HEALTH SECURITY ACT

QUESTIONS AND ANSWERS

JANUARY 6, 1994

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January 6, 1994

TITLE I

HEALTH CARE SECURITY

RATIONALE FOR ASSISTING UNDOCUMENTED PERSONS

QUESTION:

Undocumented persons are by definition residing in the United States illegally. The Health Security Act exempts them from alliance coverage yet provides assistance for them in other ways. In this era of high health care costs and huge budget deficits, why should we spend any money providing health care to this population?

ANSWER:

- Individuals residing in this country, whether legally or not, will at some time incur health care costs. If no Federal support is provided to offset these costs, hospitals and States will end up the losers.

- The Medicaid program currently pays for emergency services for undocumented individuals, allowing Federal and State governments to share the responsibility for caring for this population. The Health Security Act will continue this policy in a reformed world to ensure that hospitals do not face continued uncompensated costs.

TREATMENT OF UNDOCUMENTED ALIENS

QUESTION:

How will undocumented aliens be treated under the plan? How will providers who treat them be paid? Isn't there a danger that citizens with foreign accents and others who might be mistaken for undocumented persons will be discriminated against?

ANSWER:

In large part, the current structure in place for treating undocumented aliens will remain.

- The Health Security Act does nothing to alter current legal requirements that health care providers must treat anyone coming to them for emergency care.

- Medicaid will continue to compensate providers for emergency care for undocumented people.

- Community and migrant health centers will continue to provide primary care for uncovered people.

- The Act creates a new Vulnerable Populations Fund which will provide additional compensation for hospitals that provide a large proportion of services to underserved people, including undocumented persons. A portion of this fund will be targeted to States with large numbers of undocumented people.

The Health Security Act will enroll all Americans and legal residents and provide them with a Health Security Card. The card will entitle them to services under the comprehensive benefit package, and it will help to overcome current discriminatory practices against the uninsured. The Act specifically prohibits discrimination against any population group at the provider, plan, alliance or State level.

IS SUPPORT FOR UNDOCUMENTED PERSONS ADEQUATE

QUESTION:

The Health Security Act would continue Medicaid coverage for emergency services for undocumented persons, plus provide for hospital payment adjustments to cover services to undocumented aliens. Will these programs be enough to offset hospitals' costs of serving this otherwise uncovered population?

ANSWER:

- Hospitals uncompensated care burden should be largely reduced under the Health Security Act as formerly uninsured individuals gain access to alliance coverage. Consequently, large payment adjustments will no longer be necessary to protect the viability of hospitals serving vulnerable populations.

- We believe that the combination of the Medicaid payments for emergency services for emergency services, the new Federal Vulnerable Population Adjustment program, and the reduction in hospitals' overall uncompensated care burden should be sufficient to offset the costs of providing inpatient services to undocumented individuals.

COVERAGE OF EMPLOYED UNDOCUMENTED WORKERS

QUESTION:

What happens to undocumented persons who are employed? Will the employer be required to pay their premiums?

ANSWER:

- It is illegal to employ undocumented workers.
- Undocumented workers are not entitled to health security cards. They will be able to seek care for emergency acute care needs through hospital emergency rooms, public health clinics, and community health centers.
- The Health Security Act establishes a Vulnerable Population Fund through which hospitals which treat undocumented persons will be compensated.
- Employers are required to pay the employer share of the premium for all workers. Employer payment records for health care will <u>not</u> be made available to the Immigration and Naturalization Service.

AIDS

QUESTION:

How will the President's plan affect people with AIDS?

ANSWER:

The Health Security Plan does several very important things for people with AIDS.

First, it guarantees coverage and prohibits exclusion on the basis of a pre-existing medical condition.

Second, it mandates community rating that will spread the cost of chronic diseases like AIDS among a broad spectrum of society.

Third, it offers coverage of outpatient prescription drugs, perhaps one of the biggest medical expenses of people with AIDS.

And fourth, it limits annual out-of-pocket medical expenses and does away with lifetime limits.

WHY NOT SINGLE-PAYER?

QUESTION:

Why won't you support a single-payer system? CBO says it would save billions and cover everyone.

ANSWER:

We looked carefully at the single-payer model and while it certainly has some very attractive elements -- like universal coverage -- we felt it was not a viable option for national reform.. We do not believe in a top-down government-run health care system. We prefer to allow the market to operate under a rational system of universal coverage and cost containment.

However, we do allow states to institute single-payer if their residents and elected officials decide that it is the best model for them.. There are very few restraints on such action other than making sure that all people in the state are covered and that they get the comprehensive package of benefits that is available to every legal resident.

COST CONTROLS FOR DRUG BENEFIT?

QUESTION:

The outpatient prescription drug benefits seems rather generous and seems prime to lend itself to increasing costs. Will there be any cost controls or other restrictions such as formularies on prescription drugs to prevent this from happening?

ANSWER:

- First, it is important to distinguish the two drug benefits in the Health Security Act as their cost control approaches differ.

- Individual health plans will have great flexibility in how they manage the financial aspects of the drug benefit under the comprehensive benefit package:

  -- Plans will be permitted to establish cost containment programs, many of which are currently utilized by private health plans, to allow them to competitively manage the delivery of the drug benefit.

  -- Cost-containment programs could include managed care drug formularies; incentives for using cost-effective generic products whenever available; and drug utilization review to ensure that drug products are being prescribed appropriately and taken properly.

- For the Medicare drug benefit, the Secretary is provided with cost control authority and may choose not to cover new drugs for which the rebate level cannot be agreed upon with the manufacturer.

IMPACT OF DRUG COST CONTAINMENT ON RESEARCH & DEVELOPMENT

QUESTION:

Won't the prescription drug cost containment mechanisms stifle research and development?

ANSWER:

It's important to note that the Health Security Act significantly expands coverage of outpatient prescription drugs both in private health plans and in the Medicare program. As a result, the market for these products is expected to grow by as much as 15 percent. So, there will be more money, not less, available for research and development.

Second, despite what the pharmaceutical industry might claim, there are no cost limits on prescription drugs imposed by the government through private health plans. Such plans will continue to use the same kind of negotiating strategies that they use today to set their reimbursement rates for drugs.

The Secretary's Breakthrough Drug Committee does have the authority to look at the prices (for informational purposes only) on new breakthrough drugs, but the Secretary cannot regulate those prices. We believe this is a very moderate position considering the fact that many in Congress would like to see these prices regulated.

Finally, the new Medicare drug benefit will include a federal discount on drug prices. This is quite similar to the pricing structure already used under Medicaid and simply puts the government on the same footing as private plans.

BENEFITS -- ABORTION COVERED

QUESTION:

Will abortion services be covered under the plan?

ANSWER:

- The guaranteed benefits include all pregnancy-related services that are medically necessary or appropriate.

- Women, with their providers, will decide the question of necessity and appropriateness, as is the current practice under private health plans.

- We believe that this approach is most consistent with current insurance practices and will maintain existing coverage and access to services for women.

- The benefits of the health security plan are modeled on the comprehensive insurance packages typically offered by Fortune 500 companies. Corporate health plans usually cover abortion, as other family planning and pregnancy-related services, when the provider and patient believe it to be appropriate.

- Policy under the Health Security Act is consistent with existing Federal and state law.

- A conscience clause will permit providers to refuse to perform abortion services on the basis of a religious belief or moral conviction.

ARE DIETARY SUPPLEMENTS COVERED?

QUESTION:

Won't health reform limit my access to dietary supplements?

ANSWER:

Dietary supplements are over-the-counter products and therefore are not covered by most private insurance plans. The Health Security Act would do nothing to change the status quo.

The Food and Drug Administration has issued regulations that would govern the labeling of these products. We do not think that manufacturers should be allowed to make unsubstantiated claims about the health effects of their products. But no one in my Department is considering any action that would remove a product from the shelf unless it poses a direct threat to a person's health.

EMPLOYER WELLNESS PROGRAMS

QUESTION:

Will the Health Security Act cover employer wellness programs? If not, won't it discourage employers from continuing to offer this?
If employers are not managing their own health plans and just writing checks to alliances, won't they be discouraged from investing in their employees health?

