

MEDICARE CUTS

QUESTION:

How can you cut Medicare by \$124.4 billion dollars? Won't this cause severe damage to providers?

ANSWER:

- o The Medicare savings proposals represent reductions in the growth rate of provider payments, not cuts. Medicare spending will still be growing at over 8% annually. At the same time, providers will be receiving additional revenues from currently uninsured persons who receive coverage under the health reform plan.
- o About 27 percent of the total Medicare savings comes from proposals which eliminate or reduce subsidies unneeded after reform. These provisions include reduction in the indirect medical education (IME) adjustment, reducing the Medicare disproportionate share hospital (DSH) adjustment and lowering the Medicare secondary payor threshold for disabled workers.
- o Another 17 percent represents proposals for extension of expiring authorities, including extension of the Medicare secondary payor provisions, the Part B premium and reductions in the hospital update.
 - + \$18 billion in savings comes from lowering the hospital prospective payment update by two percent. This still gives hospitals a three percent projected growth rate. On top of this, hospitals currently are experiencing a 2 percentage point increase stemming from case-mix changes. It is estimated, however, that 1 percentage point comes from "case-mix creep" - changes in coding simply to receive higher reimbursement. Any productivity increase would also further benefit hospitals. It would not be unreasonable to expect productivity to increase one percent increase.
 - + \$18 billion come from reducing the indirect teaching adjustment from 7.7 percent to 3 percent. However, a new national pool is being created to reimburse academic medical centers and both the 3 percent Medicare contribution and an Alliance premium surcharge of 1.5 percent will contribute to this the new pool.
 - + \$15 billion comes from phasing down Medicare disproportionate share payments to hospitals.

Medicare does not need to pay for the disproportionate costs of hospitals which serve low income populations when those populations now have health insurance. Moreover, there will be a residual payment to reflect the higher costs of treating low-income Medicare beneficiaries.

- o \$13 billion comes from the reduction in hospital outpatient costs from correcting the cost limit formula which was incorrectly written and gives hospitals an incentive to increase their charges in order to obtain higher payments from beneficiary coinsurance. Fixing this flaw both helps beneficiaries and saves Medicare money.
- o Despite these proposals, PROPAC estimates that "the PPS update factor, together with changes in the case-mix index, are likely to result in increases in per case Medicare hospital payments that are somewhat higher than those received from private payers."
- o Although three of the provisions propose reducing physician fee increases, if current trends continue, there may be no reduction in the update at all. For example, in FY1992, physician spending increased at rates considerable less than their target. As a result, the following updates will apply for 1994, even after legislated reductions in OBRA -1993:
 - + 10.0 percent for surgical services,
 - + 7.9 percent for primary care services, and
 - + 5.3 percent for all other services.

MEDICARE PEER REVIEW

QUESTION:

The Health plan calls for the Medicare Peer Review Organization Program to be repealed once the National Quality Management Program is implemented. How will the timing on this work? Why would you want to repeal this wonderful program?

Answer:

- Quality is one of the fundamental tenets the President has laid down for health reform. The Peer Review Organization program will not be repealed until the National Quality Management Program is implemented. The National Quality Management Program, along with other aspects of reform that increase access to care, should lead to the ongoing, significant improvement of health care quality in the United States.
- The Peer Review Organizations, through their current participation in the Health Care Quality Improvement Initiative, are gaining valuable experience that should serve them well in the new world of health reform. Many States, alliances, health plans, and providers are likely to seek assistance on methods for achieving continuous, measurable quality improvement under the Health Security Act's National Quality Management Program.

MEDICARE MANAGED CARE

QUESTION:

What happens to the Medicare Select program under the Health Security Act?

ANSWER:

- The Medicare Select program is not affected by the Health Security Act. Authority for this program expires at the end of 1994 at which point Medicare Select will no longer be able to enroll new beneficiaries unless the program is renewed.
- The Medicare Select program introduced the concept of preferred provider organizations to the Medicare supplemental insurance market (Medigap). Under Medicare Select, Medicare beneficiaries who choose to enroll in a Medicare Select Medigap policy have their out-of-pocket expenses (such as Medicare's 20% coinsurance for physician services) reimbursed by the Medicare Select insurer only if the beneficiary uses a provider associated with the Medicare Select network of providers. Since the benefit is only available through a limited provider network, beneficiaries who choose Medicare Select plans generally pay lower monthly premiums than beneficiaries enrolled in Medigap plans that reimburse out-of-pocket costs for any provider. The legislation permitted only 10 States to offer Medicare Select as a Medigap option.
- The Health Security Act does authorize Medicare to establish "point-of-service" networks, but these would be part of Medicare, rather than Medigap. These networks are essentially preferred provider networks, consisting of providers who meet certain utilization and quality standards and who would agree to accept "bundled" payments (i.e., a global payment for a range of services associated with a particular medical procedure or surgery). The bundled payments, and the selection of providers whose practice patterns show that they provide high-quality, cost-effective care, would lead to lower Medicare payments for services provided through these networks. Medicare beneficiaries would not enroll in the network, but would be informed of the availability of point-of-service (POS) providers. Medicare beneficiaries would benefit from lower cost sharing if they choose to use a POS provider rather than a non-POS provider; and the law authorizes Medicare coverage for services not otherwise covered under Medicare which the POS network would be paid to provide.

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.

LONG TERM CARE - NURSING HOMES

QUESTION:

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

ANSWER:

- While such protection may be desirable in the long run, it is simply too expensive to include in this package.
- 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 begins to "level the playing field," since nursing home care is more available and more heavily financed 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.

MEDICAID

IMPACT OF CONTINUING STATE FINANCIAL RESPONSIBILITIES

QUESTION:

Although the Medicaid program changes dramatically under health reform, participating States will be required to maintain a significant portion of their current Medicaid spending to pay for premiums and low-income subsidies. This seems unfair to those States that have been more generous in their coverage of low-income individuals and to those States with a lower Federal matching percentage. These States argue that they will receive lower federal subsidies and therefore be disadvantaged. How does the President's plan address this?

