7. Mr. Scott:

  -- modify definition of essential community provider (ECP) to include traditional providers with a history of community practice and who serve a high percentage of low-income Medicaid and other patients with special needs. Extend the ECP protection from 5 to 10 year minimum.

Approximate Cost:

- relative to current law: the ECP program proposed in the HSA creates an capped entitlement of $800 million per year for ECPs. This proposal appears to expand the ECP entitlement for care by non-physician practitioners. The baseline would increase because mid-wives, podiatrists, osteopaths, chiropractors, and independent nurses would be eligible for ECP status.

- increase to HSA: no data available to derive estimate; certainly would be a major expansion of ECP entitlement, probably in the hundreds of millions of dollars per year.

Comments:

- would remove most of the physician "gate-keeper" effect for many ECP areas because many of these "traditional" providers are outside of the conventional health and health insurance system.

- clarification of "traditional" medicine is needed for better estimates.

- would health plans be required to cover these "traditional" services, or would the Federal government be the only required payor?

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 7 (part two). Mr. Scott

  -- Require increased enrollment of minorities as condition of receiving GME funding.

Approximate Cost:

- *Current Law.* The net effect of this proposal on current Federal spending would likely be zero, or not scorable.

- *Health Security Act.* The effect on estimated spending for the Health Security Act would also likely be zero or very small.

Comments:

- Such a requirement as proposed would be difficult for CBO or HCFA to score and would likely not cause major disruptions in either current law payments or the flow of payments proposed under the Health Security Act.

  Enforcement of this provision appears difficult. To have an impact on the scoring of the bill, the provision would likely have to set forth specific targets of enrollment and civil monetary penalties for failing to hit those targets. Current Medicare GME spending is spent on a periodic basis throughout the year, and many residents rotate through hospitals and clinics for only a few months. Look-back reviews would be required to determine whether teaching hospitals had met the targets.

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 8. Mr. Strickland wants to:

  -- ease restrictions for essential community provider (ECP) eligibility for individual providers, especially in rural areas,

  -- address pay discrepancies between primary care providers and specialists,

  -- give preference to students from rural and underserved areas applying for medical school slots.

  -- include provisions to include psychologists on the list of professions needed within the health care system, and set aside specific funds for their training.

Approximate Cost:

- relative to current law and the HSA:

  -- the ECP program is a capped entitlement adding $800 million per year; and loosening of the ECP eligibility definition would certainly increase the pressure to increase the capped entitlement amount. The amount of the increase would depend on the new definition (likely to add hundreds of millions per year).

  -- Medicare already pays a bonus of 10% above the fee schedule amount in Health Professional Shortage Areas (HPSA) for primary care services. Many of these areas would probably be eligible for ECP payments. The bonus would double (to 20%) in the HSA. This provision is budget-neutral by reduction in all other fee schedule amounts. Closing the primary care-specialist differential for non-Medicare services would require a major restructuring of the private insurance payment system, that **could** be done on a "budget neutral" basis by redistributing payments. This would require substantial government intervention in the private insurance market.

Comments:

- would remove most of the physician "gate-keeper" effect for many ECP areas because many of these "traditional" providers are outside of the conventional health and health insurance system.

- clarification of "traditional" medicine is needed for better estimates.

- would health plans be required to cover these "traditional" services, or would the Federal government be the only required payor?

Quick Analysis of Education & Labor Amendments

Topic Group 2: Provider Issues

Provision(s):

- 9. Mr. Williams, Mrs. Mink, Mr. Strickland

  -- Provider enhancement to meet rural health needs, including: increased funding to the National Health Service Corps, GME and AHC's training and funding to reflect and help rural students and rural areas, funding for non-physician providers, change reimbursement schedules to give greater incentive to practice in rural areas, expansion of ECP's to reduce state barriers to licensure of advanced practice nurses and physician assistants.

Approximate Cost:

- Additional cost not clear from details provided. However, cost could be high relative to current law depending on the nature of the expansions envisioned (likely to be hundreds of millions over current law?)

- The HSA already includes many similar increases. These provisions may add to the cost of the HSA depending on the specifics (could add hundreds of millions to the HSA depending on configuration).

Comments:

- The HSA already includes an increase of about $1 billion in the authorization for the NHSC (over 6 years). The HSA also provides GME and IME payments to residency programs and AHC's regardless of whether they are in urban or rural settings.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 1. Mr. Becerra

  -- Mr. Becerra is concerned about use of health i.d. card to deport undocumenteds and/or deny them health care. He also wants to ensure diversity of NHB.

Approximate Cost:

- This provision probably does not have a price-tag, but rather has to do with the legal uses of the card and confidentiality.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 2. Mr. Becerra, Mr. Engel, Mr. Scott:

  -- phase out DSH payments over 4 years;

  -- narrow definition of DSH hospitals; and

  -- Increase and phase-in Vulnerable Populations Adjustment (VPA).

Approximate Cost:

- Relative to current law: phasing out Medicaid DSH payments over four years could save in the neighborhood of $30 billion between FY 1996 and FY 2000. Significantly narrowing the definition of DSH could save tens of billions of dollars between now and the implementation of reform and could help avert impending difficulties in implementing the OBRA 1993 limitations on DSH payments.

