To Jen K.
From Karen P.

456 - 2878

DRAFT Talking Points - Guaranteed Benefits

Q. Why must there be a standardized benefits package?

* A standard benefit package prevents insurance companies from using benefit design to select good risks. For example, a package that fails to cover cancer would not be attractive to persons with that disease.

* A standard benefit package permits people to evaluate health plan differences (such as price) comparing "apples to apples."

Q. Instead of Congress legislating a benefits package, why can't a Board determine one later (like Chafee)?

* For purposes of fiscal responsibility, as well as scoring, Congress must know the cost of the health reform plan they enact. The specifics of the benefits package is key to deriving premium estimates on which all other cost estimates are based.

* Politically, voters will insist on knowing what health reform promises in the way of coverage so they can evaluate this promise with their current coverage. They are not interested in a "pig in a poke."

Q. Why can't the standard package be a catastrophic plan?

* A catastrophic plan (one that covers health services after a large deductible, such as $1,000 or $2,000) effectively requires families to pay out of pocket for the entire cost of preventive and primary care services. This creates perverse financial incentives that will encourage people to delay care until preventable health problems become serious.

* For the poor and lower middle class, a catastrophic policy is the same as being uninsured.

* A bare bones-type policy leaves in place a significant amount of uncompensated care. The result is higher cost shifting for that care which makes it more difficult to control costs.

Q. What's wrong with a Nickles-like approach (catastrophic coverage plus a medisave account)?

* The presence of a medisave account would not eliminate the perverse financial incentives under a catastrophic plan that encourage people to avoid preventive and primary care. People would still need to choose between putting their extra dollar in a medisave

account or using it for rent, etc.

* The poor and middle class are not likely to be able to create and maintain large (eg, $1000-2000 per person) savings accounts exclusively for health care.

* Employers are no more likely to voluntarily contribute toward medisave accounts than they are toward health plan premiums.

Q. Why can't the uninsured -- or all people -- simply join the FEHBP?

* In essence, the HSA provides all Americans with a FEHBP-like program for health insurance coverage and choice. However using the FEHBP, itself, for all Americans could be problematic for a few reasons:

* FEHBP does not now have a standard benefit package. As a result, there is a problem with adverse selection. People who anticipate being healthy tend to select the plans with less generous coverage (like the Mail Handlers plan) while people who are sick or anticipate upcoming health expenses tend to select more generous plans (like Blue Cross high option) at open season. This selection problem skews premium rates as health plans are priced according to the average heatlh expenses of their own enrollees.

* FEHBP also is a nationally rated program -- at least for fee-for-service plans. Local health plans could have problems competing in such a system depending on how local health costs compare to national average costs. In high cost areas (like New York) local plans would be unable to compete against plans rated on average national health costs.

Comprehensive Benefits

Why define a comprehensive benefit package in legislation?

- Today's insurance market offers a multitude of policies, with confusing fine print. Defining a comprehensive benefit package in legislation eliminates the confusion that exists today and prevents patients from discovering, just as they need coverage the most, that they have reached their lifetime limit or that a particular illness or condition is not covered.

- The Chafee bill defines benefits in only thirteen lines.

    - Without clearly defined benefits or cost sharing, it is impossible to estimate the costs of the benefit package to employers, individuals and the government.

    - In addition, the board may reduce benefits in the future, subject only to disapproval by Congress. If health care costs increase, benefits may be decreased, leaving individuals vulnerable to rising costs.

Why should the package be comprehensive?

- The Chafee bill provides that health plans may offer a standard benefit package and a catastrophic package. The Nichols bill requires only a catastrophic package.

    - This creates a two-tiered system. The wealthy may be able to afford a good benefit package, while the middle class and poor may be forced to purchase only catastrophic coverage with high out-of-pocket expenditures.

    - Further, if given a choice of standard and catastrophic packages, healthy individuals may choose catastrophic coverage and the sick may choose the comprehensive package. The costs of the comprehensive package will increase, making it unaffordable to many low-income people.

    - With only a catastrophic package, uncompensated care is and the cost shifting that exists today continues.

    - Catastrophic coverage discourages the use of cost-effective preventive care, and instead encourages individuals to wait until their illnesses are severe and costly before seeking treatment.

- The lack of insurance coverage for preventive services is clearly a barrier to their use. Coverage for preventive

services adds very little cost to health insurance premiums, but has been shown to be an effective way to reduce the risk of serious illness that can significantly raise future health care spending.

- Without a standard comprehensive package, plans may offer benefits designed to attract healthy customers, perpetuating their ability to compete based on adverse selection or "cherry picking", rather than forcing them to compete by providing high quality health care at an affordable price.

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to: Jennifer Klein

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from: Lisa Simpson, MB, BCh, MPH

date: 5/20/94

re: SPEECH

pages: , including this cover sheet

NOTES: Sorry for the delay - I was out all this am and yesterday was - as per usual - crazy

I have tried to call John Weintraub back at Ed and Labor - I have answers for him on this stuff - basically we do not think PSA is a good idea and can support that pretty strongly.

As to colorectal stuff - they got the periodicity all wrong but it looks like they may end up putting it in. I will not give him cost info at this time, but will check what it was with Sharman, so we have it.

GOAL OF HEALTH REFORM

= improve health status through universal coverage and real access to appropriate health care services.