ANSWER:

- Every State will be better off under reform. The growth rates of State Medicaid spending will be dramatically reduced. We recognize that some States will gain more than others. IN any new program there are issues about how to address existing differences, we decided to start where the States are now -- using each State's current Medicaid expenditures and the current Federal matching formula.
- It is important to remember that State spending to maintain current effort will remain within that State and be used only for residents of that State.
- A Commission on Regional Variations in Health Expenditures will examine inter-State "equity" in the State maintenance of effort and premium payments. A report is required to be submitted to Congress not later than July 1, 1995 with detailed recommendations including specific methods for reducing the State variation by 2002 in a budget neutral manner.

MEDICAID ENTITLEMENT IMPACT ON WELFARE REFORM

QUESTION:

How might welfare reform effect financing of benefits and discounts under the Health Security Act? Specifically -- if welfare reform is successful and people leave AFDC, won't federal spending shift from payments for cash assistance recipients (uncapped) to the subsidy pool (capped)? Do your estimates take this into account?

ANSWER:

- Our estimates on the cost of the Health Security Act were developed before the welfare reform initiative was complete, and are independent of welfare reform.
- We hope welfare reform will help low-income families leave the AFDC program. As this transformation occurs, we can re-examine payment responsibilities and shift payments to low-income subsidies, as appropriate.

SUPPLEMENTAL SERVICES UNDER MEDICAID

QUESTION:

Under health reform, payments for wraparound benefits for children previously covered under Medicaid will be paid for by the Federal government. What benefits will be covered?

ANSWER:

- The wraparound program will protect current Medicaid children by ensuring that they will continue receiving those services now provided through the Medicaid program, including EPSDT. All current Medicaid services not covered through Alliance plans nor through the Medicaid long term care program will be included in the children's wrap-around benefit. These services may include, for example, hearing aids, transportation services, and mental health clinic services beyond the coverage rules for the Alliance health plans.
- We will standardize existing benefits while moving towards a Federal uniform program within the capped funding limit. Under the Health Security Act, the Secretary will be responsible for implementing these dual goals.

STATE GAMING OF MEDICAID WRAPAROUND BENEFITS

QUESTION:

If the Federal matching rate for Medicaid in a State is 50 percent, the Federal matching rate for the new home and community based long term care program is 75 percent, and the Federal matching rate for wraparound services for children is 100 percent, won't States have incentives to redefine or move services to programs with higher federal matching?

ANSWER:

- As directed in the Health Security Act, the Secretary will define children's wraparound services. States will not be able to "game" the wraparound program because only specified services will be covered; States will not be able to shift additional services to the Federal program.
- The wrap-around benefits are defined to exclude all services being provided through the Alliance guaranteed benefit package, as well as any long-term care services being provided under Medicaid either as an institutional services or a community-based long-term care services such as home health or personal care services. In addition, the warp-around also excludes services being provided through the new community long-term care benefit.

PROTECTIONS TO ENSURE STATES MAINTAIN THEIR MEDICAID SPENDING

QUESTION:

State maintenance-of-effort (MOE) and premium payments to the alliances will be based on 1993 Medicaid expenditures trended forward until the year health reform is implemented. What protections exist to guarantee that the States maintain this 1993 spending level?

ANSWER:

- State premium payments made on behalf of cash assistance recipients will be based on 1993 expenditures trended forward to the year of reform by the lower of projected growth, as specified in the HSA, or actual growth. The actual growth rate can only be used if the State has controlled costs while protecting access. States cannot slash their Medicaid programs through reductions in services or provider payments in order to achieve a lower growth rate.
- For State MOE payment for non-cash assistance recipients, only national growth rates specified in the HSA will be used to update 1993 expenditures.
- After reform has been implemented, Federal oversight and auditing will ensure that the States are spending the amount specified by law.
- During the period before reform is implemented, States will have the same flexibility to expand or shrink their Medicaid programs as they currently have. After implementation, State payments to the alliance will be based on 1993 Medicaid spending, as described above.

MEDICAID MAINTENANCE OF EFFORT

QUESTION:

Although the Medicaid program changes dramatically under health reform, participating States will be required to maintain their current spending levels to pay the premiums. This seems unfair to those States who have been more generous in their coverage of low-income individuals because they will receive lower federal subsidies than those who haven't. How does the President's plan address this?

ANSWER:

- A Commission on Regional Variations in Health Expenditures will examine inter-State "equity" in the State maintenance of effort and premium payments as well as equity for regional differentiation in private premiums (section 6006).
- Regardless of what is determined by the Commission, it is important to remember that State spending to maintain current efforts will remain within that State and be used only for residents of that State.

HOSPITAL PAYMENTS - DISPROPORTIONATE SHARE

QUESTION:

A new vulnerable population adjustment (VPA) program is established to replace the Medicaid Disproportionate Share Hospital (DSH) program. How will these new funds be distributed? Will the payments be based on the DSH formula in current law or will it be altered?

ANSWER:

- The VPA program will provide Federal payment adjustments to qualified hospitals to offset the unreimbursed costs associated with providing services to undocumented and low-income individuals.
- The designation of qualified hospitals and the distribution of funds will be somewhat different than under the current Medicaid DSH program.
- **Designation.** Only hospitals with a low-income utilization rate of at least 25 percent will qualify for VPA payments. States will identify qualifying hospitals.
 - States currently have broad flexibility to designate hospitals as DSH. However, certain hospitals, including all hospitals with a low-income utilization rate greater than 25 percent, must qualify for Medicaid DSH payments under the federal minimum criteria.
- **Payment.** VPA payments will be made according to two parameters: hospital low-income patient loads and State populations of undocumented persons. 75 percent of the funds will be distributed based on the low-income patient loads of each qualified hospital, while 25 percent will be allocated for assistance in furnishing services to undocumented individuals not covered by alliance health plans.
 - States currently have broad flexibility to establish DSH payment methodologies.
- Annual funding for the VPA program will be \$800 million per year for five years.

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 persons. 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.

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.

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.

TITLE V

QUALITY AND CONSUMER PROTECTION

INFORMATION SYSTEMS

QUESTION:

How will the new health information systems in the Health Security Act work? Who will have access to the data? What information will be collected at the plan level? What will be the role of doctors, consumers, and plans in developing and monitoring data systems?