- Relative to the H.S.A.: phasing out Medicaid DSH payments over four years could save roughly $16-20 billion less than the phase-out schedule in the H.S.A. Phasing out DSH payments over four years would also result in lower State maintenance of effort (MOE) requirements, which could substantially increase Federal subsidies (roughly $12-15 billion). The VPA is limited to $800 million per year at full implementation. VPA payments are to last five years. Significantly increasing the VPA could cost billions of dollars.

  Narrowing the definition of DSH is pointless in the long run under the HSA, as Medicaid DSH payments are to be eliminated upon implementation of reform.

Comments:

- Significant expansion of the VPA should be considered together with other Federal subsidies for hospitals serving low-income populations (e.g., payments to academic health centers, Medicare DSH payments).

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 3. Mr. Martinez

  -- Exempt state run corporate alliances from the 1% assessment.

Approximate Cost:

- Estimated cost of about $7 billion over FY96-00 assuming that "State run corporate alliances" is a reference to State employees.

Comments:

- Exemption of state run corporate alliances would reduce the overall size of the corporate alliance premium base from which the 1% would be assessed.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 4. Mrs. Mink

  -- Allow Federal workers to be considered a corporate alliance.

Approximate Cost:

- No cost.

Comments:

- This change would only have any effect in selected areas with high numbers of Federal employees (e.g., Washington, DC).

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 5. Mr. Scott:

  a. insure access to capital for set-up of minority health facilities;

  b. hold plans accountable for meeting quality standards;

  c. coordinate elimination of DSH payments with universal coverage;

  d. promote uniform quality through increased Federal authority;

  e. single-alliance certification for inter-state plans; and

  f. amend ERISA and increase State flexibility.

Approximate Cost:

- These proposals are too vague to provide estimates. Nevertheless, provisions a), c), and f) could easily cost $10s of billions, depending on how the proposals are structured.

Comments:

- With respect to the first recommendation:

  -- how would access to capital be improved?

  -- to target improved access to capital, one would first need to define "minority health facilities." Would this definition entail some minimum number of minorities served, or some minority ratio of minority patients?

  -- would this be a grant or an entitlement.

- Holding plans accountable for meeting quality standards could be costly, depending on the mechanism employed.

- The H.S.A. already provides for the coordination of the implementation of universal coverage with the elimination of Medicaid DSH payments. If universal coverage were delayed, this proposal could add $10s of billions to the cost of the HSA.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 6. Mr. Owens:

  -- eliminate cost-sharing for families below 200% of poverty;

  -- outline duties of ombudsmen and provide for adequate consumer assistance; and

  -- add a stop/loss that limits out-of-pocket costs.

Approximate Cost:

- Relative to current law and the H.S.A.: eliminating cost-sharing for poor families would be very costly. In addition to the direct Federal cost of subsidizing cost-sharing for low-income families, premiums and premium subsidies would increase substantially by insulating recipients from the costs of excess consumption of health care.

- Eliminating cost-sharing for families below 200% of poverty could cost between $34 and $87 billion, relative to the H.S.A..

Comments:

- Medicaid recipients are responsible for nominal copayments in many States.

- the H.S.A. already includes a yearly cap on out-of-pocket costs ($1,500 for individuals and $3,000 for families under the low-cost sharing plan).

- ombudsmen: good government -- no comments.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 7. Mr. Reed and Mr. Sawyer

  -- Make sure that the Board of Directors, which governs the alliances, is accountable to the individuals they represent.

Approximate Cost:

- It is unlikely that this vague provision involves dollars -- but how will the Board be accountable? Will its members be elected?

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 8. Mr. Romelo-Barcelo

  -- Ensure that Puerto Rico is subject to Federal taxes on tobacco products and in return Puerto Rico receives full and equal benefits for its residents.

Approximate Cost:

- Potentially very high cost (hundreds of millions or billions depending on specifics).

Comments:

- It is not clear how large the revenue from application of the tobacco tax would be in Puerto Rico (and it is not clear whether this has already been accounted for in the tobacco tax revenue estimates). Nevertheless, revenue from the application of the tobacco tax in Puerto Rico is likely to be **much** smaller than the cost of extending the entitlement to Puerto Rico.

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 9. Mr. Kildee

  -- Provide a premium discount to businesses offering a qualified worksite program (standards and discounts to be determined by HHS).

Approximate Cost:

- This item will be a coster of unknown magnitude (less than $100 million, depending on what this actually is?).

Comments:

- What are the terms and conditions of eligibility for a qualified worksite program?

Quick Analysis of Education & Labor Amendments

Topic Group 3: Structure

Provision(s):

- 10. Mr. Sawyer

  -- Sawyer bill to create a national database network.

Approximate Cost:

- Modest additional cost above current law, and perhaps comparable cost to information systems provisions of the Health Security Act (like the HSA, about $1 billion above current law in year one and about $100 million more in each of the outyears.