ANSWER:

Employers will have the same incentives to offer the wellness programs that they have today -- greater productivity through a healthier workforce. These incentives included reduced sick leave, disability days, work related stress, and workers' compensation costs.

HOME HEALTH CARE BENEFIT UNFAIR TO SPECIAL NEEDS KIDS

QUESTION:

The home health care benefit is limited to services after illness or injury. What happens to children with special needs such as those born with birth defects or who have a chronic illness? Also since Medicaid spenddown is being eliminated where will they go for treatment?

ANSWER:

- o First, and most importantly, the President has proposed a comprehensive acute care benefit package that outlaws pre-existing condition exclusions and will guarantee all children access to a full range of acute care medical services, regardless of their medical condition.

- o Any child born with a birth defect that requires surgery or any other acute care professional services, will be fully covered for those services.

- o The Health Security Act is designed to address **acute** illnesses, not chronic care for the chronically ill.

  - -- Only three benefits are limited to treatment following an "illness or injury": outpatient rehabilitation services, extended care services, and home health care.

  - -- The current insurance market uses at least 3 options to structure these services to meet **acute** needs:

    - using illness or injury to define when these services are covered;
    - imposing annual day/visit limits on the services;
    - imposing strict reassessment criteria.

- o The Act never intended to exclude a particular diagnosis from coverage for any benefit. If the term "illness and injury" appears to have this effect, we are eager to work with Congress to assure that this benefit serves the **acute** care needs of all children.

- o Finally, we know that this acute care benefit will not meet all of the long-term support needs for some children. Therefore, two additional programs have been proposed:

  - -- a new federal program of wrap around services for poor children;
  - -- a major new expansion in community-based long-term care.

BENEFITS -- MAMMOGRAPHY SCREENING

QUESTION:

What is the coverage for mammography screening under the plan? How did you arrive at this decision and can you assure the women of this country that the proposed coverage is adequate?

ANSWER:

- First, let me emphasize that screening mammograms are just one of the tools that we have to address breast cancer and the Health Security Act provides a comprehensive strategy:

- Women must first be provided the information they need to reduce their risks and participate in disease prevention. They must also have regular access to a health care provider. That health care provider must be well trained so that they can elicit a risk history and do appropriate examinations. And finally, mammograms should be used when they are appropriate and effective at reducing mortality from breast cancer.

- Therefore, the Health Security Act covers screening mammograms whenever they are medically necessary or appropriate subject to the cost sharing in each plan.

- In addition, to provide additional incentives, the plan covers mammography screening **with no cost sharing** for two populations:

  -- For women age fifty and over every two years; and

  -- For women of any age who are classified by the National Health Board as "high risk" of breast cancer, at either earlier or more frequent intervals.

- The clinical preventive services benefits, including mammography, are based on the recommendations of the U.S. Preventive Services Task Force and is consistent with the recommendations of the American College of Physicians. Both of these organizations base their recommendations on the best scientific evidence available.

- This scientific evidence was also recently reviewed by the National Cancer Institute and confirms that screening mammography is effective at reducing mortality for women over 50. However, screening mammography does not significantly reduce mortality for women ages 40-49.

BENEFITS -- MENTAL ILLNESS AND SUBSTANCE ABUSE

QUESTION:

The Mental Illness and Substance Abuse benefits package seems to have been reduced since earlier Fall versions of the plan? Can you explain what the package is now and why it was reduced?

ANSWER:

- The goals and policy intent of the benefits package have been clear since the beginning and they have not changed. They are:
  - -- immediately eliminating some of the most discriminatory practices within the current insurance system, including pre-existing conditions and lifetime limits;
  - -- providing mental illness and substance abuse coverage for all Americans in the near term;
  - -- offering a flexible continuum of care with a broader range of services than in typical insurance today, allowing health plans to tailor treatment programs to an individual's special needs; and
  - -- ultimately integrating mental illness and substance abuse services without limitations as an essential component of all health coverage.
- As in other aspects of the plan, clarifications, changes and corrections have been made. We wanted to make absolutely sure that the final bill language was clear and consistent with our policy goals. In addition actuarial review of the benefit was continuing and some changes were made in response to the actuarial findings. The most important clarifications were in the coverage of inpatient care and the flexibility provided through the inpatient/outpatient trade-off options:
  - -- Coverage for inpatient and residential treatment for mental illness includes a 30 day maximum with 30 additional days available under certain conditions if deemed necessary by the health plan. Outpatient psychotherapy beyond the 30 visits is available at the discretion of the health plan by exchanging inpatient days on a 1 to 4 basis.
  - -- Coverage for diagnosis, medication management, crisis services, and somatic treatment services is comparable to that of other health services.

MENTAL ILLNESS AND SUBSTANCE ABUSE

QUESTION:

Why are the mental illness and substance abuse benefit combined? Given the limitations in the benefit how will the needs of hard core drug abusers be met? Given inadequate treatment capacity, why are you planning offsets in the MH/SA block grants? How will integration of private and public systems be achieved?

ANSWER:

- The benefit is combined because:
  - -- Some combination of mental illness and substance abuse coverage helps to prevent "gaming" by shifting diagnoses;
  - -- Where appropriate coverage for substance abuse treatment services is differentiated. For example, outpatient substance abuse counseling and relapse prevention has different coverage and cost-sharing than psychotherapy; and
  - -- Mental illness and substance abuse are combined until January 1, 2001, when the elimination of limits and specific cost sharing effectively make the coverage separate.
- The substance abuse portion of the benefit is intended to meet the basic treatment needs of hard core drugs users as a complement to other programs such as those listed below. For example, while the initial benefit continues to use day and visit limits for some services, other services important in the management of hard core substance abuse have no limits --such as medical management (e.g., methadone administration) and case management.
- Treatment capacity will be supported through:
  - -- Continuation of the block grants and a new program of grants and loans to upgrade existing primary health and substance abuse facilities.
  - -- As health care reform is implemented service providers will begin to receive payment for covered services through health insurance. The block grant funds will continue to assist States in paying for services for vulnerable populations that are beyond the scope of the guaranteed benefit package.
  - -- Offsets will be made when appropriate to assure that

Federal block grant resources are used to complement the health care benefit not duplicate the services it provides.

- Integration of public and private systems will be achieved by requiring each State to submit a plan for integration by October 1, 1998. In addition, to facilitate the process, a pilot program is established to demonstrate model methods which States could use.

MENTAL HEALTH & SUBSTANCE ABUSE BLOCK GRANTS

QUESTION:

How will health care reform affect the Substance Abuse Treatment and Prevention and the Community Mental Health Services block grants? Will there be offsets to the mental health and substance abuse block grants?

ANSWER:

The Health Security Act will give all Americans access to coverage for mental illness and substance abuse treatment - many for the first time - as an integral part of a comprehensive health benefit package.

- The block grants will continue. They will provide support to States for mental illness and substance abuse treatment services that fall outside of the covered basic benefit, including "enabling services" such as transportation, language and translation services, and outreach.

- Set-asides in both block grants for administrative costs and technical assistance will continue, as will set-asides for prevention in the Substance Abuse block grant.

As the Act covers an increasing amount of the mental health and substance abuse services currently funded under the block grants for the uninsured, providers will see new sources of revenue. As a result, service providers should see the same or more total funding but from different, often non-governmental sources.

- Services covered by the comprehensive benefit package will be paid for by health insurance, while those not covered will continue to be funded by States using block grant and other funds.

- The services now provided by the block grant funds will continue to be covered, but the amount required from governmental sources is expected to be less.

- Health plans will move to a flexible "managed benefit approach" to treating individuals with mental illness and substance abuse disorders, which relies on having available an array of services.

- The Act contains a number of incentives for States to integrate current public sector treatment systems into private health plans:

  -- States will be required to submit a plan for the

integration of public and private mental health/substance abuse services to the Secretary by October 1, 1998.

-- The Secretary will establish a pilot program to demonstrate models for integrating MH/SA services covered by the benefit package.