ANSWER:

The Act would establish a new health information system to support health care reform and simplify administration. An electronic data network would be established linking plans, alliances, States and the federal government with regional data centers.

The health information system would include the following information:

- o enrollment data,
- o premium and insurance transactions data,
- o claims and encounter data, and
- o such additional data as the Board may determine.

Most health and medical information about an individual would remain with the individual's health care provider and plan. Alliances and plans would maintain enrollment data for their own use and transmit a limited amount for use by the regional data center on a periodic basis.

Alliances would use the network to transmit data on premium transactions to the regional data center to assist in premium and subsidy management. Similarly, health plans would collect a variety of medical encounter information for their own use and transmit some of that encounter information - in the form of a uniform minimum health data set - to the regional data center.

The regional centers would process and analyze the data, and would provide a variety of information services to plans, alliances, States and the federal government. While the enrollment and premium data would be available for health care administrative uses, the medical encounter data would be made available only in statistical form. Individually identifiable health information would not be released outside the health information system except with the written authorization of the individual and in accordance with disclosure policies developed by the Board.

National privacy protection standards and legislation would assure that individuals would have much greater control over the disclosure and use of their health information than they do now, and enjoy much greater protection against abuses of health information than they now enjoy.

To assure wide consultation in the development of the information system and privacy protection policies, a National Privacy and Health Data Policy Council would be established to advise the National Health Board. The Council would have broad representation including providers, consumers, plans, alliances, public health representatives, privacy experts and others.

HEALTH INFORMATION SYSTEMS - PRIVACY

QUESTION:

The new health information systems included in the President's plan will manage enormous amounts of data including clinical encounter information on each beneficiary. What protections does the plan have to ensure privacy?

ANSWER:

The President's plan recognizes the critical importance of protecting the privacy of individual health information. Accordingly, the plan outlines a national framework for privacy protection of health information which would provide citizens:

- o much greater protection and control over the use and disclosure of their own health records than they enjoy now (Currently, although the public believes otherwise, there are very few protections over health record information at the federal or State level), as well as
- o rigorous protections against many of the current abuses of information contained in health records.

Most of the clinical information collected on patients would remain at the provider and plan level. Only a minimum amount of data, contained in uniform data sets such as the standard encounter data set, would leave the plan to become part of the overall information system and network.

The National Health Board, advised by a National Privacy Council, would be required to develop and promulgate standards for privacy and security of individually identifiable information in the system. The standards would have to incorporate certain principles:

- o information could not be disclosed outside the system without the written consent of the patient;
- o the disclosure of individually identifiable information would be restricted to the minimum necessary to accomplish the intended purpose; and
- o no individually identifiable information could be provided by a plan or alliance to set premiums based on risk adjustment factors.

Individuals would be guaranteed certain rights concerning the use of information contained about them in the system including:

- o the right to know whether any individual or entity uses or maintains individually identifiable information about them and for what purposes the information is maintained;

- o the right to access to information - including the right to see the information, to copy it and to have a notation made in the information about any amendment or correction requested by the enrollee; and
- o the right to notice about use of information, including a written statement concerning the purposes for which information they provide may be disclosed.

The unique identification number could not be used to link health information with other sources of data about the individual. In addition, individually identifiable health care information could not be used in making employment decisions.

The Board would subsequently be required to submit a detailed proposal for national privacy legislation to the President and the Congress. The proposal would include a code of fair information practices to advise enrollees of their rights with respect to health information. Civil monetary penalties and criminal sanctions would be established to enforce the privacy standards and protect against abuses.

INFORMATION ON HEALTH SECURITY CARDS

QUESTION

According to the President's plan, everyone would be issued a Health Security Card? What information will the card contain? How will it be used? Who will have access to the information on the card?

ANSWER

Every citizen and legal resident will receive a Health Security Card. The card would contain a minimal amount of information intended solely to demonstrate enrollment in a plan and describe insurance coverage.

The card would include the following information:

- o the identity of the individual to whom the card is issued including a unique identifier;
- o the applicable health plan in which the individual is enrolled;
- o any supplemental health insurance policy, and
- o such additional information as the Board determines is necessary.

The card would not include any sensitive medical information. The Health Security Act expressively forbids the use of the card or the unique identifier for any purpose other than health care, and includes very strong civil monetary penalties and criminal sanctions for misuse of the card or the unique identifier. The card would not be a "smart" card, a credit card or a national identification card.

The individual's complete medical records would remain at the provider and plan level, where they will only be available to health professionals who have a need to see them.

MEDICAL MALPRACTICE

QUESTION:

The Medical Malpractice provisions in the plan are very limited. Why didn't you do more? Why not include caps on damages?

ANSWER:

The Health Security Act includes many important tort reforms which will reduce both the risk of malpractice suits and the amount of malpractice awards, including a requirement that any collateral sources of recovery be counted toward the total amount of damages awarded, and a limit on contingency fees. A cap on damages would disproportionately reduce awards to those most injured (and thus most in need of compensation). Some persons are badly injured early in life, and will require medical and custodial services for decades. A cap on damages could result in failure of an award to cover the costs of such legitimate support.

We do not agree that the malpractice provisions of the Health Security Act are limited. Significantly, all malpractice claims must begin with plan-based alternative dispute resolution, including arbitration, mediation, and/or early offers of settlement. In addition, no claimant may proceed to court without obtaining a certificate of merit from a qualified specialist. The Act also calls for demonstration projects to test the use of enterprise liability, and pilot project to test the use of practice guidelines in resolving liability actions.

The Health Security Act does not preempt States from enacting additional reforms or even more stringent reforms.

No one would argue that malpractice suits are the way to enforce quality in a health care system. Our plan will change the practice environment to assure high quality health care by: encouraging continuity of care; developing and monitoring nationwide quality standards; focusing on the importance of preventive care; and improving health care data systems.

CORPORATE ALLIANCE GRIEVANCE PROCEDURES

QUESTION:

The Health Security Act includes grievance procedures for resolving disputes over the delivery of benefits in regional alliances. What about in Corporate Alliances?