Comments:

- The Sawyer bill establishes structure for information systems for **Federal programs only**. Like the Health Security Act, the emphasis of the Sawyer bill seems to be on a Federal role of setting standards and oversight.

Quick Analysis of Education & Labor Amendments

Topic Group 3/4: Structure/Underserved

Provision(s):

- 11. (structure) and 6. (underserved) -- Mr. Williams, Mrs. Mink, Mr. Strickland

  -- Propose system development to meet rural health needs, including: funding to help develop community health plans, creation of a reinsurance fund for rural community health plans, a new rural hospital-based Community Health Center program, linking up academic health centers with other programs, provide for comprehensive coverage for Emergency Medical Services (i.e., transportation), and allow some consumers in a corporate alliance to opt-into a regional alliance to be able to receive local care, rural population represented on the National Health Board, National Qualify Management program to focus on appropriate geographical standards, rather than uniform standards, and appropriate reimbursement levels.

  -- Meet capital/system development needs of rural areas, including: system development, provider enhancement, capital/infrastructure/benefit related concerns, and funding issues.

Approximate Cost:

- Could be costly compared to current law (+hundreds of millions?), depending upon specific details and the scope of the new programs envisioned.

- The HSA includes many similar provisions, although not specifically targeted to rural areas. Could add to HSA costs, depending on configuration (hundreds of millions?).

Comments:

- It is not clear whether these new programs would be supported with discretionary grants, or whether a mandatory funding mechanism is envisioned.

- The Health Security Act includes $2.5 billion in authorizations to support the development of community health plans and networks.

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Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

- 1. Mr. Becerra:

    -- ensure coverage of undocumented aliens.

Approximate Cost:

- relative to current law and HSA: $30-50 billion from FY 1996-2000 (***rough*** point estimate of $40 billion).

    -- Based on INS estimate of 3.2 million undocumented aliens in October, 1992, with annual growth of 300,000.

    -- Assumes per capita Federal cost of $1,700-$1,800 for HSA (or equivalent) coverage.

    -- Assumes roughly $.5 billion per year in offset savings from Medicaid coverage for emergency services.

Comments:

- Estimate does not take into account induced immigration due to unrestricted health coverage.

- Would States be responsible for a share of the premium for (otherwise) Medicaid-eligible recipients?

Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

2. Ms. Woolsey

   -- Broaden legislative language so that grantees eligible to provide school-related health services must serve "school-aged" children (defined as 4-19 years old) not "adolescents," but with an emphasis on "adolescent" services.

Approximate Cost:

- Unspecified positive cost above current law, probably discretionary. There are no current grant programs for school-based health programs, especially as contemplated in the HSA. As a discretionary authorization, it would score as zero for BEA purposes.

- The HSA school-based health services authorization is probably what this amendment is referring to. The change in definition may broaden children eligible for these services, but probably would not affect cost relative to the HSA, especially under a discretionary authorization.

Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

3. Mr. Owens

   -- Amendments regarding comprehensive school health education and school-based health services.

   -- Assure equitable treatment of underserved populations and essential community providers. Develops effective primary and other health service capacity for underserved populations and communities. Insures coverage and proper services are extended to victims of child abuse and neglect.

   -- Amends the PHS Act and the Social Security Act to provide improved and expanded access to comprehensive primary health care and related services for medically underserved and vulnerable populations. Proposes amendments from AIDS Action Council.

Approximate Cost:

- Relative to current law, all of these provisions would likely be fairly costly depending on the specifics (likely to cost hundreds of millions above current law).

- The cost of these provisions relative to the HSA is harder to quantify given the lack of specifics. The HSA already includes comprehensive school health and school based health services, favorable treatment for essential community providers, increased service capacity for underserved populations, and access and enabling provisions for underserved and vulnerable populations. Depending on the specifics, these provisions could add to the cost of the HSA, but it is very hard to tell (a guess: within a couple hundred million dollars over the HSA?).

Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

4. Mr. Martinez

- "Insure uninterrupted coverage of victims of domestic violence and runaway and homeless youth," also "to protect runaway and homeless youth and assure that they get appropriate services."

Approximate Cost:

- The provision is too vague to tell what the cost might be, perhaps Mr. Martinez envisions an authorization for dollars to provide services to target populations (likely in the tens of millions of dollars?).

- Target populations are not specifically addressed in the HSA.

Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

5. Mr. Reed

   -- Amends Subtitle G to insure the percentage of children in poverty and the scope and quality of the state's school-health education and school-related health services are taken into account in awarding grants.

Approximate Cost:

- No additional cost relative to current law or HSA. Simply changes the criteria for awarding the HSA school-based health services grants to assure they go to poorer children where state school-health programs are below average.

Quick Analysis of Education & Labor Amendments

Topic Group 4: Underserved

Provision(s):

- 7. Mr. Scott:

  -- Medicaid wrap-around services for non-cash assisted children.

  -- Supplemental services and lower cost-sharing for low-income adults.

  -- Outreach for underserved populations.

Approximate Cost:

- **Relative to current law:** There would be no additional costs if this group only includes Medicaid-eligible kids. Non-cash children who are Medicaid recipients under current law already receive wrap coverage.