STATE FLEXIBILITY

QUESTION:

How much flexibility will States have to develop their own systems for providing health care to their residents? Do they have to institute an employer mandate?

ANSWER:

- Within the framework set forth in the Health Security Act, States will have considerable flexibility to design a health care system to meet the unique needs of their population.

- All States will retain the authority to shape the delivery system by determining alliance boundaries, certifying plans, and licensing providers.

- States may opt for a single payer system, either State-wide or within the boundaries of a single regional alliance. If a State chooses this option, it may finance the system through means other than as employer mandates, but it must include a payroll-based component in which employers pay no less than those in other states.

- States will have the ability to enforce cost containment by having a rate-setting authority for all providers.

- States may establish statewide or alliance-wide fee schedules for fee-for-service providers.

CORPORATE ALLIANCES IN SINGLE PAYER STATES

QUESTION:

You give large companies the power to set up their own alliances, but in single-payer states those workers are pulled into the state system. Why?

ANSWER:

- The Health Security Act allows states whose citizens want a single payer system the flexibility to provide that system.

- A firm must have a minimum of 5,000 employees nationally in order to form a Corporate Alliance. If a state chooses a single-payer approach, it has the right to integrate all corporate employees in the state into the single payer system. Those employees of the corporation residing in the state will be in the state system, but they will still count towards the 5,000 total that will enable the company to form a corporate alliance serving its employees in the rest of the country.

- If a state chooses not to form a single payer system statewide but only in selected alliance areas, employees of corporate alliances within that state remain with the corporate alliance no matter which part of the state they work or reside in.

ALLIANCE BIDDING PROCESS - EXPLAIN

QUESTION:

During the first year of implementation could you please explain how the alliance bidding process for health plans works? How long does the process take and what happens if all of the plans bid over the average weighted premium amount?

ANSWER:

1. How does the process work?

- On or before July 1 in the first year of implementation, health plans must submit premium bids for the following year with their respective alliances.

- Before or during the bidding process the health plan may or may not be informed of the alliance premium target (depending on whether or not the alliance chooses to disclose this information).

- After the initial bidding process, each state can provide for negotiations with health plans related to the premiums charged by such plans. As a result, the health plan could resubmit their bid, but the new bid cannot exceed the old one.

- In the first year, the final bid submitted by a plan is the final accepted bid.

2. How long does the process take?

- There are two specific time periods for complying plans in the first year: September 1 and October 1. If the plan is in compliance, the bidding ends with the October 1 date.

- By September 1 of the first year for which bids are obtained, each alliance must submit a report to the National Health Board. This report will contain information on plan bids and, for the first year only, any information the Board requests about enrollment in a plan or alliance.

- By October 1 of the first year for which bids are obtained, the Board must notify each alliance if the weighted average accepted bid for the alliance is greater than its per capita premium target and its reduced weighted average accepted bid.

- Plans not in compliance are also subject to the September 1 and October 1 dates above. In addition, a noncomplying plan is subject to a additional process time if it wishes to

voluntarily reduce its accepted bid in order to avoid premium reductions provided by the Board (on October 1). The time limit for voluntary reductions will be stipulated by the National Health Board.

3. What happens if all of the plans bid over the weighted average premium amount?

- The process for plan reductions to maintain expenditure targets would be the same if one or all plans within an alliance bid over the weighted average premium.

- First, all plans would be asked to re-bid to see if the Alliance's average weighted premium amount is achieved.

- If that doesn't work, an assessment would be imposed on each and every plan.

- Revenues from these assessments would be used to reduce the required employer premium contributions and to keep the Alliance within budget.

ALLIANCES
IMPACT ON DC AND OTHER MSAs CROSSING STATE LINES

QUESTION:

Alliances are not supposed to subdivide Metropolitan Statistical Areas (MSA) -- presumably to broaden risk pools and keep suburbs and inner cities together. Yet, as a separate alliance, the District of Columbia, by definition, would be cut off from its suburbs. What will be the impact on the District of Columbia? Will other MSAs which are divided by state lines (e.g. Kansas City, St. Louis, etc.) be in a similar situation?

ANSWER:

The District of Columbia has an adequate population to sustain an alliance without the adjoining suburbs in Maryland and Virginia. However, because it is an entirely urban community, premiums for health plans in the district could be somewhat higher than those in surrounding communities. Other predominantly urban alliances may face similar premium differences with surrounding, more rural alliances.

Due to its number of unemployed and poor families, District families and business will receive substantial Federal subsidy assistance. Furthermore, some of the burden of supporting academic health centers will be removed from local residents and replaced with direct federal subsidies. The District, which has a number of such centers, should substantially benefit from this change. In addition, the tertiary care facilities and academic health centers which are based in the District will be contracting with Maryland and Virginia health plans to provide services to their members. There will continue to be a high level of linkage in health care service delivery across health care boundaries.

WHY ARE ALLIANCES NECESSARY?

QUESTION:

The way alliances are established in the Health Security Act it seems to be just adding another layer of bureaucracy. Why are they really necessary?

ANSWER:

Today, we do not have true competition between, or choice among, health plans. Plans compete to enroll the healthiest individuals, not to provide the best care most efficiently. Alliances remedy this situation by changing the conditions that today preclude true competition and choice.

Maximum Choice

- Our alliance structure allows consumers to choose from all health plans in their area. The consumer, not the employer, makes the choice and there is no disruption when consumers change jobs or other circumstances.

- Our alliance structure eliminates insurance company choice, such as the "choice" not to serve high-risk persons -- they increase consumer choice.

- The alliance collects health plan information and makes that information available in a standard, comparative format to further facilitate consumer choice.

Market Fragmentation

- If there are multiple alliances, or an insurance market outside the alliance system entirely (as with voluntary alliances), insurers can continue to use risk selection tactics and providers can continue to cost shift.

- An alliance creates the community risk pool that real insurance is designed to secure, so premiums can be community rated.

- Small, multiple alliance would dilute the market clout that small employers and individuals wield through the single alliance.

Ease of Administration

- To protect consumers in a world of multiple or voluntary alliances would require an enormous regulatory apparatus. Because alliances collect, pool, and pay premium dollars, it is the simplest way to administer discounts for low-income consumers and small business, to provide premium equity for two-worker families, and to administer budget targets.

Cost containment

- The alliance creates the forum in which consumer choose among competing health plans, so that competition, not direct regulation, can be used to bring down costs. Without a large mandatory pool we will not have the competitive marketplace that will bring down costs.

Accountability

Consumers will have a variety of means of influencing alliance action and seeking change, including:

- Local consumers will sit on the boards of alliances, whether those alliances are non-profit corporations or independent or state executive branch agencies. Half of each alliance board must consist of consumer representatives. Providers are excluded from board participation.

- Alliances will be required to maintain an ombudsman for the specific purpose of providing a channel for criticism and feedback from consumers, employers, providers, and other interested parties. The ombudsman requirement is additional to each plan's grievance resolution procedures.

Consumers need choice of provider and choice of health plan -- the Health Security Act provides both. Health plans serving more than one region can contract with multiple alliances, and can contract with providers in any area. Alliances must accept any health plan whose premium is not more than 120 percent of the budget target premium and which otherwise meets Federal and State requirements. In this way, a single alliance within a geographic area will assure maximum competition among health plans.

WHY NOT VOLUNTARY ALLIANCES?

QUESTION:

Why are you requiring everyone to go through an alliance?

ANSWER:

- The only way to assure universal coverage is to require that everyone obtain coverage, and our plan does that.

- Insurers will be required to go through alliances if they wish to sell comprehensive benefit package coverage to covered people. Alliances are important in providing access to insurers because:

  -- alliances will provide a rational marketplace for people to obtain health insurance.

  -- alliances will help prevent insurance companies from engaging in current abusive business practices.

  -- alliances provide a way to have insurers competing in the same market.

WHY NOT COMPETING ALLIANCES?

QUESTION:

What is wrong with allowing for competition among alliances instead of having a single bureaucratic entity?