ANSWER:

The Health Security Act includes grievance procedures for enrollees in corporate alliances health plans, as well.

- Just as for regional alliance health plan enrollees, a corporate alliance health plan enrollee must first request reconsideration from the health plan.
- Appeals from this reconsideration are handled by the Complaint Review Office established by the state, just as are appeals from regional alliance plan.
- At the Complaint Review Office, a regional alliance claimant may chose a hearing or an alternative dispute resolution process, or may bypass these administrative procedures and take the claim to court.
- Consistent with practices for enrollees in self-insured plans under ERISA today, the corporate alliance claimant must utilize the administrative process at the complaint review process, and may not take the claim to court. However, the Health Security Act expands the damages available today to enrollees in self-insured plans -- in addition to actual costs, the administrative hearing officer may award incidental damages such as attorneys' fees and witness' fees.

MEDICARE PEER REVIEW

QUESTION:

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ANSWER:

- Quality is one of the fundamental tenets the President has laid down for health reform. The Peer Review Organization program will not be repealed until the National Quality Management Program is implemented. The National Quality Management Program, along with other aspects of reform that increase access to care, should lead to the ongoing, significant improvement of health care quality in the United States.
- The Peer Review Organizations, through their current participation in the Health Care Quality Improvement Initiative, are gaining valuable experience that should serve them well in the new world of health reform. Many States, alliances, health plans, and providers are likely to seek assistance on methods for achieving continuous, measurable quality improvement under the Health Security Act's National Quality Management Program.

TITLE VI

**PREMIUM CAPS
PREMIUM-BASED FINANCING
PLAN PAYMENTS**

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.

ENFORCEMENT OF PREMIUM TARGETS

QUESTION:

During the bidding process, how does the enforcement mechanism work when all the plans exceed the budget target?

ANSWER:

The enforcement mechanism 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 could be achieved.
- If that did not work, an assessment would be imposed on each and every plan to bring it into compliance.
- Revenues from these assessments would be used to reduce the required employer premium contributions and to keep the alliance within budget.

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.

CAN LOW-INCOME AFFORD CO-PAYMENTS AND DEDUCTIBLES?

QUESTION:

Does the Health Security Act make health care affordable to low and modest wage earners? Is the cost sharing in the plan too high? Will the discounts be enough, or will some families find themselves in the Emergency room because they can't afford the co-payments in a Doctors office?

ANSWER:

- Under the Health Security Act, low and modest income Americans and legal residents will have the same quality health care choices as everyone else.
- Low-income individuals who enroll in lower cost sharing plans will have no deductibles, \$10 copayments for most services, and an out-of-pocket limit of \$1,500 for individuals, \$3,000 for families.
- If low-income individuals live in regions where there are no lower cost sharing plans, these individuals will receive subsidies that reduce their costs to the level of cost sharing in lower cost sharing plans.
- Cost sharing for individuals receiving cash assistance (AFDC or SSI) is further reduced to a \$2 copayment.

PROTECTIONS FOR LOW-INCOME WORKERS

QUESTION:

You offer special protections for low-income workers in the regional alliances, so why don't you have the same protections in corporate alliances?

ANSWER:

- Low income workers are protected in both corporate alliances and regional alliances.
- Low wage workers (defined as annual income less than \$15,000/year) in corporate alliances are entitled to premium subsidies from their corporate alliance employer.
- Whether in a regional or corporate alliance health plan, the low-income family's premium contribution is capped at a percent of income which increases as family income increases, up to 3.9% of income for families with incomes at 150% of the federal poverty level.

--If the family is an AFDC or SSI family, it makes no payments toward health plan premiums.

--The 3.9% cap applies to families with income of less than \$40,000/year.

ADEQUACY OF LOW-INCOME DISCOUNTS

QUESTION:

Given the structure of your discounts and cost-sharing requirements, isn't it true that the low-income population will not get a choice of plans?

ANSWER:

Due to reduced cost sharing, it is likely that low-income Americans will be enrolled in managed care plans. However, the Health Security Act has built-in protections to make sure that such plans provide the full comprehensive benefit package, that health care professionals are available to all members, and that quality is monitored. In addition, low-income enrollees will be able to identify problems with plans and report them to the Alliance for action.

The HSA provides cost sharing subsidies to help low income families afford high or combined cost-sharing plans.

The bottom line is that the vast majority of low-income Americans will have access to a high-quality mainstream system of health care that does not discriminate against them on the basis of their income or their type of insurance coverage.

IS THERE DATA TO SUPPORT THESE CAPS?

QUESTION:

Aren't we trying to enforce the premium caps too soon? What available data do we have to support these caps?

ANSWER:

1. Aren't we trying to enforce the premium caps too soon?
 - The premium caps will be based on the most current information on health care expenditures (1993) with adjustments made to account for regional variation in those expenditures.
 - By enforcing caps in the first year based upon 1993 data, we can limit possible behaviors on the part of providers and insurers that would artificially raise the cost of health care in anticipation of impending reductions.
 - We do not have unrealistic expectations. Reasonable annual adjustments to those premiums will be made. These include using an inflation factor.
 - One of the goals of health care reform is to reduce the rapid increase in health care costs. It may take a year or so after reform is initiated before we begin to see some effect. So, the sooner we begin, the sooner we'll have a positive impact on the system.
2. What available data do we have to support these caps?
 - There are many sources of data that can and will be used to determine the cap levels for alliances. However, it should be noted that the data are not perfect. But what is available will provide very good estimates of the kinds of things we need to measure.
 - There are national surveys on medical expenditures which provide detailed utilization estimates.
 - Medicare Program data can provide good estimates of health costs.
 - The Consumer Price Index (CPI), which will be used in the inflation adjustment for premium caps, is readily available through The Bureau of Labor Statistics.
 - Other pertinent data will be provided from many other agencies, including the Health Care Finance Agency (HCFA) and the Census Bureau.

WILL PREMIUM TARGETS REFLECT STATE VARIATIONS?

QUESTION:

By 1996, the National Health Board will calculate a premium target for each State and alliance. Premium targets will reflect current spending in States. Won't it be unfair to lock-in historical payment and coverage inequities across States? How will the plan account for State by State variations once the distribution is done?