  Under current law, low-income adults who are Medicaid recipients receive supplemental benefits and have no or nominal cost-sharing. Costs would increase above current law if supplemental services and lower cost-sharing were made available to non-Medicaid adults.

  It is unclear what "outreach for underserved populations" would involve.

- **Relative to the HSA**: Continuing wrap benefits under Medicaid would be about $1 billion cheaper for non-cash kids than the HSA wrap proposal. Non-cash kids receive wrap benefits through a new Federal program. If this amendment continues wrap benefits under Medicaid, costs would be split between the Federal and State governments. Shared expenditures could reduce Federal costs, but wrap spending would also be an entitlement rather than a capped program -- which could result in higher overall spending.

  Restoring Medicaid wraparound services to current law adult noncash recipients would cost approximately $5.7 billion between FY 1996 and FY 2000.

  Extending Medicaid wraparound services to individuals age 22 and under, assuming no State maintenance of effort, could cost about $13.6 billion between FY 1996 and FY 2000.

Extending "supplemental benefits" to non-cash adults could increase HSA costs by $10s of billions depending on the definition of low-income adults, the definition of services and the proportion of costs borne by the Federal government. The relative expense of lower cost-sharing depends on how the cost-sharing is structured. Lower cost-sharing would also increase premium and subsidy costs by insulating recipients from the costs of excess consumption of health care.

	HSA		Model 4.14.1	
	1 year	1996-2000	1 Year	1996-2000
Employer Subsidies	42.7	179	50.4	211.4
1-25	21.3		23.0	
25-99	8.6		9.0	
101-499	6.9		6.9	
500-999	2.2		2.2	
1000-4999	3.7		3.7	
5000+	0		5.7	
Household Subsidies	48.1	217	51.1	230.5
Total Subsidies	90.8	396	101.5	441.9
Corporate Assessment Revenue	NA	8	NA	33

Estimate assumes that firms above 1000 cannot join the regional alliance, do not reorganize themselves into smaller units to qualify and pay the 1% of payroll assessment.

If subsidies were not given to firms above 5000, then the five year savings of this plan over the HSA would be: $3 billion.

Notes

On converting the kids wrap into a premium surcharge:

Klemm's five year estimate of the kids wrap was 13.6 billion. If you treat this as a household subsidy, then the appropriate multiple that converts one year model numbers to five year CBO estimates is 4.5. Dividing 13.6 by 4.5 yields 3. This is the amount to be spread throughout the alliance. CBO's one year 1994 estimate of alliance premiums is 385 billion. 3/385 = 0.78%. So, a ROUGH ballpark for the premium surcharge is 0.8%.

Women's preventive services:

The mark does less than the services that were estimated by Mays. Rough non-actuarial appraisal = 1/2 less.

Overall subsidy vs. 1% assessment revenue (model results):

Attached.

State and Local Government subsidies:

Additional Ed and Labor Provisions

- Mental health -- Miller amendment
  May be large costs due to coordination of government systems, expanded enrollment

- Home health and outpatient rehabilitation -- remove illness and injury language
  No significant costs associated

- Outpatient rehabilitation -- add language about preventing deterioration, maintaining functioning
  Estimates range from 1-6.5% of premium costs, maybe higher

- Inter-island air transportation -- one trip plus trip for companion if patient is minor or needs assistance
  Probably minimal cost

- Outpatient rehabilitation -- adds vision-related rehabilitation

- Outpatient speech pathology -- language clarification
  probably no costs

- DME -- adds grab bars, canes, etc., to definition

- Hearing aids for kids under age 18
  Interaction with wrap program, probably substitution
  single $0.01 couple $0.02
  1 adlt fam $1.36 2 adlt fam $1.50

- Dental care for individuals with seizure disorders
  Minimal costs if *limited* to dental care needed because it is a result of seizure disorder

- No cost-sharing for family planning services
  adds 1% of premium costs

TO: Sharman
FROM: Jennifer
DATE: 4/29/94
RE: Benefits Estimates

Attached please find all of the written estimates that I have collected. All of these were prepared for House Energy and Commerce or Senate Labor. I have also included a list of requests that we received from Senator Wellstone's staff. Most of their requests are repeats.

In addition, you can look at the Education and Labor Mark. We have either given the committee staff estimates for the additional benefits they have included or have promised to give them those estimates. In addition, Gary Claxton has noted the costs of expected amendments. You might want to borrow his notes.

Thank you very much for collecting and organizing this information. We will be very glad that you invested the time to do this!

Memorandum

To: *Jennifer Klein*

From: *Gordon R. Trapnell*

Date: *April 27, 1994*

Re: *The Cost of a Maintenance Outpatient Rehabilitation Benefit with Maximum Annual Number of Visits*

A. Objective

The purpose of this note is to estimate the effect on regional alliance premiums of adding a professional maintenance level benefit to the coverage in the HSA of outpatient rehabilitation services, including services that are directed to "minimizing limitation of functioning" in addition to "maintaining functioning", but imposing limits of 100 or 120 annual visits on all outpatient rehabilitation care.