ANSWER:

Alliances are consumer-pooling, premium administration, and information spreading-entities. Competition among them would decrease their effectiveness and efficiency, and would add complexity, administrative costs, and confusion to the system -- without securing any competitive or other advantage.

Multiple alliances would:

- o increase the administrative costs of the system;
- o decrease the membership of each, thus reducing their ability to negotiate effectively with health plans;
- o make establishing uniform weighted average premiums across alliances a highly regulatory, difficult to administer, and overly complex process;
- o make it difficult to calculate appropriate premium targets for each of the competing alliances (especially if risk segmentation across alliances occurred).

A single alliance within an area:

- o assures maximum competition among health plans;
- o avoids risk segmentation among the alliances in an area;
- o stabilizes and allows capping employer contributions;
- o avoids duplicative paperwork from plans offering themselves through multiple alliances in a single area;
- o avoids the risk that the same plan will cost enrollees different amounts solely because the plan comes to them through different alliances;
- o avoids the risk that providers will receive different payments from the same plan for the same services simply because the patients come through different alliances.

Competition. Consumers need choice of providers and health plans -- the Health Security Act provides both. Health Plans serving more than one region can contract with multiple alliances, and

can contract with providers in any area. Alliances must accept any health plan whose premium is not more than 120 percent above the budget target premium and which otherwise meets Federal and State requirements.

Safeguards. States have great flexibility to determine number and boundaries of alliances. Nonetheless, the Health Security Act includes protections with respect to alliance boundaries: the geographic area assigned to each alliance must encompass a population large enough to provide adequate market share for effective negotiation with health plans; states may not establish alliance boundaries that concentrate racial or ethnic minority groups, socio-economic groups or Medicaid beneficiaries; a State may not subdivide a primary metropolitan statistical area.

ALLIANCE FEE SCHEDULES - MORE FEDERAL REGULATION?

QUESTION:

It is my understanding that each alliance will establish a rate schedule for providers. Isn't this just another federal regulatory nightmare? How is this different from single payer rate-setting?

ANSWER:

It is critical that individuals have the opportunity to choose their provider and to receive out-of-plan services if they wish. To enable this to occur, we need a predictable payment system in which families pay based on predetermined coinsurance schedules (so they are not subject to unknown and unlimited costs) and providers also know what they can expect to receive (so they can negotiate fees accordingly). To make the point-of-service option viable, a fee schedule is required in each Alliance area.

In addition, we are changing the rules under which fee-for-service operates: the budget caps will require that fee-for-service plans live within a premium cap for each enrollee. A fee schedule is required to enable fee-for-service plans to proportionately lower the rates they pay if the budget enforcement system lowers the premiums they are paid.

The Act requires that the fee schedules be negotiated in each Alliance area to give providers a role in determining what they will be paid. Since the fee schedule is negotiated, it is not government regulation. In single-payer systems, the government sets the payment rates.

PROTECTIONS AGAINST REDLINING

QUESTION:

Won't health plans locate in areas to attract only healthy enrollees?

ANSWER:

To prevent such selectivity, the Health Security Act imposes a variety of obligations and constraints on health plans, alliances, and states.

1. Health Plans

   o Health plans are prohibited from engaging in any activity -- including selection of service area -- which has the effect of discriminating.

   o Health plans must distribute their marketing materials to their entire service area; marketing material must be approved by the regional alliance.

   o In selecting providers, health plans are prohibited from discriminating based on the provider's racial or socio-economic characteristics or the characteristics of the provider's patients.

2. Alliances

   o An alliance area may not split a metropolitan statistical area. The Health Security Act prevents states from isolating poor or racially distinct areas for purposes of setting community rates.

   o Regional alliances are obligated to make certified health plans available to all legal residents in their areas, and have the authority to adjust payments to health plans (or use other financial incentives) to encourage health plans to expand into underserved areas.

3. States: To assure access to plans at the weighted average premium, states can require health plans to serve particular areas.

ENFORCEMENT OF PREMIUM TARGETS IN CORPORATE ALLIANCES

QUESTION:

Corporate alliances will be given the flexibility to control the rate of growth on their insurance premiums using the same methods as health alliances. Will they be subject to the same enforcement measures as regional alliances?

ANSWER:

The enforcement of premium targets for corporate alliances is somewhat different than it is for regional alliances. If a corporate alliance exceeds its premium cap in two of any three years, it is required to disband as a corporate alliance and join the system of regional alliances.

WILL HEALTH PLANS CONTRACT WITH ALL "WILLING PROVIDERS"

QUESTION:

Since competing health plans will be permitted to establish limited panel plans, won't some providers be shut out?

ANSWER:

Every corporate and regional alliance will be required to contract with at least one fee-for-service health plan. This means that every community will have health plans in which any willing provider may participate. As they do now, managed care plans will have the option to limit the number and type of providers in the plan. However, network-based plans will also be required to offer a "point of service" option which allows enrollees to chose a provider outside the plan.

Providers are free to -- and will be encouraged to -- set up their own plans to offer efficient, high quality care in their communities.

Under the HSA, Plans are free to use any mix of providers to meet the needs of their enrollees. Improved competition among health plans will create new incentives for effective use of primary care providers. This, in turn, will create incentives for use of alternative practitioners whose services have proven to be cost effective, such as chiropractors.

NATIONAL HEALTH BOARD: A WHOLE NEW BUREAUCRACY?

QUESTION:

Isn't your plan just creating a whole new bureaucracy? Why do we need a National Board? Couldn't HHS perform the same functions without creating a whole new bureaucracy?

ANSWER:

- The Health Security Act does a tremendous amount to eliminate public and private bureaucracy by streamlining the administrative end of the health care system and removing barriers which inhibit providers from offering quality care.

- The National Health Board will be a policy-making body composed of seven members, who will be nominated by the President and confirmed by the Senate. The NHB is expected to have a staff of about 100 people.

- It is important that national health policy be guided by an expert panel. Board members will be selected based upon their expertise and national reputation in a variety of areas: health services delivery, intergovernmental relations, economics, employers, consumers, health law, etc. (Note: In contrast, other proposals require the Board to be elected.)

- The National Board will represent the <u>public</u> interest at the federal level. The board has a variety of functions, including interpreting the benefit package, determining the alliance premium caps and enforcing them, overseeing state implementation of the new system including the quality and data components.

- HHS will have significant administrative and operational tasks related to the reformed system. HHS will continue to operate existing programs, such as Medicare and Public Health Service programs. We expect that the tasks of auditing alliances, data systems development, data collection, research and evaluation will continue to be performed in existing Cabinet Departments.

CLARIFYING NATIONAL BOARD QUESTION ON HHS RESPONSIBILITIES

HHS is given a broad set of responsibilities under the Health Security Act.

--HHS is responsible for administering its new responsibilities under Medicare and Medicaid and the PHS titles of the Act.

--HHS is responsible for developing and administering the new Long Term Care program and the new Medicare drug benefit program.

--HHS is responsible for assuring that Alliances determine individual subsidies correctly and for auditing regional Alliance financial functions.

--HHS, on determination by the National Health Board that a state is out of compliance with the Act, establishes and administers health Alliances within states.

--HHS also supports the board in its broad responsibilities for developing the benefit package, developing and enforcing budgets, and developing quality and data reporting systems.

--HHS also has detailed responsibilities for enforcing the fraud and abuse sections of the statute and for establishing a high-risk insurance pool for individuals whose health plans leave the market during the transition to Alliances.

--HHS must conduct specified research, create specific advisory committees, and conduct specified demonstrations such as the joint demonstration with the Department of Labor of alternative methods for integrating Workers Compensation programs into the Alliance structure.

TITLE II

NEW BENEFITS

COST CONTROLS FOR DRUG BENEFIT?

QUESTION:

The outpatient prescription drug benefits seems rather generous and seems prime to lend itself to increasing costs. Will there be any cost controls or other restrictions such as formularies on prescription drugs to prevent this from happening?

ANSWER:

- First, it is important to distinguish the two drug benefits in the Health Security Act as their cost control approaches differ.