3 QUESTIONS

Are the right health care services covered?

Can patients receive the services appropriate to their needs regardless of age, geographic location, and financial status?

"access safeguards"

Are these services of high quality and will they improve health which is defined broadly to include functioning and quality of life?

"quality safeguards"

FIRST QUESTION: Are the right health care services covered?

- uniform and comprehensive benefits package defined **in statute**

  why uniform? competition based on quality and costs, comparison
  why comprehensive? cherry picking, design to recruit healthy, catastrophic
  why in statute? security, costs, vulnerable populations - kids and women

- range of services

  services not providers
  prevention - cornerstone
  wholistic approach to needs - physical, mental, SA, dental, vision

- role of NHB

  uniformity of application of benefits package
  plan flexibility
  updates:

SECOND QUESTION: Can patients receive the services appropriate to their needs regardless of age, geographic location, and financial status?

First, we must assure that services are **AFFORDABLE** while promoting personal responsibility:

- choice of plans
- cost sharing structure -
- reductions in cost burden for low income

Second, we must assure that services are **AVAILABLE** in communities where patients live

- plans requirements:

  -no pre-existing conditions, community rating, ECP contracts
  - must be reimbursed for level of risk of enrollee population - risk adjustment
  - Medicaid payments same as other
- states certifies based on ability to deliver full benefit package
- must assure choice of plans, including FFS plan
- may require plans to serve entire areas
- may provide incentives to expand into underserved areas
- must have right type, mix and distribution of providers:

  - market forces toward primary care and cost effective, efficient providers
  - GME reform
  - tax incentives for providers in underserved areas
  - grants and loans for community based provider networks
  - NHSC

Third, we must assure that services are **ACCESSIBLE** to all, especially those that have been traditionally left out of the private insurance system

- enabling services
- school related initiatives for high risk youth

Fourth, we must assure that services are **APPROPRIATE** to the needs of individual patients

- medical necessity decisions: physician and patient
- promote shared decision making - later in quality
- assure access to both primary care services
  most people need most of the time for most of their problems
- **AND** access to specialty services

First, health plans are to be held accountable by States for assuring access to <u>all</u> the benefits, INCLUDING emergency and specialty services, not just primary care.

Second, alliances must assure that health plans enter into sufficient contracts with academic health centers to assure access for their enrollees to the specialty services they provide.

Third, a special fund is established for academic health centers to offset their added costs related to their teaching and research functions. This will go a long way toward levelling the playing field, making tertiary care providers more competitive for negotiating contracts with managed care providers.

Finally, plans will be monitored for the quality of the full range of services they provide, include specialty services.

- the final way we assure the appropriateness of services is through promoting the development and diffusion of effective technologies:

- **First,** the Act establishes universal coverage for all Americans and expands Medicare to include a prescription drug benefit. Together these provisions will significantly increase the market for the appropriate use of effective medical technologies and drugs.

- **Second,** the Act specifically charges health plans with coverage of the routine costs of medical care provided during approved research trials. Routine medical costs are defined as those that would have been provided to the individual even if the individual were not receiving the investigational treatment.

- In addition, the benefits package allows health plans to cover the investigational treatment itself for certain life threatening or other health conditions that the National Health Board would define.

- These provisions significantly enhance our ability to conduct clinical research as it spells out the coverage responsibilities of health plans ensuring that clinical trials will be supported to an extent rarely seen today even in the best insurance plans.

- **Third,** the Act recognizes that academic health centers are essential in the delivery of services to communities and that they play an important role in the development and diffusion of new technologies. In fact, AHC's are often the place where new technologies are first adopted.

- For these reasons, alliances must assure that health plans enter into sufficient contracts with academic health centers to assure that patients have appropriate access to the specialty services and the technologies of these centers.

- A fund is also established to support the extra costs that Academic Health Centers incur by their research and teaching functions.

- **Fourth,** the Act increases funding for research at both the NIH and the Agency for Health Care Policy and Research. This includes both prevention research and research on the quality and outcomes of care and technology assessment.

- **Fifth,** the Act promotes the practice of appropriate medical care through the use of practice guidelines, research dissemination, and consumer education.

Fifth, we must assure that services are **ACCEPTABLE** to patients by:

- relying on competition and consumer satisfaction and choice driving responsiveness into system
- promoting the role of consumers in decision making.

THIRD QUESTION: Are these services of high quality and will they improve health which is defined broadly to include functioning and quality of life?

The Act adopts an approach where plans, providers, and consumers each share a responsibility for improved quality.

The Administration's approach to quality management rests on three interrelated strategies.

First, it provides information for consumer choice through performance measurement.

Second, it expands the tools and information available for quality improvement, including:

- the establishment of dynamic, community based, organizations focused on quality;
- expansions in outcomes and quality research and technology assessment;
- a new and comprehensive strategy for maximizing the effectiveness of clinical practice guidelines; and
- expansions in research on the prevention of diseases and disorders.

Third, it includes several provisions for consumer protection designed to assure that consumers know what they are getting, have opportunities to question practices, and plans are held accountable for their practices.

Each of these three approaches has at its core a commitment to producing and providing information, moving us beyond the "black box" of medical care and health care systems, to a system that is explicit and accountable.