ANSWER:

Clearly, we recognize the differences in spending across States. We believe, however, that we should wait to address those differences until we have better information about the nature of the differences and until the Act activates new incentives to change the way spending occurs. Our reasons for this decision are as follows:

- In order to set premium targets, we have to start somewhere, so we are beginning with the current levels of spending for health care in the State.
- However, we are adjusting these spending levels to eliminate differences in health care spending that are attributable to varying rates of health care coverage. Per capita premium limits throughout the country will reflect universal coverage, thereby eliminating some of the existing discrepancy.
- The remaining differences in State costs will still be significant, however. We will want to understand the causes of these variations in order to narrow them appropriately, and we want to move cautiously to avoid causing undue dislocations or disruptions.
- The Health Security Act charges the National Health Board (NHB) to conduct a study and make recommendations to Congress to address variations in spending across alliances. The NHB is to establish an advisory commission on regional variations in health care expenditures to examine ways of eliminating State variations attributable to practice patterns, historical reimbursement differences, and scope of benefits and coverage in State Medicaid plans.
- The NHB is to report and make recommendations to Congress by July 1995, so that the variation can be reduced by 2002 in a budget neutral manner. Congress must consider these recommendations under "base closure" rules.

ENTITLEMENT CAP

QUESTION:

The Health Security Act provides that the federal government will provide each regional alliance with payments to fund family and employer discounts under a capped entitlement. What happens when the money runs out?

ANSWER:

- o A 15 percent cushion has been built into our estimates of the costs of discounts. We believe this is more than adequate to meet unforeseen circumstance.
- o We further tested the adequacy of the cushion by assuming a major jump of 2 percent in the unemployment rate. This would increase the cost of discounts by \$4 billion, well within the safety margin we have built in to our estimates.
- o Independently, Lewin-VHI examined the costs of health care reform. Even though they assumed higher premiums than ours, they found our cost estimates to be fully adequate.
- o If, despite our best estimates and the protection built in through the cushion, funds do run out, Congress will be timely informed and appropriate recommendations made for its consideration. Congress can choose appropriate action at that time depending upon the reason that the funds became insolvent. If Congress chooses not to vote additional funds, Congress must specify how the lower budget will be met. This approach is similar to that used in Social Security. If the Social Security Trust Fund becomes insolvent, appropriate action to reconcile fund balances with spending lies within Congress' jurisdiction.

INDEPENDENT CONTRACTORS

QUESTION:

In order to prevent mischaracterization of employees as independent contractors, the Health Security Act calls for the Treasury Department to issue regulations clarifying the employment status of independent contractors for tax purposes. How will this affect independent contractors?

ANSWER:

Because employers are required to contribute part of the health insurance premium for each employee, we need rules to prevent employers from gaming the system by mischaracterizing employees as independent contractors. The Department of Treasury will publish regulations clarifying which workers qualify as independent contractors, and which are employees. We intend these rules to prevent gaming while allowing employers to maintain current business practices. We do not intend to alter employers' tax obligations.

RISK ADJUSTMENTS AND HOW THEY WORK

QUESTION:

Will premiums be risk-adjusted and how will that work? Isn't your ability to risk adjust limited?

ANSWER:

- On December 9, 1993, Alice Rosenblatt of the American Academy of Actuaries submitted testimony to the Subcommittee on Health and Environment, Committee on Energy and Commerce which stated, "An appropriate risk adjustment mechanism can be developed and implemented in the 18-month time frame stated in the President's proposal."
- The Act anticipates a short-term and a longer-term strategy to risk adjustment. In the short-term, we expect the Board to rely on a combination of mandatory reinsurance and health care status adjustments based on self-reported health status collected through surveys of plan enrollees.
- Over the longer-term, the National Health Board will develop and implement a risk adjustment methodology to be used by alliances to assure that payments to health plans reflect expected utilization of services and protect health plans that enroll a disproportionate share of higher-risk people.
- The Board must consider a number of factors in developing the risk adjustment methodology, including demographic characteristics, health status, and geographic residence.

TWO-EARNER FAMILIES

QUESTION:

Since the Health Security Act establishes a "family" premium, how is the employer payment worked out in two-earner families? Wouldn't it be easier for one employer to pay the premium?

ANSWER:

It would not be fair to have just one employer pay the premium for a two earner family under health reform. It also would require a complicated administrative system to keep track of employer obligations in cases where the working spouse who is supplying coverage stops working or changes jobs. This premium structure distributes the employer responsibility equitably across all employers in the alliance.

PREMIUM CAPS AND SUPPLEMENTAL INSURANCE

QUESTION:

Do premium caps apply to supplemental/Medigap plans? If not, isn't there an incentive for plans to raise their premiums for these supplemental benefits? Won't we end up with more cost shifting?

QUESTION:

No. The supplemental benefits market contains a number of insurers and is reasonably competitive. Many insurers specialize in supplemental benefits. Health plans that tried to shift costs to this market would not be price competitive.

DISCOUNTS FOR LOW-INCOME SELF-EMPLOYED

QUESTION:

I am self-employed but my income is fairly low. Will I be eligible for any discounts?

ANSWER:

- Self-employed persons are responsible for both the employer share and the family share of the premium.
- Employer share. The Health Security Act treats self-employed individuals just like companies that have only one worker. On the employer share of the premium, they are eligible for the same discounts as small businesses. So, a person with a payroll of less than less than \$24,000 will pay no more than 7.9 percent of payroll for premiums, and will pay a lower percentage as the payroll decreases.
- Family share. On the family share of the premium, the self-employed person is eligible for the same income-related discounts available to all families.

EMPLOYER PAYMENT OF ENTIRE PREMIUM

QUESTION:

My employer currently pays 100% of my premium. The plan states that employers must pay at least 80 percent of the weighted average premium cost for an employee. Does this mean that I will have to pick up the 20% of the average weighted premium?