- Individual health plans will have great flexibility in how they manage the financial aspects of the drug benefit under the comprehensive benefit package:

  -- Plans will be permitted to establish cost containment programs, many of which are currently utilized by private health plans, to allow them to competitively manage the delivery of the drug benefit.

  -- Cost-containment programs could include managed care drug formularies; incentives for using cost-effective generic products whenever available; and drug utilization review to ensure that drug products are being prescribed appropriately and taken properly.

- For the Medicare drug benefit, the Secretary is provided with cost control authority and may choose not to cover new drugs for which the rebate level cannot be agreed upon with the manufacturer.

IMPACT OF DRUG COST CONTAINMENT ON RESEARCH & DEVELOPMENT

QUESTION:

Won't the prescription drug cost containment mechanisms stifle research and development?

ANSWER:

It is important to note that the Health Security Act significantly expands coverage of outpatient prescription drugs both in private health plans and in the Medicare program. As a result, the market for these products is expected to grow by as much as 15 percent. So, there will be more money, not less, available for research and development.

Second, despite what the pharmaceutical industry might claim, there are no cost limits on prescription drugs imposed by the government through private health plans. Such plans will continue to use the same kind of negotiating strategies that they use today to set their reimbursement rates for drugs.

The Secretary's Breakthrough Drug Committee does have the authority to look at the prices (for informational purposes only) on new breakthrough drugs, but the Secretary cannot regulate those prices. We believe this is a very moderate position considering the fact that many in Congress would like to see these prices regulated.

Finally, the new Medicare drug benefit will include a federal discount on drug prices. This is quite similar to the pricing structure already used under Medicaid and simply puts the government on the same footing as private plans.

SINGLE-SOURCE DRUGS SUPPLIERS AND SMALL PHARMACIES

QUESTION:

Health plans are guaranteed the ability to use single-source suppliers for pharmaceuticals. What does this mean for small pharmacies? Will they no longer be able to compete for the discounts?

ANSWER:

- Under the Health Security Act, small pharmacies may get, for the first time, access to discounts that others receive today.

- The Health Security Act requires manufacturers wanting to do business with the Medicare program to offer discounts to all pharmacies on a nondiscriminatory basis.

- This "equal access to discounts" provision assures that all pharmacies, regardless of size, purchasing similar quantities of drugs on substantially the same terms such as cash payment, volume purchase, single-site delivery etc. may receive the same discount.

- Because small pharmacies will have better access to discounts offered by manufacturers, their ability to offer competitive prices may be enhanced. Therefore, because of the wide geographic distribution of smaller pharmacies, health plans may be more inclined to use small pharmacies in their networks.

IMPACT OF NEGOTIATING NEW DRUG PRICES ON NEW DRUG DEVELOPMENT

QUESTION:

Doesn't the Secretary's negotiation authority permit her to exclude drugs, and won't that have a chilling effect on new drug development?

ANSWER:

- Since Medicare has not established a formulary, the program needs some mechanism to control the cost of new drugs.

- Drug manufacturers have traditionally charged whatever the market will bear for new drugs. These prices may be extremely high because other manufacturers are prohibited from copying patented drugs, and alternative drug therapies may be ineffective or even more expensive.

- There is no particular formula for calculating rebates for new drugs. Instead, the Secretary will negotiate special rebates for new drugs with manufacturers.

- The provisions of the drug benefit do not allow the Secretary to automatically or imprudently exclude any new, expensive drug from coverage under Medicare.

- The Secretary will consider a number of factors when determining the special rebate for a new drug including -- the prices of other drugs in the same therapeutic class, cost information supplied by the manufacturer and prices of the drug in other industrialized countries.

- Manufactures will have up to six months to negotiate a special rebate with the Secretary. If an agreement cannot be reached, the Secretary may decide to exclude coverage of the new drug.

- The reason the Secretary has the authority to exclude new drugs from Medicare is to have a fall-back negotiating mechanism in case the Medicare trust fund and the taxpayers who support it become at risk because a few drug companies price their products at unreasonably high levels. However, we hope and expect that the industry is now much more sensitive to launch prices.

- Allowing the Secretary to negotiate special pricing provisions with manufacturers is not a new, radical concept. The Congress just gave the Secretary the same authority to do just that with drug products used for immunizations.

- Lastly, other countries negotiate new drug prices with

manufacturers under a scheme similar to that proposed in the Health Security Act.

"BLACKLISTING" DRUGS FOR COVERAGE

QUESTION:

Doesn't the Secretary have the authority to blacklist drugs? Won't this harm patients?

ANSWER:

The Secretary will want to make effective breakthrough drugs available to everyone.

Health Plans negotiate prices with drug companies. The Secretary is not involved in drug pricing for anyone in the alliance system. Thus, for everyone under 65 and for Medicare beneficiaries enrolled in alliances, there can be no "blacklisting" by the Secretary.

For those over 65 who remain in Medicare, there is no mechanism to maintain competitive pricing (i.e., these prices will not be part of Health Plan negotiations). Therefore, special provisions are required:

- Drugs already on the market are subject to a rebate mechanism which is set by Congress and implemented by the Secretary, based on average prices.

- For new drugs, even this system cannot apply, because there will be no average competitive price. For these drugs, the Secretary is authorized to negotiate an additional rebate prices with the manufacturer.

The Health Security Act establishes a Breakthrough Drug Committee to review the pricing of new pharmaceuticals that represent a breakthrough or significant advance over existing therapies. This is an advisory committee authorized to provide information about drug pricing; it does not have the ability to "blacklist" or otherwise directly affect drug prices or the availability of drugs.

LONG TERM CARE - NURSING HOMES

QUESTION:

Why haven't you included nursing home coverage in your plan?

ANSWER:

- In a world of limited resources, we decided to focus our efforts on the area of long term care in which need is greatest and where current resources will be most helpful--home and community based care.

- We have learned from our experience with the very successful Medicaid home and community based waiver program that most people prefer to receive services at home, in regular community based settings. A policy decision was made that this initial effort at long term care reform should be aimed at expanding access to home and community-based services including personal assistance.

- Emphasizing community care will expand options for people since nursing home care is currently more available and more heavily financed by Medicaid than community care.

- The plan does provide states with the option of offering additional resource protections for individuals qualifying for Medicaid nursing home coverage by allowing them to increase the amount of protected assets from $2,000 to $12,000. In addition, the personal needs allowance for nursing home residents is raised from $30 to $50 per month.

- The plan will stimulate the development of a variety of residential arrangements for people with disabilities that will substantially expand their choices about where to live and still receive necessary supports.

HOME AND COMMUNITY BASED CARE - ELIGIBILITY

QUESTION:

In determining eligibility for the new home and community-based long-term care program, what is the significance of using a need for assistance in three activities of daily living (ADLs)?

ANSWER:

- The new home and community-based long term care benefit is targeted to individuals of all ages with severe cognitive and/or physical disabilities. The Health Security Act outlines four categories of eligibility:

  -- a need for hands-on or stand-by assistance, or cuing or supervision in carrying out three of five ADLs -- eating, bathing, dressing, toileting, and getting in and out of bed;

  -- a severe cognitive or mental impairment;

  -- severe or profound mental retardation; or

  -- for a child under six, a demonstrated need for hospital or institutional care.

- Recognizing that financing for long-term care would be substantially increased, but that there would have to be a budget cap, a policy decision was made that new federal dollars should be targeted to those with the most need -- and those whose families are the most likely to be overburdened with providing informal (unpaid) care -- people with the most severe disabilities.

- Approximately 3.1 million Americans will receive benefits using these eligibility criteria.

HOME AND COMMUNITY BASED CARE - INDIVIDUAL ENTITLEMENT?

QUESTION:

The Health Security Act includes a new home and community-based long-term care program which is a capped entitlement to states. Wouldn't people be better served by an individual entitlement? Doesn't this leave the states with too much discretion to limit services?

ANSWER:

- The budget for the new long-term care program was calculated based on our best estimates of how much money would be needed to adequately serve the eligible population. While we believe our estimates are accurate, the data are not perfect, particularly regarding people under age 65. Thus, federal funding was capped.