BENEFITS

1. Comprehensive

   - All Americans are guaranteed the package wherever they are in the country and wherever they work.

   - No lifetime limits on coverage for any service and no exclusions for preexisting conditions.

   - One package

     - Replaces the confusing variety of insurance products on the market.

     - Also important that there is only one package -- currently insurers structure coverage to attract younger, healthier population.

   - Generally, we provide the level of benefits provided by Fortune 500 companies.

     In some important respects, we provide more -- range of preventive services; prescription drugs; dental; mental illness and substance abuse.

2. What's covered

   - Hospital services; health professional services; emergency and medical ambulatory and surgical services; clinical preventive services; mental illness and substance abuse services; family planning services and services for pregnant women; hospice care; home health care; extended care services; ambulance services; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs; outpatient rehab; durable medical equipment and prosthetic and orthotic devices; dental care; and vision care.

   - 3 cost sharing schedules -- lower (HMO type); higher (fee-for-service type); and combination (lower in network and higher out of network). Lower equals $10 copayments $5 for prescription drugs, no deductible, out of pocket limit of $1500 for individual/$3000 for families. Higher equals 205 coinsurance, same out of pocket limit as lower, $200 deductible for individual/$400 for families, $250 deductible for prescription drugs, no deductible for preventive services.

   - To highlight

     - Clinical preventive services -- age-appropriate immunizations, tests and clinician visits according to a periodicity schedule in legislation; plus National

Board can define services for high risk populations; plus Natioanl Board can modify. Examples: lead testing for kids, mammograms every two years for women 50 or older.

- Prescription drug benefit -- addition for Medicare too

- Health professional services -- we define this as services that are lawfully provided by a physician and that may be provided by another health professional if that person is legally authorized to perform those services in the state. Also we prevent states from restricting practice beyond what is justified by the skill or training of the professionals.

3. Hot issues

- Mental illness and substance abuse -- complaints that we have changed the package, limitations before 2001, controls on utilization, especially for substance abuse unnecessary.

  Describe package.

  Response -- moving toward a flexible, managed benefit in 2001 -- all day limits and higher cost sharing ends. Between now and then, we leave in place current market practice of day limits, but eliminate lifetime limits and preexisting condition exclusions, and expand range of treatment options (e.g. behavioral aide services, partial hospitalization). In interim, capacity that does not currently exist will develop.

- Abortion

  Included as "services for pregnant women". Covered, as is any other service in the package, if the doctor and the patient decide that it is medically necessary or appropriate. There is a conscience clause that applies to all services that permits a provider -- whether a facility or an individual -- to refuse to perform a service if they have a moral or religious objection to that service.

  Pressures -- one side wants explicit statement that plan must contract to provide service and providers must refer patients if the provider will not perform service him or herself. Other side wants all providers in a plan to be able to refuse to perform service.

  What we say -- All plans provide the services in the comprehensive benefit package. A provider may refuse to perform a service for moral or religious reasons.

- This is an acute care benefit. e.g. rehab services -- restore capacity or minimize limitations as a result of illness or injury -- reevaluation after 60 days and covered if functioning is improving; extended care covered for rehab from illness or injury -- annual limit of 100 days; home health care after illness or injury -- reevaluation at end of 60 days.

  We are working with actuaries on what we can do to broaden the benefit. We were conservative in our estimates.

THE COMPREHENSIVE BENEFIT PACKAGE

Use during presentation as talking points e.g. dental

THE HEALTH SECURITY ACT OF 1993

PRINCIPLES OF BENEFIT PACKAGE

- Guaranteed, comprehensive benefits

  -- strong emphasis on prevention
  -- no exclusions for pre-existing conditions
  -- no lifetime limits on benefits
  -- guaranteed renewal
  -- choice of 3 standard cost sharing arrangements

- Protection against catastrophic costs

  -- annual out of pocket maximums
  -- reasonable deductibles

ITEMS AND SERVICES COVERED

Hospital Services:
Inpatient, Outpatient, &
Emergency

Health Professional Services

Emergency & Ambulatory Medical &
Surgical Services

Clinical Preventive Services

Mental Illness & Substance Abuse
Services

Family Planning Services & Services
for Pregnant Women

Hospice Care & Home Health Care

Extended Care Services

Ambulance Services

O/P laboratory, radiology, &
diagnostic services

O/P Prescription Drugs & Biologicals

O/P Rehabilitation Services

Durable Medical Equipment

Vision & Dental Care

Health Education Classes

Investigational Treatments

ITEMS AND SERVICES COVERED

- Hospital services
- Health professional services
- Emergency & ambulatory medical & surgical services
- Ambulance services
- Outpatient laboratory, radiology, & diagnostic services

CLINICAL PREVENTIVE SERVICES

- Establishes complete set of preventive benefits with no cost sharing

  -- prenatal care, well baby and well child care, & adult physicals

  -- preventive screenings: blood and urine tests, pap smears and mammograms, and cholesterol

  -- immunizations for children and adults

- National Health Board updates periodicity and defines additional items & services for high risk populations

ITEMS AND SERVICES COVERED

- Family planning services & prescription contraceptives
- Services for pregnant women
- Vision care
- Health education classes

ITEMS AND SERVICES COVERED

- Hospice care
- Home health care
- Extended care services
- Outpatient rehabilitation services
- Durable medical equipment