B. Cost Estimates

In a previous memo (to Ken Thorpe on Feb. 8, 1994, which I presume you have), I estimated the cost of a professional maintenance benefit to be "relatively small, between 0.15% and 0.25% of premiums in the first year or two of the program, but that there could be a rapid rate of expansion of the services over the next decade or two, with the result that the proportion of the premium devoted to this benefit could rise as high as 6.5% of premiums. I have also opined that the addition of the minimizing limitations of functioning in a manner that implies an intent to expand coverage beyond "maintaining function" would have a small but significant cost, estimated (mid-range) to increase the premium from 0.20% to 0.22% of premiums in the short run.

The question at hand is what is the effect of limiting all of the services involved (physical therapy, occupational therapy, speech language therapy) to 100 or 120 visits per year.

I estimate that the 100 day limit will reduce the short run cost by 0.02% and the 120 day limit will reduce the short run cost by 0.01%, with somewhat greater than proportional savings in the longer run.

20 April, 1994

MEMORANDUM FOR: Jack Lew, Len Nichols, Jennifer Klein, Linda Blumberg

FROM: Ken Thorpe

RE: Ed and Labor Markup Estimates

****

We have completed the following estimates for markup.

1. **WRAP ESTIMATES** (from HCFA) Billions $

	1996	1997	1998	1999	2000	96-00
Wrap for all kids under 22 under 200% pov	.3	1.1	3.2	4.4	4.6	13.6
Non-cash wrap	.2	.5	1.1	1.1	1	3.9
Non-cash wrap, preg. women to 185%	0	.1	.2	.3	.3	1.0
Non-cash wrap <100%	.1	.3	.8	1	1.2	3.3

NOTE: THE FIRST ESTIMATE ASSUMES NO STATE MOE, THE LAST THREE ASSUME REGULAR STATE MATCH UNDER MEDICAID. ALSO, THE FIRST OPTION ASSUMES A "CLOSED-GROUP"; THAT IS, THE COSTS ARE FOR THOSE CURRENTLY NON-CASH ELIGIBLE. THE $5.7 BILLION COST ITEM FOR NON-CASH ADULT WRAP ASSUMES AN ON-GOING PROGRAM.

2. **BENEFIT PACKAGE ESTIMATES**

I have already summarized the ARC estimates for the women's preventive package and family planning services. The newest one

completed relates to Mr. Miller's mental health issue. Though the HCFA actuary has not specifically priced it, he is concerned that it would have more that a modest increase in costs. This principally results from the liklihood that coordination as envisioned would increase the number of kids served under the benefit.

3. COST SHARING WAIVERS

These waive cost sharing for low income populations. The estimates are from ARC and are for two scenarios.

A. ALL IN FFS.

I have attached Jim Mays letter. In short, there are two effects; an indirect effect which results in increasing the premium, and the direct effect of paying for the cost-sharing. Jim's memo from April 18 shows the combined effect; his April 19 memo notes that the split is 41% (indirect) and 59% direct.

Impact on the subsidy was determined as follows: the indirect effect uses the 1.7% elasticity assumption. The direct impact multiplies the number (for instance 3.2% in option 1) times the premiums in the regional alliance. You may want to re-do this, as I have slightly overestimated the direct effect (since I used alliance and corporate alliance premiums) and underestimated the indirect (since I did not increase the premium pool by the indirect bump-up). If you want to fix, I would suggest the following:

--Total premiums between 96-00 are $1.715 Trillion (92% of which are regional alliance--From Jeff L.) You could adjust the direct numbers down by this amount. You could also increase the $1.715 Trillion for each scenario by the the indirect increase in the premium.

B. ALL IN HMOs.
5 year increases in subsidies

Eliminate HMO Cost Sharing for those under 200% poverty.	$34 Billion
Reduce HMO Cost Sharing for those under 200% poverty to the cash assistance level	$29 Billion
Eliminate HMO Cost Sharingfor those under 150% of poverty	$26 Billion
Reduce HMO Cost Sharing for those under 150% of poverty to cash assistance level	$22 Billion

CNQDCW1

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To Ken Thorpe	From Jim Mays
Co.	Co.
Dept.	Phone # 202-401-7900
Fax # 202-401-7321	Fax #

Page

MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : Cost-sharing Waiver Ballpark Numbers (FFS Estimate)

5 yr subsidy impact

Ballpark numbers phoned to Gary Claxton, 17 April 1994

1. Waive cost-sharing on pregnant women and children < 200% of Poverty, all Cash Assistance; others < 100%P + $15.5 Billion $55 Billion = $.70 B.Ill.

increase: 5.5% 2.3% indirect 3.2% direct

2. Waive cost-sharing for all below 200% of Poverty

increase: 6.7% $47 B.Illion 2.7% + $69 B 4% Direct = $87 Billion

3. Not quite waive - retain nominal amounts of cost-sharing for all below 200% of Poverty (nominal assumed to mean 10% of the original level):

increase: 6.1% $17 2.5% In + $62 B 3.6% Dir = $79 B

4. Waive all cost-sharing for persons below 100% of Poverty, retain nominal amounts to 200% (except pregnant women have no cost-sharing):

increase: 6.4% $17 2.6% IN + $65 B 3.8% Dir. = $82 B

cnqdcw1 /a /e

$1.75 B

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To Ken Thorpe	From Jim Mays
Co.	Co.
Dept.	Phone # 703-941-2400
Fax # 202-401-2321	Fax #

MCSWEL

MEMORANDUM

To : Ken Thorpe

From : Jim Mays

Subject : Cost-sharing Waiver Estimates

1. Direct vs. indirect effects - for the 4/18/94 premium increases, 41% is induced demand and 59% is direct payment of out-of-pocket expenses.