- To offer an individual entitlement with capped funding would put the states at enormous financial risk. Placing a predictable but generous limit on federal funds will help to encourage prudent use of scarce resources and close integration of informal care and paid services.

- The long-term care population is extremely diverse. The only way to meet their diverse needs is with a program that allows a great deal of discretion in service design and delivery. While there are risks in allowing flexibility, it is the only way to ensure that people with diverse needs, circumstances, and strengths will have the service packages that work best for them.

- Under the President's plan, the people who will make decisions about long-term care services will be consumers and their families, working in partnership with local community providers and agencies -- not government bureaucrats far removed from the scene.

TITLE III

PUBLIC HEALTH INITIATIVES

MENTAL HEALTH & SUBSTANCE ABUSE BLOCK GRANTS

QUESTION:

How will health care reform affect the Substance Abuse Treatment and Prevention and the Community Mental Health Services block grants? Will there be offsets to the mental health and substance abuse block grants?

ANSWER:

The Health Security Act will give all Americans access to coverage for mental illness and substance abuse treatment - many for the first time - as an integral part of a comprehensive health benefit package.

- The block grants will continue. They will provide support to States for mental illness and substance abuse treatment services that fall outside of the covered basic benefit, including "enabling services" such as transportation, language and translation services, and outreach.

- Set-asides in both block grants for administrative costs and technical assistance will continue, as will set-asides for prevention in the Substance Abuse block grant.

As the Act covers an increasing amount of the mental health and substance abuse services currently funded under the block grants for the uninsured, providers will see new sources of revenue. As a result, service providers should see the same or more total funding but from different, often non-governmental sources.

- Services covered by the comprehensive benefit package will be paid for by health insurance, while those not covered will continue to be funded by States using block grant and other funds.

- The services now provided by the block grant funds will continue to be covered, but the amount required from governmental sources is expected to be less.

- Health plans will move to a flexible "managed benefit approach" to treating individuals with mental illness and substance abuse disorders, which relies on having available an array of services.

- The Act contains a number of incentives for States to integrate current public sector treatment systems into private health plans:

  -- States will be required to submit a plan for the

integration of public and private mental health/substance abuse services to the Secretary by October 1, 1998.

-- The Secretary will establish a pilot program to demonstrate models for integrating MH/SA services covered by the benefit package.

OFFSETS - PHS

QUESTION:

What about "offsets"? Will PHS health services delivery programs lose funding as health care reform is implemented?

ANSWER:

Under the Health Security Act, all Americans and legal residents will have health insurance coverage for the comprehensive benefit package. As a result, many of the personal health services currently provided by PHS programs for the uninsured will be covered and paid for within the new system.

- PHS programs that subsidize the delivery of health care services will not lose funding as the result of health care reform. However, the funding streams will change.

- Once health care reform is fully implemented, insurance revenues will be the source of funding for services contained in the basic benefit package. Federal grant funds may be reduced to the extent that those grant funds now subsidize such services.

- As you know, the Act has several important new PHS initiatives to help increase access. Funding for these programs ($19.8 billion, FY1995-2000)is authorized under spending caps provided by the Budget Enforcement Act. The reductions, or offsets ($7.6 billion), in the current program funding will reduce the amount of new spending required to accomplish the important public health goals in the Act.

- In the future, Federal grant funds would be used to expand services or to cover services not contained in the basic benefit package. This would include, for example, enabling services, such as outreach, transportation, and translation; medical services not included in the basic benefit package and services for undocumented persons.

ESSENTIAL COMMUNITY PROVIDERS

QUESTION:

Health plans are required to enter into agreements with essential community providers for the first five years of the program. What happens at the end of the five years? Will there be criteria for determining if this provision should be extended?

ANSWER:

The essential community provider provisions in the Act are designed to protect providers that have traditionally provided services to underserved populations from exclusion from the newly reformed system, as well as to help assure their integration with health plans.

- The Health Security Act provides that its essential community provider requirements will apply to all alliance health plans for at least a 5-year period.

- Near the end of the 5-year period, by March 31, 2001, the Secretary of the Department of Health and Human Services is required to study essential community providers and to make recommendations to Congress on whether these provisions should continue, and if so, to what extent, where, and under what circumstances.

- To prepare these recommendations, the Department will conduct studies of the definition of essential community providers, the adequacy of funding for providers, the effects that contracting requirements have had on plans, providers and patients, and the impact of these provisions and health care reform, more generally on providers.

- The Department's recommendations will take effect unless Congress issues a joint resolution of disapproval within 60 days.

IMPROVING ACCESS IN UNDERSERVED AREAS

QUESTION:

What does the plan do to improve access in underserved areas?

ANSWER:

First and foremost, under the Health Security Act, all Americans and legal residents will have insurance coverage. Their insurance will provide for a package of basic benefits that can never be taken away. However, insurance alone will not assure access to care. Thus, the President's proposal will expand the system's capacity and increase the number of primary care providers, especially in underserved rural and inner city areas so that people living there have an adequate choice of providers and plans.

In addition, the President's plan enhances services to underserved populations in the following ways:

- The Act builds on the strengths of successful programs, such as Community and Migrant Health Centers, which receive increased funding to expand the number of people they serve.

- Through the new capacity expansion program, funds are authorized for integrating into the reformed system of care providers who now care for the low-income people and helping them work together and negotiate effectively with plans. Loans and loan guarantees are also available to help establish new practice sites and renovate existing sites.

- The essential provider provisions help assure the viability of health care providers who have been successfully serving vulnerable populations by requiring that health plans contract with all certified essential providers in their area.

- Some services are not included in the comprehensive benefit package that are important in meeting the needs of low-income, hard-to-reach populations. These "enabling services," including outreach, transportation, translation, and non-medical case management, will help assure that underserved populations will be able to overcome non-financial barriers to care. The Act includes an authorization for a new flexible enabling service program, and additional services from existing PHS programs will be available to meet these needs.

- A five-fold expansion of the National Health Service Corps field strength and tax incentives for non-NHSC primary care providers will help assure that there are more people

providing care in underserved areas.

CHOICE OF PLANS IN RURAL AREAS

QUESTION:

What does the President's plan do to ensure that people in rural areas will have a choice of health plans?

ANSWER:

The Health Security Act will greatly benefit rural and frontier areas. Provisions affecting rural and frontier areas are scattered throughout the Act. Together they provide a comprehensive array of improvement that will offer rural residents more choices.

- Universal coverage will insure millions of uninsured and underinsured rural residents and assure reimbursement for providers who care for them.

- The Act will provide funding for increasing the supply of primary health care providers and payment and tax incentives to retain them in rural practice.

- Rural providers may form health plans with the support of grants and loan guarantees from the Public Health Service.

- Rural providers will be able to offer residents more choices of plans because they will be able to join multiple health plans offered in their alliance areas. Alliances are permitted to offer incentives to health plans to encourage them to provide coverage in rural areas or to help establish new plans.

- States are tasked with maximizing the choices of alliance health plans offered to its residents. States are also responsible for certifying all health plans operating in the state, and they may require health plans to cover an entire alliance area or selected parts of an alliance area.

- States may also opt for a single payer system within their whole state or in an alliance area. This option, combined with provisions to increase the supply of primary care providers, could offer rural residents an increased choice of providers.

- Despite these efforts, some more remote rural or frontier areas may have the limited choice of only a fee-for-service plan, but these areas should be able to increase choice by increasing the number of providers available to them.

ASSURING FUNDING FOR FUNDING PUBLIC HEALTH INITIATIVES IN LIGHT OF SPENDING CAPS

QUESTION:

The legislation includes additional spending authority for public health activities (e.g., new community health centers, expansion of the National Service Corps, increasing prevention research at NIH.) How does the bill assure that these funds will be available?