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

Inpatient hospital & residential services

Intensive nonresidential treatment (e.g. partial hospitalization, day treatment, behavioral aides)

Screening & assessment, diagnosis, medical management, crisis services, somatic treatments

Psychotherapy & collateral services

Outpatient substance abuse services including substance abuse counseling & relapse prevention

Case management

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

- All day & visit limitations eliminated by 2001. Before January 1, 2001, day & visit limits apply to most services:

  -- inpatient hospital/residential services
  -- intensive non-residential services
  -- psychotherapy and collateral services
  -- outpatient substance abuse services

- Screening & assessment, diagnosis, medical management, crisis services, somatic treatments covered with no visit limits

OUTPATIENT PRESCRIPTION DRUGS & BIOLOGICALS

- All FDA approved drugs & biologicals
- Unapproved (off label) use of FDA approved drugs & biologicals if:
  - -- appears in 1 of 3 specified compendia; or
  - -- other compendia identified by HHS Secretary; or
  - -- supportive medical literature
- Outpatient blood clotting factors

INVESTIGATIONAL TREATMENTS

- Defines approved research trials
- Establishes coverage of routine care in approved research trials
- Allows health plans to cover investigational treatments for certain life threatening conditions as defined by the National Health Board

COST SHARING CHOICES

SERVICES	LOWER COST SHARING*	HIGHER COST SHARING
	ind / family	ind / family
Out of pocket max	$1,500 / $3,000	$1,500 / $3,000
Deductible	None	$200 / $400**
Preventive svcs (incl. prenatal care)	None	None
Inpatient hospital svcs, O/P diagnostic svcs, & ancillary svcs	None	20% co-ins
Most O/P svcs inc vision & dental care	$10	20% co-ins
Prescription drugs	$5	20% co-ins

* POS option & reduced cost sharing for low income
** No deductible for preventive services; $50 deductible for dental treatments; $250 deductible for outpatient prescription drugs

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES: COST SHARING

- For many services cost sharing comparable to other

Prior to January 1, 2001:

- 1 day deductible per admission for inpatient hospital, residential and intensive non-residential services
- $25 / 50% cost sharing on psychotherapy & collateral
- $25 / 50% cost sharing on additional 60 days of intensive non-residential services
- not all cost sharing applies to out of pocket maximums

BENEFIT EXCLUSIONS

any service that is not medically necessary or appropriate

custodial care*

cosmetic surgery except as defined in Act

hearing aids

eyeglasses & contact lenses for less than 18 year olds

in vitro fertilization

sex change surgery & related services

private duty nursing

personal comfort items*

certain dental services, e.g. crowns, pin/post implants, denture fitting

* except for hospice services

ROLE OF THE NATIONAL HEALTH BOARD

- Write regulations & guidelines to assure uniformity of application of benefit package across all plans
- Accelerate the benefit expansions planned in 2001 *only* if the increase in expenditures will not cause any regional alliance to exceed its per captia target
- Modify & update the clinical preventive services in consultation with experts in clinical preventive services
- Establish standards regarding medical necessity
- May not establish regulations which restrict health plans from choosing providers and methods to deliver benefits

ADDITIONAL PROVISIONS

- No other limitations in duration or scope or additional deductible, copayment, or co-insurance requirements
- All dollar amounts specified are indexed using the general health care inflation factor & rounding is used
- Override of restrictive State practice laws
- Conscience clause for health professionals and health facilities

THE COMPREHENSIVE BENEFIT PACKAGE

PRINCIPLES OF BENEFIT PACKAGE

- Guaranteed, comprehensive benefits

  -- Strong emphasis on prevention
  -- No exclusions for pre-existing conditions
  -- No lifetime limits on benefits

- Protection against catastrophic costs

  -- Choice of 3 standard cost sharing arrangements
  -- Annual out-of-pocket maximums
  -- Reasonable deductibles

ITEMS AND SERVICES COVERED

Hospital Services:
Inpatient, Outpatient, &
Emergency

Health Professional Services

Emergency & Ambulatory Medical &
Surgical Services

Clinical Preventive Services

Mental Illness & Substance Abuse
Services

Family Planning Services & Services
for Pregnant Women

Hospice Care
Home Health Care

Extended Care Services

Ambulance Services

O/P Laboratory, Radiology, &
Diagnostic Services

O/P Prescription Drugs & Biologicals

O/P Rehabilitation Services

Durable Medical Equipment

Vision & Dental Care

Health Education Classes

CLINICAL PREVENTIVE SERVICES

- Establishes complete set of preventive benefits with no cost sharing

  -- Prenatal care, well-baby and well-child care, and adult physicals

  -- Preventive screenings: blood and urine tests, pap smears and mammograms, and cholesterol

  -- Immunizations for children and adults

- National Health Board updates periodicity and defines additional items and services for high risk populations