2. Impact of cost-sharing waivers if low-income populations are in HMOs. Assuming all persons below 200% of poverty are in HMOs, the direct cost of waiving cost-sharing is cut to approximately .3 of the fee-for-service based estimates in the 4/18 estimates. Thus, waiving cost-sharing on persons below 200% of poverty would have direct costs equal to about 2% of alliance premiums. If the cost-sharing is reduced to the Cash Assistance population level ($2 copays, etc.), the direct cost is cut to approximately .25 of the 4/18 estimates, or about 1.7% of alliance premiums.

½ of direct

If the cost-sharing waiver is for persons below 150% of poverty (rather than 200%), the corresponding estimates would drop to 1.5% and 1.3%, respectively.

3. Impact of 5% cut in premiums on out-of-pocket expenses. Starting at the HSA benefit level, cutting 5% off the premium is $88 (single coverage, CBO premiums). With induced demand, this only increases out-of-pocket by $52.50, an 11.5% increase (larger percentage since much smaller base).

mcswel
/a /e

OOP-$100/YR ⇒ HMO

FAX TRANSMITTAL # of pages ▶ 1

To Ken Thorpe From John Klemm
Phone # 966-7914

Cost of Alternative Kid Wrap Program II
Covering Children < 22 for wraparound services - no State MOE
4-19-94

$ billions

	FY96	FY97	FY98	FY99	FY00	96-00
Curr Fed Baseline (w/ phase-in)	0.1	0.4	1.2	1.9	2.2	5.9
New Program Fed Spending (100% match)						
Curr HSA pricing (no elig changes)	0.2	0.7	2.0	2.9	3.1	8.9
Curr Law Max Participation	0.3	0.9	2.7	3.8	4.1	11.8
150% PL Max Par	0.3	1.3	3.6	5.1	5.5	15.7
200% PL Max Par	0.4	1.6	4.5	6.3	6.8	19.5
State MOE	0.0	0.0	0.0	0.0	0.0	0.0
Net Fed Cost						
Curr HSA pricing (no elig changes)	0.1	0.3	0.8	1.0	0.9	3.0
Curr Law Max Participation	0.1	0.5	1.5	1.9	1.9	5.9
150% PL Max Par	0.2	0.8	2.4	3.2	3.3	9.9
→ 200% PL Max Par	0.3	1.1	3.2	4.4	4.8	13.8

Ken — Turns out the run I sent yesterday was for <22 pop (not <19). Sorry for the confusion. Jo

Five-year costs for additional low-income protection proposals

i) Provide wrap for current non-cash adults who continue to meet eligibility requirements (closed group) with regular match

CY96	CY97	CY98	CY99	CY00	CY96-00
0.2	0.5	1.1	1.1	1.0	3.9

ii) Provide wrap to non-cash < 100% PL, regular match

CY96	CY97	CY98	CY99	CY00	CY96-00
0.1	0.3	0.8	1.0	1.2	3.3

iii) Provide wrap to non-cash preg wm to 185% PL

CY96	CY97	CY98	CY99	CY00	CY96-00
0.0	0.1	0.2	0.3	0.3	1.0

4/20/94 6pm

To: Jim Mays

From: Sharman Stephens

I have tried to create a list of what I think are the areas in the (Williams?) bill Jennifer is seeking a response on. The ones with an * appear to be the same or similar to the list I faxed you earlier today. Per our conversation I have noted the ones where you think we have something to say.

1. Mental Illness/Substance Abuse: Special Delivery Requirements for Services Provided to Children

   Ken has faxed something to Jennifer already

2. Removing Illness / Injury on home health

3. Removing illness/injury on extended care facility

4. Inter-island transportation

   minimal cost (rationale very few people live on the islands)

*5. Outpatient vision-related rehabilitation services

*6. Outpatient rehabilitation limitations

*7. Durable Medical Equipment

*8. Hearing care (hearing aids) kids (previous numbers:

single $0.01	couple $0.02
1 adlt fam $1.36	2 adlt fam $1.50

*9. Dental care for individuals with a seizure disorder

   (with the understanding of the language that it is for dental care needed because it is a result of illness, injury, or disorder associated with a seizure disorder, but not general dental care for individuals with seizure disorders then very minimal cost implication)

cc: Jennifer Klein

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

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

Date:

From: Shauman Stephens

To: Jennifer Klein

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

Phone: _____

Fax: _____

Number of Pages (Including Cover): 2

Comments: So you know what I sent to AKC

4/25/94 4:00 PM

TO: JIM MAYS
ROSE CHU

FROM: Sharman Stephens

SUBJECT: Costs Requests for (1) Ed and Labor on Preventive and Family Planning Services for Low Income Women (200% of poverty) and (2) Request from Ellen Schaeffer (staff Senator Wellstone)

Per my conversation with Rose I have been asked by Ken and Jennifer to transmit the following two requests.