ANSWER:

- The minimum contribution of all employers will be 80% of the weighted average premium in the area for each full time employee (i.e., 80% of the average premium times the number of full time employees), unless:
 - The employer is a small business and 80% of the weighted average premium exceeds the applicable cap on percent of payroll contributed for coverage. Depending on the average wage and number of FTEs, the health premium contribution of small firms are capped at between 3.5 and 7.9% of payroll.
 - Eighty percent of the weighted average premium exceed 7.9% of payroll. The 7.9% cap applies to all firms, regardless of size or average wage.
- The employer contributes a pro rated share of the 80% for part-time workers.
- However, an employer is free to pay a greater share of its employees' premiums as long as it pays the same for all workers in that class of enrollment and alliance area.
- An employer may voluntarily contribute 100% of the premium. Employers must rebate the difference between the amount of premium contributions they voluntarily make and the value of the insurance plan chosen by the employee. Rebate requirements do not apply when voluntary contributions are pursuant to a collective bargaining agreement.
- There is no change in tax preferred treatment in this regard.

TITLE VII
REVENUE PROVISIONS

CREDIBILITY GAP

QUESTION:

You claim you can raise \$20 billion in new revenue from employers as a result of lower insurance premiums. Isn't this just another example of the kind of smoke and mirrors financing that got us into so much trouble with Medicare and Medicaid?

ANSWER:

No, this is a very credible estimate. Under current law, money spent by employers on health insurance premiums for their workers is tax-exempt. Under the Health Security Act, we estimate that many employers will spend less on health coverage than they do now. As a result, they will have more money available for higher wages, investment, and higher profits. All of these items are taxable income. Thus federal tax revenue would rise by the amount we estimate. This is consistent with the estimating practices of the Joint Economic Committee.

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- However, we are adjusting these spending levels to eliminate differences in health care spending that are attributable to varying rates of health care coverage. Per capita premium limits throughout the country will reflect universal coverage, thereby eliminating some of the existing discrepancy.
- The remaining differences in State costs will still be significant, however. We will want to understand the causes of these variations in order to narrow them appropriately, and we want to move cautiously to avoid causing undue dislocations or disruptions.
- The Health Security Act charges the National Health Board (NHB) to conduct a study and make recommendations to Congress to address variations in spending across alliances. The NHB is to establish an advisory commission on regional variations in health care expenditures to examine ways of eliminating State variations attributable to practice patterns, historical reimbursement differences, and scope of benefits and coverage in State Medicaid plans.
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ANSWER:

Because employers are required to contribute part of the health insurance premium for each employee, we need rules to prevent employers from gaming the system by mischaracterizing employees as independent contractors. The Department of Treasury will publish regulations clarifying which workers qualify as independent contractors, and which are employees. We intend these rules to prevent gaming while allowing employers to maintain current business practices. We do not intend to alter employers' tax obligations.

WILL SAVINGS BE ACHIEVED IN TIME FOR IMPLEMENTATION?

QUESTION:

The President's plan requires that universal coverage be achieved by January 1, 1998. It doesn't seem possible that we will be able to achieve enough savings by this time to cover everyone, so won't we then be forced to raise taxes?

ANSWER:

- The President's plan is fully financed over the period 1995 to 2000.
- The principal sources of new revenue include premium payments by previously uninsured families and employers who did not previously offer health insurance, new tobacco taxes, assessments on corporate alliances, and Medicare and Medicaid savings.
- These sources of revenue not only fully finance the plan's new benefits but also produce approximately \$58 billion in deficit reduction over this period.
- The Lewin-VHI study essentially verifies our estimates and the soundness of the financing of our proposal. The study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000.

WILL THE SYSTEM PAY FOR ITSELF?

QUESTION:

In light of past budget estimating errors, how can we be sure the financing numbers add up?

ANSWER:

In contrast to Medicare, which, when enacted, simply added financing resources to the system, the Health Security Act makes important changes to the underlying health care system to control costs.

- o In developing estimates for financing the President's Health Security Act, economists consistently made **conservative assumptions**. For example:
 - They chose the highest of three different estimates of the national average health plan premiums.
 - They calculated the availability of discounts to firms with less than 100 employees, even though the policy only provides special protection to those with fewer than 75 employees.
 - They assumed that all dual worker families would join regional alliances, where they would potentially be eligible for government-discounted premiums, rather than joining corporate alliances, in which they would not qualify for discounts.
 - In addition, a 15 percent cushion was built into the final estimates.
- o The numbers have been subjected to a **rigorous review**:
 - A team of actuaries and economists from the National Economic Council, the Council of Economic Advisors, the Office of Management and Budget, the Departments of Health and Human Services, Treasury, and Labor, and modelers on contract have reviewed the estimates underlying the President's health reform legislation.
 - An unprecedented external review process was also undertaken. Experts from nationally recognized consulting and accounting firms and Fortune 500 companies were solicited for their advice and analysis.
- o Cost estimating capabilities have improved in the last 20 years:
 - The development of data sets on health services utilization, medical expenditures, insurance coverage, income, and experiments such as the RAND Corporation's

Health Insurance Experiment, have helped us to understand the factors that influence health care costs.

- Computer modeling techniques have advanced considerably, making it possible to produce estimates quickly and accurately.
- o Additionally, a recent study by an independent, private consulting firm, Lewin-VHI, found that the Administration's cost estimates were similar to their own.

WHAT IF SYSTEM RUNS OUT OF MONEY?

QUESTION:

Under the Health Security Act there are premium caps which are designed to slow health care spending, but what happens if the premium caps are too low and the plans run out of money?

ANSWER:

The limits on the rate of growth in health plan premiums will not cause a health plan to "run out of money." Growth rate limits will be based on an area's current cost experience. The National Health Board takes into account geographic variations in utilization rates, current costs, and administrative costs. Further, the Health Security Act does not rely on inflation limits as the primary means to control costs, it relies on competition among plans. Premium caps are a back-up mechanism.

- Plans will have incentives to reduce unnecessary services and provide services more efficiently without compromising quality. Any plan that "ration" care will lose enrollees.
- Plans will have incentives to negotiate more effectively with providers.
- Instead of hassling with providers on a claim-by-claim basis, plans will have data on provider practice patterns.

Health plans fail today, causing dislocation for patients and providers. Under the President's plan, no one loses coverage when a plan goes out of business. In addition, there are safeguards to prevent plan failure and to protect consumers and providers in the event of a plan failure.