TABLE 1: CLINICAL PREVENTIVE SERVICES

AGE GROUP	IMMUNIZATIONS	TESTS	CLINICIAN VISITS
Under 3 yrs	Age-appropriate immunizations for: • Diphtheria • Tetanus • Pertussis • Polio • Haemophilus influenzae type B • Measles • Mumps • Rubella • Hepatitis B	• One hematocrit • Two blood tests to screen for blood lead levels for children at risk for lead exposure	Eight age-appropriate visits, including a newborn visit
3 to 6 yrs	Age-appropriate immunizations for • Diphtheria • Tetanus • Pertussis • Polio • Measles • Mumps • Rubella	• One urinalysis	Three clinician visits
6 to 12 yrs			Three clinician visits
13 to 19 yrs	Age-appropriate immunizations for • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females who have reached childbearing age and are at risk for cervical cancer every 3 years, but annually until 3 negative smears have been obtained, if medically necessary, and annually for females who are at risk for fertility related infectious disease • Annual screening for chlamydia and gonorrhea for females who have reached childbearing age and are at risk for fertility-related infectious illnesses	Three clinician visits
20 to 39 yrs	Booster immunizations every 10 years against • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams every 3 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every three years
40 to 49 yrs	Booster immunizations every 10 years against • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every two years
50 to 64 yrs	Booster immunizations every 10 years against • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years • Mammograms for females every 2 years • Cholesterol every 5 years	One every two years
65 or older	• Booster immunizations every 10 years against tetanus and diptheria • Age-appropriate immunizations against invasive influenza and pneumococcal disease	• Papanicolaou smears and pelvic exams every 2 years for females who are at risk for cervical cancer • Mammograms for females every 2 years • Cholesterol every 5 years	One each year

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

Inpatient hospital & residential services

Intensive nonresidential treatment (e.g. partial hospitalization, day treatment, behavioral aide)

Screening & assessment, diagnosis, medical management, crisis services, somatic treatment

Psychotherapy & collateral services

Outpatient substance abuse services including substance abuse counseling & relapse prevention

Case management

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

- All day and visit limitations eliminated by 2001. Before January 1, 2001, day and visit limits apply to the following services:

  -- Inpatient hospital and residential services
  -- Intensive non-residential services
  -- Psychotherapy and collateral services
  -- Outpatient substance abuse services

- Screening & assessment, diagnosis, medical management, crisis services, somatic treatments covered with no visit limits

COST SHARING CHOICES

SERVICES	LOWER COST SHARING*	HIGHER COST SHARING
	ind / family	ind / family
Out-of-pocket max	$1,500 / $3,000	$1,500 / $3,000
Deductible	None	$200 / $400**
Preventive svcs (incl. prenatal care)	None	None
Inpatient hospital svcs, O/P diagnostic svcs, & ancillary svcs	None	20% co-ins
Most O/P svcs incl. vision & dental care	$10	20% co-ins
Prescription drugs	$5	20% co-ins

* POS option & reduced cost sharing for low-income

** No deductible for preventive services; $50 deductible for dental treatments; $250 deductible for outpatient prescription drugs

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES: COST SHARING

Most cost sharing comparable to other services

Prior to January 1, 2001:

One day deductible per admission for inpatient hospital, residential and intensive non-residential services

$25/50% cost sharing on psychotherapy

$25/50% cost sharing on additional 60 days of intensive non-residential services

Not all cost sharing applies to out-of-pocket maximums

BENEFIT EXCLUSIONS

***Any* service that is not medically necessary or appropriate**

Custodial care*

Cosmetic surgery except as defined in Act

Hearing aids

Eyeglasses & contact lenses for indiv 18 years or older

In vitro fertilization

Sex change surgery & related services

Private duty nursing

Personal comfort items*

Certain dental services, e.g. crowns, pin/post implants, denture fitting

* Except for hospice services

ROLE OF THE NATIONAL HEALTH BOARD

Write regulations and guidelines to assure uniformity of application of benefit package across all plans

Accelerate the benefit expansions planned in 2001 if the increase in expenditures will not cause any regional alliance to exceed its per capita target

Modify and update the clinical preventive services in consultation with experts in clinical preventive services

Establish standards regarding medical necessity

May not establish regulations restricting health plans from choosing providers and methods to deliver benefits

ADDITIONAL PROVISIONS

- No limitations in duration or scope or additional deductible, copayment, or coinsurance requirements except as described above
- Health plans may cover investigational treatments for certain life threatening conditions as defined by the National Health Board
- Overrides restrictive State practice laws
- Permits health professionals and health facilities to object to a particular service on moral or religious grounds

Copayments and Coinsurance for Items and Services

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Inpatient hospital services	1111	No copayment	20 percent of applicable payment rate
Outpatient hospital services	1111	$10 per visit	20 percent of applicable payment rate
Hospital emergency room services	1111	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Services of health professionals	1112	$10 per visit	20 percent of applicable payment rate
Emergency services other than hospital emergency room services	1113	$25 per visit (unless patient has an emergency medical condition as defined in section 1867(e)(1) of the Social Security Act)	20 percent of applicable payment rate
Ambulatory medical and surgical services	1113	$10 per visit	20 percent of applicable payment rate
Clinical preventive services	1114	No copayment	No coinsurance
Inpatient and residential mental health and substance abuse treatment	1115	$25 per visit	50 percent of applicable payment rate
Intensive nonresidential mental health and substance abuse treatment	1115 1115(d)(2)(c)(ii)	No copayment $25 per visit	20 percent of applicable payment rate 50 percent of applicable payment rate
Outpatient mental health and substance abuse treatment (except psychotherapy, collateral services, and case management)	1115	$10 per visit	20 percent of applicable payment rate