ANSWER:

- Our budget estimates assume new funds are, in fact, spent.
- We want to assure that a secure funding stream is developed for these initiatives. We are committed to working with Congress to make sure that funding is available in future years to achieve our expanded public health initiatives.
- We remain steadfast in our commitment to expand our public health efforts.
  - -- To make sure that all Americans have access to health care, and to enable them to use the health care system and to facilitate the transition to the new system, also means improving, creating and expanding existing public health infrastructure in some communities.
  - -- Through expanded efforts in preventing disease and controlling chronic disease, including expansion of prevention research and traditional public health approaches to disease control, we will be able to reduce the increasing demand for costly clinical health services.

MEDICARE CUTS AND RURAL HOSPITALS

QUESTION:

Since rural hospitals tend to take care of higher proportions of the elderly, won't the Medicare cuts in the plan hurt them more?

ANSWER:

The Health Security Act will have many benefits for rural hospitals, including:

- Universal coverage will eliminate their uncompensated care;
- Workforce initiatives will provide valuable new resources for training health providers that are in great demand in many parts of rural America;
- Tax incentives and increased bonus payments to help retain the doctors currently providing services in rural hospitals;
- Funding in the new PHS access initiatives that will help rural hospitals and other providers in underserved communities develop community-based health plans; and
- Essential community provider certification which may be available to some rural hospitals will assure that they will be integrated into health plans.

Despite these benefits, rural hospitals are going to share in the responsibility for reductions in the Medicare program. The burden of these cuts is somewhat eased by the following:

- In spite of rural hospitals' disproportionately elderly case load, the proposed Medicare savings do not fall disproportionately on rural hospitals. This is because many of the savings are targeted at special payment rules that tend not to affect rural hospitals.

CHANGING THE MIX OF SPECIALIST AND PRIMARY CARE RESIDENCIES

QUESTION:

Is the Health Profession Workforce Account intended to change the mix of specialist and primary care doctors trained?

ANSWER:

- Yes, the Health Security Act is structured to reduce the number of, and funding for, residents training in specialties gradually, while increasing primary care training.
  - The Health Security Act requires that beginning in 1998, the mix of first year residents must be such that 55 percent will enter practice in primary care specialties upon completing their residency training in the years 2001 through 2008.
  - Primary care programs include family medicine, general internal medicine, general pediatrics and obstetrics and gynecology.
  - Some believe that market forces are already beginning to refocus new medical graduates on primary care residencies. To promote and accelerate this trend, the bill contains a system of transition payments. These payments will go to hospitals which eliminate excess residents, based on the numbers in training in academic year 1993-94.
  - To be realistic, however, we believe more active management of the overall system will ultimately be required to achieve meaningful change.

LIMITS ON RESIDENCY POSITIONS AND EFFECT OF EXCESS POSITIONS

QUESTION:

Does the Health Security Act set limits on the number of residency positions? Will hospitals be free to train residents which are not paid through the national allocation system?

ANSWER:

- The bill does not set a specific limit on the total number of residency positions.

- However, it does specify that the National Council on Graduate Medical Education should:

  - reduce the total number of positions in academic years 1998-99 through 2002-03 by a percentage which it establishes; and,

  - beginning in 1998-99, assure that the total number of authorized positions bears a relationship to the number of U.S. medical school graduates.

- Limits need to be established if we are to achieve increases in the number of primary care physicians trained and to slow the excessive and costly growth in overall physician supply.

  - Right now, there are about 16,000 medical students graduating from U.S. medical schools every year, but fully 24,000 first year residents in training.

  - Many groups have suggested that the number of first year positions should be set at 110 percent of U.S. medical graduates, which still leaves room for students who completed medical school in other countries.

  - Limits in that range are probably reasonable.

  - However, we have avoided citing a specific number in order to give the National Council more flexibility.

Some residents--especially those in high-tech specialties--may bring in enough patient care revenues to make it worthwhile for a hospital to sponsor their training even without payments from the workforce account. Thus, the system could be undermined unless there are penalties to guard against specialty proliferation.

- Thus, the penalty for training unapproved residents is loss

of status as a participating provider. [The September draft was less stringent--an institution with unapproved trainees would have lost educational payments for all trainees.]

WHO GETS THE RESIDENCY TRAINING MONEY--WINNERS/LOSERS

QUESTION:

Which institutions will receive payments from the proposed all-payer physician workforce account to fund residency training programs? How does this differ from the current system and who do we expect the winners and losers to be?

ANSWER:

- Under the Health Security Act, payments from the workforce account would go to individual residency training programs, whoever the sponsor.
  - At present, almost all accredited residency programs are teaching hospitals and payments from Medicare flow to the hospital, rather than to the program.
- While creating an important opportunity for development of ambulatory-based programs, we do not believe that the change will make a dramatic difference in who ultimately receives the funding.
  - The majority of residency programs will continue to be sponsored by, and operate within, teaching hospitals.
  - The change would open the door for other types of providers to sponsor training, including managed care organizations and community clinics, by providing access to training funds.
  - This will help primary care.

There will be winners and losers, but until the National Council acts, it is difficult to predict which programs will be affected.

- The National Council will be considering factors such as the historic distribution of training programs; program quality; and diversity of trainees.
  - Nevertheless, entities which are training large numbers of specialists will be affected by reductions.
- Also, because payments will be based on a standard per resident amount, institutions with a higher than average training cost will lose funds.
  - Many of the potential losers are inner city hospitals, and we have already heard from some who

are concerned.

- We are looking closely at this issue, and at whether a phase-in of payment levels would be desirable, on a budget neutral basis.

HELP FOR AREAS BURDENED BY UNDOCUMENTED PERSONS

QUESTION:

Undocumented individuals will not be eligible for alliance coverage under the Health Security Act. Does the plan provide special funds for this population?

ANSWER:

- Yes. The plan provides relief in several ways.

- First, the Medicaid program will continue to pay for emergency services for eligible undocumented individuals, just as it does today. This policy maintains a Federal-State shared responsibility for caring for this population.

- Second, a five year, Federal Vulnerable Population Adjustment (VPA) program will be established. This program will replace the Medicaid DSH program once a State implements reform. It is designed to make payments to qualified hospitals to offset the unreimbursed costs associated with providing services to undocumented and low-income individuals.

- Annual funding for the VPA program will be $800 million per year for five years. Seventy-five percent of the funds will be distributed based on the hospitals' low-income utilization, while twenty-five percent will be allocated for assistance in furnishing services to undocumented individuals not covered by alliance health plans.

- Finally, undocumented persons can also receive health care services at community health plans and networks. These networks, which will be given developmental grants and loans as part of the HSA, will serve all persons seeking care, whether or not they are eligible for alliance coverage.

Key Information:

While the Health Security Act language provides $800 million for the VPA program, budget estimates for the Act, in fact, assume $1 billion. The final draft of the bill failed to conform the language to the estimates.

TITLE IV

MEDICARE AND MEDICAID

MEDICARE

PAYMENT BY MEDICARE BENEFICIARIES IN ALLIANCES

QUESTION:

Once health alliances are established, individuals newly eligible for Medicare may remain in their alliance health plan rather than enroll in Medicare, as long as the alliance based plan either has a risk contract with Medicare or is capable of having such a contract. Individuals who remain in these alliance health plans must pay the difference between the premium amount and the amount paid by Medicare. Is there a limit to the amount of this premium?

ANSWER:

- Plans will be allowed to charge Medicare beneficiaries who choose to stay in the alliance based plan more than non-Medicare individuals. This extra premium amount takes into account the higher utilization of medical services by Medicare beneficiaries. The rules determining calculation of this extra premium amount are established by the Secretary. Thus, plans cannot charge higher than allowed premium amounts; they are limited by a factor determined by the Secretary.

VA HOSPITALS AND MEDICARE

QUESTION:

As of January 1, 1998, HHS will make payments on behalf of Medicare beneficiaries who are enrolled in health plans sponsored by the Department of Veterans Affairs. How will this impact the Medicare Trust Fund?

ANSWER:

- Under current statute, Medicare is precluded from paying for care delivered at other Federal facilities to individuals entitled to coverage through another Federal program (e.g. Medicare does not pay for care at VA or DoD).