- States certify the financial stability of each plan and each plan's capacity to deliver the comprehensive benefits package. States establish capital standards, reporting and auditing requirements, and reserve requirements for plans.
- States may require health plans to purchase reinsurance for unexpected catastrophic medical expenses.
- If a health plan fails, the alliance must ensure that the failed plan's enrollees are enrolled in another health plan.
- States establish a guaranty fund that meets federal requirements. In addition, if a health plan fails the State may impose a surcharge on other plans to cover claims against the failed plan. If a plan fails, providers' claims against the failed plan are paid first, before claims for administrative expenses and other claims. Providers may not seek payment from consumers.

EARLY RETIREES AND IMPACT ON SOCIAL SECURITY TRUST FUND

QUESTION:

Doesn't the early retiree benefit provide an incentive for people to retire early and cut short the period of time they are paying into the Social Security trust fund? Won't this threaten the viability of the trust fund?

ANSWER:

There are no good data on the extent to which people continue to work beyond the age of 55 solely or chiefly to obtain health insurance coverage. However, there are clearly some people who will retire once government subsidized health insurance is available at age 55. Because there will be some induced retirements, the American Health Security Act provides for an assessment for three years on employers of early retirees that will raise approximately \$11.4 billion dollars.

We believe, however, that early retirements stemming from the early retiree benefit provided in the Health Security Act will have essentially a nugatory impact on the Social Security Trust Fund's solvency.

TITLE VIII
HEALTH AND HEALTH-RELATED PROGRAMS
OF THE FEDERAL GOVERNMENT

UNIFORMED SERVICES HEALTH PLANS

QUESTION:

The Secretary of Defense may establish one or more Uniformed Services Health Plans for active duty service men or their spouses. Could you please explain how this works? Will these active-duty members have a choice of plans?

ANSWER:

All active duty military personnel must be in a DOD health plan. However, the Department of Defense may establish several plans from which military personnel may choose.

If a spouse of a military person works for a civilian employer, the spouse will have the choice of receiving coverage from the military plan or from the regional or corporate alliance to which their employer contributes.

VETERANS AFFAIRS

QUESTION:

Could you please explain and give examples of how veterans will be treated under the Health Security Act? Will they have choices?

ANSWER:

Veterans will have choices; indeed for many their choices will be expanded.

- o Veterans with service connected disabilities or who meet income thresholds will continue to be eligible for free care from a VA health plan. Moreover, the Department of Veterans Affairs will be given a special fund with which to improve the attractiveness of VA facilities to veterans who choose to use them.
- o In addition, all veterans can freely choose to enroll in the VA health plan, a plan through the regional alliance within whose boundaries they reside, or from their employer's Corporate Alliance if the employer has one. Veterans who decide to enroll in an alliance plan are eligible, like all others, for discounts linked to their income.

VA TRUST FUND

QUESTION:

The Health Security Act provides for a veterans health care investment fund to renovate/upgrade their hospitals. Where does this money come from?

ANSWER:

As veterans are given choice between the VA health system and Regional Alliances, the Veterans Administration requires funds to improve VA facilities to prepare for this competition.

There are specific funds included within the financing of the Health Security Act to pay for this.

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. What impact will this have on 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--WHY INCLUDED?

QUESTION:

Why include the Federal Employee Health Benefit Plan enrollees when that plan is doing so well? Why not have the FEHBP as a separate corporate Alliance? Why should federal employees be pooled with lower risk groups and face higher community rated premiums when large corporations are being allowed the option of remaining separate?

ANSWER:

Under the Health Security Act federal employees will get coverage through their alliance health plans.

- The majority of employees will be at least as well off financially as under FEHBP. Coverage will be improved by requiring that standardized benefit packages will be available to all Federal employees. In the past, FEHBP has suffered from risk segmentation among different plans because of uneven benefits.
- Federal employees will benefit from increased federal payments on the employees' behalf. Using the current formula for the federal employer contribution, the average government contribution is now 73 percent with a maximum of 75 percent of any plan premium. Under the Alliances, the Federal government will pay eighty percent of the average premium. That could amount to the entire cost of a low cost plan in an Alliance.
- By virtue of joining an alliance, government employees will be protected from arbitrary cuts in their health benefits in the political process.
- Some Federal employees may have to pay more because the premium will be higher in a particular regional alliance than it is currently in the Federal employees program. The twenty percent family share of a higher premium could represent an increased payment. However, the cost for some federal employees could go down in other alliances.
- Overall, we expect that access to a standardized benefit package, an increase in the employer contribution, and added insulation from the political process will benefit Federal employees.

Revised 1/12/94

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.

MEMBERS OF CONGRESS/TEMPORARY RESIDENCES

QUESTION:

Will Members of Congress have special privileges under the new system? What will happen to people (Like Members of Congress) whose residence is in their home state, but temporarily live in the other area? In what regional alliance will they enroll?

ANSWER:

- Members of Congress will be treated like everyone else in the system.
- The Health Security Act allows for short term (3-6 months) residents of an area to choose among the following options:
 - Continue coverage through the health plan in which they are enrolled at their permanent place of residence. In this case, coverage for care in the area of temporary residence may be limited to emergency services and urgent care.
 - Register with the regional alliance in the area of temporary residence (in a Member's case, the District of Columbia alliance), and choose a health plan in that alliance.
 - Change enrollment in the home state alliance area to enrollment in a health plan which provides for coverage on a fee-for-service basis for services provided outside of the home state alliance area.
- States may allow or require alliances to coordinate activities, including adoption of joint operating rules, contracting with health plans, enforcement activities, and establishment of fee schedules. Assuming that such arrangements are beneficial, coordination of activities between home state alliances and the District's regional alliance will assure that Members of Congress are able to receive the health services they require in both locations.

INDIAN HEALTH SERVICE

QUESTION:

How will people currently enrolled in Indian Health Service programs receive services? Will they have a choice under the plan? Could you please give some examples.

ANSWER:

The Health Security Act significantly enhances the choice available to IHS beneficiaries. They may remain within the IHS health care service system or elect to join an alliance-sponsored plan.