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Outpatient psychotherapy and collateral services	1115	$25 per visit until January 1, 2001, and $10 per visit thereafter	50 percent of applicable payment rate until January 1, 2001, and 20 percent thereafter
Case management	1115	No copayment	No coinsurance
Family planning and services for pregnant women (except clinician visits and associated services related to prenatal care and 1 postpartum visit)	1116	$10 per visit	20 percent of applicable payment rate
Clinician visits and associated services related to prenatal care and 1 post-partum visit	1116	No copayment	No coinsurance
Hospice care	1117	No copayment	20 percent of applicable payment rate
Home health care	1118	No copayment	20 percent of applicable payment rate
Extended care services	1119	No copayment	20 percent of applicable payment rate
Ambulance services	1120	No copayment	20 percent of applicable payment rate
Outpatient laboratory, radiology, and diagnostic services	1121	No copayment	20 percent of applicable payment rate
Outpatient prescription drugs and biologicals	1122	$5 per prescription	20 percent of applicable payment rate
Outpatient rehabilitation services	1123	$10 per visit	20 percent of applicable payment rate
Durable medical equipment and prosthetic and orthotic devices	1124	No copayment	20 percent of applicable payment rate
Vision care	1125	$10 per visit (no additional charge for 1 set of necessary eyeglasses for an individual less than 18 years of age)	20 percent of applicable payment rate

Benefit	Section	Lower Cost Sharing Schedule	Higher Cost Sharing Schedule
Dental care (except space maintenance procedures and interceptive orthodontic treatment)	1126	$10 per visit	20 percent of applicable payment rate
Space maintenance procedures and interceptive orthodontic treatment	1126	$20 per visit	40 percent of applicable payment rate
Health education classes	1127	All cost sharing rules determined by plans	All cost sharing rules determined by plans
Investigational treatment for life threatening condition	1128	All cost sharing rules determined by plans	All cost sharing rules determined by plans

DENTAL SERVICES

- Emergency treatment for children and adults
- Prevention & diagnosis for children: oral examinations, Xrays, cleaning, dental sealants & fluoride applications
- Treatment of dental disease for children: fillings, prosthetics for genetic defects, & other services
- Expansions in 2001: prevention & diagnosis & treatment of dental disease for adults & limited orthodontics for children

THE COMPREHENSIVE BENEFIT PACKAGE

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- Protection against catastrophic costs

  -- Choice of 3 standard cost sharing arrangements
  -- Annual out-of-pocket maximums
  -- Reasonable deductibles

ITEMS AND SERVICES COVERED

→ Guaranteed in legislation -- not left to define later by Bd

Hospital Services:
Inpatient, Outpatient, &
Emergency

Health Professional Services

Emergency & Ambulatory Medical &
Surgical Services

Clinical Preventive Services

Mental Illness & Substance Abuse
Services

Family Planning Services & Services
for Pregnant Women

Hospice Care
Home Health Care

Extended Care Services

Ambulance Services

O/P Laboratory, Radiology, &
Diagnostic Services

O/P Prescription Drugs & Biologicals

O/P Rehabilitation Services

Durable Medical Equipment

Vision & Dental Care

Health Education Classes

CLINICAL PREVENTIVE SERVICES

- Establishes complete set of preventive benefits with no cost sharing

  -- Prenatal care, well-baby and well-child care, and adult physicals

  -- Preventive screenings: blood and urine tests, pap smears and mammograms, and cholesterol

  -- Immunizations for children and adults

- National Health Board updates periodicity and defines additional items and services for high risk populations

Currently -
- Only 36% of plans cover preventive benefits for children
- Only 30% cover routine adult physicals
- Even in HMOs, over 50% of enrollees must pay cost sharing.

TABLE 1: CLINICAL PREVENTIVE SERVICES

AGE GROUP	IMMUNIZATIONS	TESTS	CLINICIAN VISITS
Under 3 yrs	Age-appropriate immunizations for • Diphtheria • Tetanus • Pertussis • Polio • Haemophilus influenzae type B • Measles • Mumps • Rubella • Hepatitis B	• One hematocrit • Two blood tests to screen for blood lead levels for children at risk for lead exposure	Eight age-appropriate visits, including a newborn visit
3 to 6 yrs	Age-appropriate immunizations for • Diphtheria • Tetanus • Pertussis • Polio • Measles • Mumps • Rubella	• One urinalysis	Three clinician visits
6 to 12 yrs			Three clinician visits
13 to 19 yrs	Age-appropriate immunizations for • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females who have reached childbearing age and are at risk for cervical cancer every 3 years, but annually until 3 negative smears have been obtained, if medically necessary, and annually for females who are at risk for fertility related infectious disease • Annual screening for chlamydia and gonorrhea for females who have reached childbearing age and are at risk for fertility-related infectious illnesses	Three clinician visits
20 to 39 yrs	Booster immunizations every 10 years against: • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams every 3 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every three years
40 to 49 yrs	Booster immunizations every 10 years against • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years, but annually, following an abnormal smear, until 3 negative smears have been obtained, and annually for females at risk of fertility-related infectious disease • Annual screening for chlamydia and gonorrhea for females who are at risk for fertility-related infectious illnesses • Cholesterol every 5 years	One every two years
50 to 64 yrs	Booster immunizations every 10 years against • Tetanus • Diphtheria	• Papanicolaou smears and pelvic exams for females every 2 years • Mammograms for females every 2 years • Cholesterol every 5 years	One every two years
65 or older	• Booster immunizations every 10 years against tetanus and diptheria • Age-appropriate immunizations against invasive influenza and pneumococcal disease	• Papanicolaou smears and pelvic exams every 2 years for females who are at risk for cervical cancer • Mammograms for females every 2 years • Cholesterol every 5 years	One each year