1. Ed and Labor Preventive and Family Planning Services for Low Income Women

Using the earlier ED and Labor list of preventive (e.g., more frequent mammograms, osteoporosis screening, annual pap, pelvics and breast exams for women of child bearing age, check earlier list for completeness) and family planning services without cost sharing, please provide and estimate of what it would cost to do this only for low income women (200% poverty).

-- mammograms (more frequent than HSA but don't know periodicity check earlier list from ED and Labor)

-- osteoporosis screening

-- annual pap, pelvic, and breast exams for women of child bearing age

-- family planning without cost sharing

2. Ellen Schaeffer (Senator Wellstone)

(asterisk indicates that you may have done this already)

-- *STD screening for men

-- *Annual paps, pelvics for sexually active women

-- Health education classes not discretionary; cost with cost sharing (assume $10 or 20%) and without

-- *Include endodontic services for over age 18 in 2001 (Gordon's detailed dental estimates table may have this even though HSA did not include it for adults.)

cc: Jennifer Klein
Ken Thorpe

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
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PHONE: (202) 690-6870 FAX: (202) 401-7321

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From: Sharman Stephens

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Fax: _____

Number of Pages (Including Cover): 10

Comments:

_____

_____

_____

NOTE TO KEN

From: Sharman

Between my conversation with you and Jen I have prepared the attached three documents. These represent my thoughts, as I have not asked for a reaction from Wayne or Jim Mays. If you want me to talk with them please let me know.

- Comments on cost uncertainties around Mr. Miller's Amendment #1
- Rationale for why organized systems of care can be considered a cost.
- Comments on Mr. Miller's Amendment #2.

COST UNCERTAINTIES AROUND
MR. MILLER's AMENDMENT #1 (Stark Mental Health Provisions)

1. It is not clear how the provision -- "The Secretary would be directed to develop standards for the appropriate management of these services" -- is to be interpreted, and thus its potential impact on the nature of the mental health benefit package. For example, it could be interpreted as permitting all plans including FFS to have a "carve-out" managed mental health benefit with a closed panel of providers that functions like an HMO, or it could mean simply the Secretary establishing rules about the nature of utilization review that plans can conduct. These varying interpretations potentially have different cost implications.

2. It is not clear whether the 190 lifetime limit applies only to psychiatric hospital, or it applies to other psychiatric specialty facilities such as intensive residential facilities.

3. It is not clear how this amendment operates in relationship to the out-of-pocket maximum provisions of the HSA. The Stark bill did not have out-of-pocket maximum provisions so the mental health provisions did not address the issue of whether mental health cost sharing counted toward the o-o-p.

RATIONALE BEHIND ORGANIZED SYSTEMS OF CARE FOR CHILDREN POTENTIALLY HAVING COST IMPLICATIONS

- Mental illness affect an estimated 12 percent of children and adolescents impairing functioning in more than 8 million younsters
- Estimated four-fifths of children with mental and emotional disorders are inappropriately served
- There is a limited amount of data available on the costs of systems of care. There are some demonstrations that have focused on working with severely ill children. There appears to be only one (CHAMPUS Ft. Bragg) which has done it from both a client and population based perspective.
- Organized systems of care might be cost-effective particularly when looked at from a cost per child basis:
  - -- CHAMPUS Demonstration in Ft. Bragg found that cost per client in demonstrations was $5380 compared with $10,922 at comparison sites
  - -- Impact, Kentucky: Estimated costs of child services were $9.5 million during the first year of services as compared with $13.5 million prior year.
  - -- Savings come from shift in site of care from hospital and residential to community-based, and also from the more expensive out-of-state placements.
- Organized systems of care might also result in costs:
  - -- Increase Access - Anecdotally reports from the Ft. Bragg indicate that while per child costs went down, total program costs went up. Percentage of kids getting mental health services in Ft. Bragg was larger than in comparison sites. The expenses at Ft. Bragg may be high because it was not a capitated or heavily managed program. The data from the Ft. Bragg demonstration is still under analysis, the program indicated that they hope to have some program level cost figures in the next 10 -14 days.
  - -- Not in Baseline - Organized systems of care are not part of the delivery system of services for children now, thus the impact of the systems, start up costs, and administrative expenses associated with the systems are not part of baseline expenditures.