- Current IHS program enrollees wishing to continue to receive services from the IHS will face no change. They will continue to go to IHS facilities for their care without charge, premium, deductible, or copayments for any of the health services they receive. The IHS will continue to provide the supplemental services now provided beyond the basic benefit package. If IHS facilities cannot provide the specific needed service the patient can continue to receive care under the contract health care provisions of IHS without charge.
- Alternatively, any individual now eligible for IHS may choose instead to join a non-IHS plan through the health alliance. In this case, the individual will be treated the same as any other citizen, becoming responsible for the individual portion of the plan's premium and co-payments but eligible, too, for appropriate deductions based on income. The costs of these deductions, however, are not borne by the IHS.

TITLE IX

AGGREGATE GOVERNMENT PAYMENTS TO REGIONAL ALLIANCES

ALLIANCES - LOANS FOR FUNDING SHORTFALLS

QUESTION:

According to the plan, the Federal Government will have the authority to make loans to regional alliances to cover temporary cash flow shortfalls. Aren't these a potentially unlimited draw on federal dollars?

ANSWER:

No.

- o Section 9201 of the Health Security Act establishes authority to make temporary loans to alliances that experience cash shortfalls for any of three specified reasons:
 - 1) estimation errors;
 - 2) administrative errors; and
 - 3) timing discrepancies.
- o In each case the loan must be repaid within two years. If there has been an administrative error, the state's maintenance of effort payments increase to repay the loan. Other loans are repaid by reducing federal payments to the alliance in subsequent periods.
- o In total, the sum of any and all such loans to alliances may not exceed \$3.5 billion, and the loan to any single alliance may not exceed 25 percent of its actual premiums for the previous year.

TITLE X

**COORDINATION OF MEDICAL PORTION
OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE**

INTEGRATION OF WORKERS COMPENSATION AND AUTO INSURANCE

QUESTION:

Could you please explain how the plan will integrate workers' compensation and automobile insurance within alliances? Won't employers see savings from this integration?

ANSWER:

The Health Security Act integrates workers compensation medical benefits into the reformed health care system in two steps.

The first step integrates the delivery systems. Injured workers receive medical services through their health plans, which must demonstrate their capacity to treat work-related illnesses and injuries and meet new standards for quality and efficiency. Current workers compensation carriers retain the financial responsibility to reimburse health plans for the services they provide to injured workers. The costs remains 100% financed by employers.

The second step develops a detailed strategy for more complete integration of the financing of workers compensation medical benefits into the reformed health care system. A Commission on the Integration of Health Benefits is created and tasked with the responsibility of developing an integration strategy by June, 1995.

The Act has a number of advantages for workers and employers, including premium savings.

- Workers will be able to go to their health plans for all of their medical care.
- Medical services provided to injured workers will be subject to the same standards and oversight for quality of care as other medical services delivered by health plans.
- Workers compensation medical costs will be reduced in the short-run because:
 - The growth of fees for workers compensation medical services will be constrained by the alliance fee schedules, which are constrained by the rate of growth permitted under the premium caps.
 - Fraud and excessive utilization will be reduced because services will be provided through certified health plans and be monitored through the quality management program.
 - Experiments with capitated payments for workers compensation medical services will reduce current

costs and pave the way for full capitation of health plans for work-related medical benefits.

-- The Departments of Labor and Health and Human Services will develop protocols for the efficient treatment of common or costly work-related injuries and illnesses.

○ Costs will be further reduced in the longer-run if the financing of the two systems can be integrated.

OTHER BILLS

WHY NOT AN APPROACH LIKE THE COOPER BILL

QUESTION: Representative Cooper's health reform proposal includes purchasing cooperatives, but without the heavy-handed mandates included in the President's bill. Why not adopt this approach?

ANSWER:

The Cooper bill, and any bill without a mandate, does not achieve universal coverage. Universal coverage is not only a matter of fairness and security. Effective cost containment cannot be achieved without universal access. Absent universal coverage:

- cost-shifting to payers outside the system will continue.
- individuals who cannot purchase coverage will still require health care, necessitating funding for providers of last resort and placing a continued burden on the public and private providers who treat the uninsured.
- the cost-saving aspects of improved competition between health plans will be significantly diluted.
- cooperatives represent fewer consumers, so their market power to negotiate efficient contracts is limited. The Cooper bill compounds this problems by limiting the number of consumers who can purchase through the cooperative.

The Cooper bill includes no backup budget or other means of ensuring reductions in national health expenditures. If the voluntary purchasing cooperatives do not reduce the growth in health care costs, there is no back-up cost reduction system.

The Cooper bill approach leaves insurance market reform incomplete:

- Because the number of persons who can purchase through a cooperative is limited and there is no mandate to join a certified health plan, insurers remain free to stay outside the system and continue the risk selection practices they employ today.
- The bill allows a six month waiting period for treatment of preexisting conditions for the newly insured.

So-called "guaranteed access" is not enough. If insurers remain free to price high-risk persons out of the market, we will be left with the problems we have today: a large uninsured population, runaway costs, market segmentation and no guarantee of security for those who are covered.

WHY NOT AN APPROACH LIKE THE CHAFEE BILL

QUESTION: Senator Chafee's health reform proposal achieves universal coverage, but without an employer mandate. Why not adopt this approach?

ANSWER:

Individual mandates alone are unlikely to work.

Where 100% of financing comes from an individual mandate, enforcement requires heavy handed government oversight and intervention, to which the President is opposed.

An employer mandate builds on the system which today provides coverage to millions of people; reliance solely on an individual mandate would undermine existing employer contributions to health coverage.

- Collection of employers' contributions involves lower administrative costs than collection of individuals' contributions.

- We agree that individual responsibility is important. That is why the President's bill includes both an employer and an individual mandate; everyone contributes something.

The President's system is designed to achieve a fair sharing of costs. Everyone pays something, but the small employer and individual discounts, and employer premium caps, ensures that no one pays more than their fair share.

In addition, the Chafee bill calls for small, voluntary purchasing cooperatives. See Answer to "Why Not An Approach Like the Cooper Bill" for why these do not accomplish our goals.