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

3 points: 1. flexible benefit -- continuum of care
2. expands range of services covered

Inpatient hospital & residential services

Intensive nonresidential treatment (e.g. partial hospitalization, day treatment, behavioral aide)

Screening & assessment, diagnosis, medical management, crisis services, somatic treatment

Psychotherapy & collateral services

Outpatient substance abuse services including substance abuse counseling & relapse prevention

Case management

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES

- All day and visit limitations eliminated by 2001. Before January 1, 2001, day and visit limits apply to the following services:

  -- Inpatient hospital and residential services
  -- Intensive non-residential services
  -- Psychotherapy and collateral services
  -- Outpatient substance abuse services

- Screening & assessment, diagnosis, medical management, crisis services, somatic treatments covered with no visit limits

COST SHARING CHOICES

SERVICES	LOWER COST SHARING*	HIGHER COST SHARING
	ind / family	ind / family
Out-of-pocket max	$1,500 / $3,000	$1,500 / $3,000
Deductible	None	$200 / $400**
Preventive svcs (incl. prenatal care)	None	None
Inpatient hospital svcs, O/P diagnostic svcs, & ancillary svcs	None	20% co-ins
Most O/P svcs incl. vision & dental care	$10	20% co-ins
Prescription drugs	$5	20% co-ins

* POS option & reduced cost sharing for low-income

** No deductible for preventive services; $50 deductible for dental treatments; $250 deductible for outpatient prescription drugs

MENTAL ILLNESS & SUBSTANCE ABUSE SERVICES: COST SHARING

Most cost sharing comparable to other services

Prior to January 1, 2001:

One day deductible per admission for inpatient hospital, residential and intensive non-residential services

$25/50% cost sharing on psychotherapy

$25/50% cost sharing on additional 60 days of intensive non-residential services

Not all cost sharing applies to out-of-pocket maximums

BENEFIT EXCLUSIONS

***Any* service that is not medically necessary or appropriate**

Custodial care*

Cosmetic surgery except as defined in Act

Hearing aids

Eyeglasses & contact lenses for indiv 18 years or older

In vitro fertilization

Sex change surgery & related services

Private duty nursing

Personal comfort items*

Certain dental services, e.g. crowns, pin/post implants, denture fitting

* Except for hospice services

ROLE OF THE NATIONAL HEALTH BOARD

Write regulations and guidelines to assure uniformity of application of benefit package across all plans

Accelerate the benefit expansions planned in 2001 if the increase in expenditures will not cause any regional alliance to exceed its per capita target

Modify and update the clinical preventive services in consultation with experts in clinical preventive services

Establish standards regarding medical necessity

May not establish regulations restricting health plans from choosing providers and methods to deliver benefits

ADDITIONAL PROVISIONS

- No limitations in duration or scope or additional deductible, copayment, or coinsurance requirements except as described above
- Health plans may cover investigational treatments for certain life threatening conditions as defined by the National Health Board
- Overrides restrictive State practice laws
- Permits health professionals and health facilities to object to a particular service on moral or religious grounds

POINTS TO BE MADE DURING CONGRESSIONAL BRIEFING ON BENEFITS

SLIDE 2 - PRINCIPLES OF BENEFIT PACKAGE

- Comprehensiveness similar to most indemnity plans
- Prevention more fully covered than ever before:

  - only 36% of plans cover preventive benefits for children (BLS, 1994 projected);
  - only 30% cover routine adult physicals (BLS, 1994 projected);
  - even in HMO's which are required to cover preventive services, over 50% of enrollees are in plans which impose cost sharing (GHAA, 1993);

- No exclusions will finally bring into the health insurance mainstream individuals who have been increasingly excluded from coverage: persons with disabilities and chronic illness.

- Choice of cost sharing provides range of at least three plan types: HMO, PPO, and indemnity.

  - IOM study (national survey) in 1991 showed about 50% of those who had access to employer based health insurance **50%** had no choice of plans.

- No lifetime limits means unprecedented security for those with chronic conditions such as a family with a child with multiple problems.

SLIDE 4 - ITEMS AND SERVICES COVERED (2)

- Hospital services are covered whether inpatient, outpatient, or emergency. This includes hospitalization for medical detoxification and the management of medical conditions associated with withdrawal from alcohol or drugs. A hospital is defined as in the SSA: 1861(e) but also includes hospital facilities of the uniformed services, the Department of VA, and the Indian Health Service. Other hospital services for mental illness and substance abuse will be detailed later.

- Health professional services include those services that are lawfully provided by a physician. In addition, services of other health professionals are covered to the extent that the professional is legally authorized to provide such services in the State in which the services are provided and are those services that a physician is legally authorized to provide. This includes services provided in the office, home, and other ambulatory or institutional settings.