- The VA serves veterans 1) with service connected disabilities, 2) low income veterans, and 3) higher income veterans on a space-available basis. Few Medicare beneficiaries receive care in this third category.

- Under the Health Security Act, Medicare will pay for care from high income (by VA definition) non-service connected dual-eligible veterans (covered by both the VA and Medicare) who choose to enroll in a VA plan. Medicare would pay VA plans or facilities for services using a payment plan agreed to by both Secretaries.

- While this would impose additional costs on the Medicare Trust Fund, the costs would be relatively small.

FOLLOWUP QUESTION:

Will the VA facilities receiving Medicare payments be required to meet Medicare conditions of participation?

ANSWER:

- The Plan requires that additional resources be targeted to further improve the quality of care in VA facilities.

- The Veterans Health Care Investment Fund helps ensure that VA plans have the financial resources necessary to meet their obligations, including quality. Indeed, the VA Secretary must prepare a Report to Congress by March 1, 1997 which, among other requirements, evaluates the quality of care provided in VA plans and the adequacy of plan funding.

FEHBP AND SUPPLEMENTAL INSURANCE

QUESTION:

Could you please explain how supplemental plans will be offered to federal employees and who will pay for them? Will the government be responsible for continuing to offer coverage above the basic benefits package if they are doing so now? What about Medicare supplemental plans? Is there an authorization without appropriations for this?

ANSWER:

The Federal government will hold annuitants harmless so that they will not have to pay more for equivalent coverage than they are currently paying under FEHBP. The Office of Personnel Management has authority to buy annuitants with Medicare a wrap-around policy equivalent to their current FEHBP wrap-around benefits. OPM also has authority to provide supplements to annuitants without Medicare and active employees who purchase insurance through the regional alliances.

Regarding supplemental plans, Congress must both authorize and appropriate funds before they can be spent for any purpose. The Health Security Act does not change this basic fact of government.

IMPACT OF NEGOTIATING NEW DRUG PRICES ON NEW DRUG DEVELOPMENT

QUESTION:

Doesn't the Secretary's negotiation authority permit her to exclude drugs, and won't that have a chilling effect on new drug development?

ANSWER:

- Since Medicare has not established a formulary, the program needs some mechanism to control the cost of new drugs.

- Drug manufacturers have traditionally charged whatever the market will bear for new drugs. These prices may be extremely high because other manufacturers are prohibited from copying patented drugs, and alternative drug therapies may be ineffective or even more expensive.

- There is no particular formula for calculating rebates for new drugs. Instead, the Secretary will negotiate special rebates for new drugs with manufacturers.

- The provisions of the drug benefit do not allow the Secretary to automatically or imprudently exclude any new, expensive drug from coverage under Medicare.

- The Secretary will consider a number of factors when determining the special rebate for a new drug including -- the prices of other drugs in the same therapeutic class, cost information supplied by the manufacturer and prices of the drug in other industrialized countries.

- Manufactures will have up to six months to negotiate a special rebate with the Secretary. If an agreement cannot be reached, the Secretary may decide to exclude coverage of the new drug.

- The reason the Secretary has the authority to exclude new drugs from Medicare is to have a fall-back negotiating mechanism in case the Medicare trust fund and the taxpayers who support it become at risk because a few drug companies price their products at unreasonably high levels. However, we hope and expect that the industry is now much more sensitive to launch prices.

- Allowing the Secretary to negotiate special pricing provisions with manufacturers is not a new, radical concept. The Congress just gave the Secretary the same authority to do just that with drug products used for immunizations.

- Lastly, other countries negotiate new drug prices with

manufacturers under a scheme similar to that proposed in the Health Security Act.

COMPARISON OF ALLIANCE COVERAGE AND MEDICARE

QUESTION:

Isn't there a decline in benefits when individuals become eligible for Medicare? Will the Health Security Act force beneficiaries to go to work in order to receive "better" coverage under an alliance plan?

ANSWER:

- There are a few important differences between Medicare and the standard benefit package, but they are not significant enough to draw beneficiaries into the workforce. Indeed, the Health Security Act significantly improves upon the current Medicare program.

- One of the most important differences between current Medicare benefits and the standard benefit package is coverage of outpatient prescription drugs. Since the Plan proposes to cover Medicare outpatient drugs, this difference will not be an issue.

- Another important difference is the annual catastrophic limit of $1,500 (in 1998) in alliance plans. The vast majority of Medicare beneficiaries already receive this coverage through retiree health coverage, Medigap plans, or Medicaid.

- The plan does not allow alliance plan providers to balance bill patients. Under the plan, Medicare beneficiaries will have the same protection from balance billing.

- The Health Security Act creates new opportunities for Medicare beneficiaries to enroll in Medicare managed care plans or to use networks of providers on a service-by service basis without enrolling in managed care. The presence of these opportunities further reduces the differences between alliance and Medicare coverage.

FOLDING MEDICARE INTO STATE SYSTEM

QUESTION:

States may request permission from the Secretary to integrate all Medicare beneficiaries (employed and retired) into alliance plans. We believe that this is most likely to happen in states that implement single payer systems. Indeed, alliances that implement alliance-specific single payer systems may also integrate Medicare beneficiaries into health plans with permission from the Secretary. What do these options mean for a Medicare beneficiary's choice of health plans?

ANSWER:

- If a state receives permission from the Secretary to integrate Medicare beneficiaries into alliance based health plans, Medicare beneficiaries will be given the same choice of plans as everyone else in the state or alliance area.

- In order to integrate beneficiaries into the alliance system, the state must ensure that Medicare beneficiaries have equal or better access to services, no greater out of pocket costs and quality as good or better than under Medicare.

- In addition, at least one fee-for-service plan that includes the Medicare benefits package must be offered at no additional out-of-pocket cost to the beneficiary. And, if only a plan with benefits in excess of the Medicare benefits package is offered, it must be offered to Medicare beneficiaries at no additional out-of-pocket cost than traditional Medicare.

MEDICARE WORKERS

QUESTION:

The Health Security Act requires that Medicare beneficiaries (and spouses) who work at least 40 hours in a month (for 2 consecutive months, with the expectation of working the third month) receive their health insurance coverage through the alliance. Why are you forcing Medicare beneficiaries to stay in the alliance? Why not give working Medicare beneficiaries the option to enroll in traditional Medicare as under current law?

ANSWER:

- Based on various scenarios that we constructed, beneficiaries would always be significantly better with Alliance coverage and Medicare as secondary payor rather than just having Medicare. The annual savings to a beneficiary with coverage through the alliance would be anywhere from $332 to $497.

- The average 65 - 69 year old beneficiary in Medicare would have expenses that total $1,319 per year. This consists of $601 for the Part B premium and $718 for cost sharing (deductible and coinsurance).

- Under the Alliance, that same beneficiary would have to pay either $822 or $987 depending on whether or not the beneficiary enrolled in Part B.

    + Beneficiaries who choose not to enroll in Part B would pay $386 for their share of the community rated alliance premium and $436 for cost-sharing related to Part B services under the plan (Medicare would pay for the cost-sharing for Part A related services).

    + Beneficiaries who choose to enroll in Part B would pay $601 for Part B and $386 for their share of the community rated alliance premium.

	Total Cost to Individual	Premium (Part B and or Alliance)	Cost-Sharing
Medicare	$1,319	$601	$718
Alliance	$822	$386	$436
Alliance+ Part B	$987	$601 + $386	$0

MEDICARE CUTS

QUESTION:

What is the impact of the Medicare cuts on hospitals, doctors and seniors?

ANSWER:

- In the context of a plan that will bring down private sector costs, we can achieve health care reform without shifting costs or endangering beneficiaries services.

- Seventeen percent of the savings in Medicare are simply extensions of expiring authorities such as the Medicare secondary payer provisions and the reduction in the hospital payment update.

- Twenty-seven percent of the savings result largely from eliminating or reducing provider payments that were originally intended to ease the financial pressures created by uncompensated care. Payments to hospitals for indirect medical education and disproportionate share adjustments are examples of such payments. With universal coverage, virtually all care will be compensated.