COMMENTS ON MR. MILLER'S AMENDMENT #2

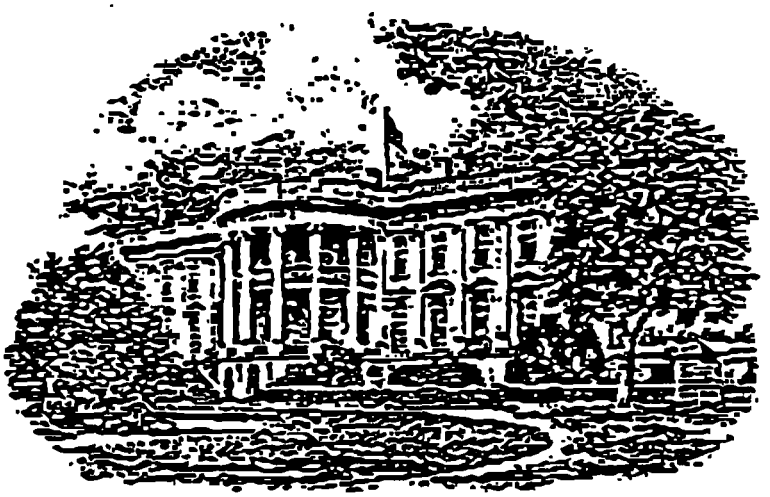
- It is not clear what the impact of this amendment might be.

- Does the provision for states to establish comprehensive managed mental health programs override the HSA provisions on fee for service (any willing provider)? If it does then potentially if the same HSA limits are in place this could be a cost saver. If it does not, then I'm not sure what it might be doing. Conceivably if it requires the fee for service plans to do coordination with states, there might be actually be an administrative cost increase associated with such a provision.

DATE: _____
TIME: _____

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Sharman Stephens

PHONE: (___) _____

FAX: (___) 401-7321

URGENT

FROM: Jennifer and Ken

PHONE: (202) 456-_____

PAGES FOLLOWING COVER SHEET: _____

MENTAL HEALTH AND SUBSTANCE ABUSE AMENDMENT #1

OFFERED BY MR. MILLER OF CALIFORNIA

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

April 15, 1994

The Subcommittee Chairman's Mark would be amended to provide the following benefits specific to the needs of individuals with mental illness and substance abuse disorders. This amendment amends the mental health and substance abuse benefits offered in Title I of the Health Security Act.

I. Enhanced Benefits

A. Residential

1. Inpatient Psychiatric

Coverage would be provided for up to 90 days annually in general hospitals; and 45 days annually in psychiatric hospitals with a lifetime limit of 190 days.

2. Intensive Residential Services

Coverage would be provided in the following residential programs: (i) residential detoxification centers; (ii) crisis residential programs or mental illness residential treatment programs; (iii) therapeutic family or group treatment homes; (iv) community residential treatment centers; and, (v) recovery centers for substance abuse.

These services would be available for up to 135 days per year. Beneficiaries receiving this benefit would have their inpatient psychiatric benefits reduced by one day of inpatient care for every three days residential services received and vice versa. The Secretary would be directed to develop standards for the appropriate management of these services.

B. Intensive Non-residential Community Services

The following intensive community services would be made available: (i) psychiatric rehabilitation services; (ii) day treatment services for children; (iii) behavioral aide services; (iv) in-home services; (v) ambulatory detoxification services. This benefit would be limited to 90 total days per year and would have a 20 percent copayment. The Secretary would be directed to develop standards for the appropriate management of these services.

C. Outpatient psychotherapy

Outpatient psychotherapy visits for children through age 18 would be provided with a 20 percent copayment. Outpatient psychotherapy visits for adults would be provided with a 50 percent copayment.

MENTAL HEALTH AND SUBSTANCE ABUSE AMENDMENT #2

OFFERED BY MR. MILLER OF CALIFORNIA

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

April 15, 1994

Replace section 3521 of H.R. 3600 (page 626) with the following new section.

I. Comprehensive Managed Mental Health Programs

A. State flexibility

Broad flexibility would be available to States to establish comprehensive managed mental health programs. The programs would promote the development of integrated delivery systems for the management of mental health services for low-income adults and children with serious mental illness or emotional disturbance. The programs would allow individuals to continue to receive the services defined in the national guaranteed benefit package for mental health (as amended by this proposal), but without the limits and, at state option, with reduced copayments. Omit

Strike Mark + org. system of care for kids

B. Eligibility

Eligibility of individuals to participate in comprehensive managed mental health programs would be based on Federal standards, although States would have the ability to define eligibility in greater specificity.

The Federal standards would assure that the State programs focused services on adults with serious mental illness and children with serious emotional disturbance, as evidenced by a need for multiple services (either a past history, or prediction of future needs), and who have a disorder which is expected to last at least one year.

Day visit limits

Omit — Limitations on benefits would not apply to individuals participating in a comprehensive managed mental health program

C. State Planning and Other Requirements

States would be required to submit a plan for a comprehensive managed mental health program which specifies:

1. The management, access and referral structure which the State would use to promote and achieve integration of the basic benefits and other appropriate services which the State intends to integrate under the State's comprehensive managed mental health program

2. The detailed specifications for the program which will assure that eligible individuals have access to each service, as appropriate.

3. The definition of "serious mental illness for adults" and "severe emotional disturbance in children" within the State's program, based on Federal standards

4. Additional Federal, state, and local funds that the state proposes to integrate in order to finance the program (e.g., Title IV E, A, and Public Education sources).