Also covered are services "incident" to a professional services. For example, if a physician carries out a diagnostic or other test, or administers a drug - e.g. an asthma treatment, then this is also covered.

- Emergency services are covered whether in a hospital, a free standing urgent care center or any other health facility that is legally authorized in that State to provide that service.

- Outpatient laboratory, radiology, & diagnostic services would include such items as radiation therapy for cancer, outpatient services such as MRI's, and hearing testing and laboratory testing in a hospital outpatient department.

SLIDE 5 - CLINICAL PREVENTIVE SERVICES

- By fully covering prevention with no copayment and no deductible, the benefit package removes an important financial barrier to individuals seeking the care they need.

- Coverage of prenatal care includes coverage for tests routinely done as part of care, e.g. blood test and urine tests.

- Since some services may be important more frequently or at different ages for certain risk groups, such as mammograms, the National Health Board is provided with this authority to define additional fully covered benefits.

SLIDE 7 - ITEMS & SERVICES COVERED (3)

- Family planning services coverage includes all FDA approved prescription contraceptives.

- Vision care includes routine eye examinations and the diagnosis and treatment of defects in vision. Eyeglasses and contact lenses are covered only for individuals less than 18 years and according to a periodicity established by the National Health Board.

- Health plans may cover health education classes. This includes education a;nd training classes to encourage healthy behaviors and risk reduction. Examples of these types of activities are smoking cessation, nutrition counseling, stress management, support groups - such as those for breast cancer survivors - and physical training classes.

SLIDE 8 - ITEMS & SERVICES COVERED (4)

- Hospice care coverage is similar to that under Medicare except that there is not the requirement to waive therapeutic benefits.

- Home health care, extended care services, and outpatient rehabilitation services are covered after illness or injury.

- Home health care coverage is similar to that under Medicare except that the Act specifies that home infusion therapy services are part of this coverage. The Act further specifies that home health care is covered only as an alternative to inpatient treatment in a hospital, SNF, or rehab facility and for a 60 day period. Continued coverage is dependent on a determination by the person providing the home health care that it continues to be necessary as an alternative to inpatient care. This determination must be made every 60 days.

- Extended care services coverage is also similar to Medicare when provided to an inpatient of a SNF or rehab facility and are after an illness or injury. These services are only covered as an alternative to inpatient treatment in a hospital and are subject to an aggregate annual limit of 100 days.

- The Act also defines rehabilitation facilities and skilled nursing facilities. These definitions are modeled to those in Medicare. [Medicare does not have a specific rehabilitation definition so adopted the CORF and SNF.]

- Outpatient rehabilitation services are defined as O/P occupational therapy, O/P physical therapy; O/P speech pathology services for the purposes of attaining or restoring speech. Coverage is limited to services after illness or injury and for a 60 day period. In addition, only those services used to restore function or minimize limitations are covered. Additional 60 day periods may be covered only if the person who is primarily responsible for providing the services determines that there has been improvement in functioning.

- Durable medical equipment coverage includes any item or service that improves functional ability or prevents further deterioration in function. It includes coverage for the accessories and supplies necessary for the function, repair, and maintenance of the equipment. For example, glucose strips used by diabetics with a home glucose monitor are covered. Prosthetic devices, except dental devices, are covered as are their accessories and supplies. In addition, artificial limbs and eyes and braces are covered, as well as all the fitting and training needed for all DME.

SLIDES 9 - 10 MENTAL ILLNESS & SUBSTANCE ABUSE

- These benefits are designed to offer a flexible continuum of care allowing plans to tailor treatment to individual's needs.

- They provide coverage for a wider range of services than typical insurance today and encourage the use of cost effective innovative alternatives to inpatient treatment such as partial hospitalization, day treatment, home based and behavioral aides, and case management.

SLIDE 11 - OUTPATIENT PRESCRIPTION DRUGS & BIOLOGICALS

- Similar coverage to that in the new Medicare benefit. Language related to unapproved uses of approved drugs (i.e. off label use) is based on the language of the OBRA 1993 Medicare amendments.

SLIDE 12 - DENTAL SERVICES

- This coverage emphasizes prevention and early intervention by covering fluoride applications and dental sealants for children. Coverage based on oral health package developed by Public Health Service Chief Dental Officer's Office.

SLIDE 13 - INVESTIGATIONAL TREATMENTS

- Approved research trials include any approved by the Secretaries of HHS, VA, or Defense, the NIH Director, the FDA Commissioner, or a qualified nongovernmental research entity as defined by NIH guidelines. Also included in the definition is any peer reviewed and approved research program as defined by the HHS Secretary.

- The coverage of routine care during approved research trials includes any item or service that would have been provided even if they were not enrolled in a trial.

- Health plans may cover the costs of the investigational treatment itself. The National Health Board is charged with defining life threatening diseases or disorders or other health conditions that would be included.

SLIDE 14 - COST SHARING CHOICES

SELF EXPLANATORY WITH ATTACHMENT FROM SECTION BY SECTION.

SLIDE 15 - MENTAL ILLNESS AND SUBSTANCE ABUSE COST SHARING

Sharman - any thing else you want to add here?

SLIDES 16 & 17

SELF EXPLANATORY