SUMMARY OF PROVIDER SPONSORED ORGANIZATION PROVISIONS IN DASCHLE/ADMINISTRATION BILL

- **ELIGIBLE ORGANIZATION**. Provider Sponsored Organizations (PSOs) would be a new type of managed care plan eligible to enroll Medicare beneficiaries.

- **DIRECT PROVISION OF SERVICES**. PSOs would be defined as a health care provider or a group of affiliated health care providers (including one or more hospitals) that provide at least a substantial proportion of Medicare covered services directly. At a minimum, PSOs would provide physician and hospital services.

Who is this?

- **FISCAL SOUNDNESS AND PROVISIONS AGAINST INSOLVENCY**. As with all eligible organizations, PSOs would be required to meet requirements for fiscal soundness and provisions against insolvency established by the Secretary. However, there would be special fiscal soundness and solvency standards for PSOs.

- **PRE-EMPTION OF STATE LAW**. Prior to approval of a state's certification and monitoring program (see below), the Medicare program would not require PSOs to be state licensed in order to obtain a Medicare contract. However, if a state required that the PSO obtain a license in order to contract with Medicare, the State could not impose any requirements different from Medicare's contracting requirements. Once the state has a certification and monitoring program approved by the Secretary, the PSO would be required to obtain a license from the State.

Don't track conflict

- **DEVELOPMENT OF STANDARDS**. Federal standards for certification of health plans (including special fiscal soundness and solvency standards for PSOs) and for monitoring and enforcement would be developed in consultation with appropriate parties and would be promulgated as interim final rules by January 1, 1997.

Lake std setting in Conf. & Coalition -- spell out criteria

- **PRIVATE ENROLLMENT**. Like other eligible organizations, PSOs would have to meet 50/50 and minimum private enrollment requirements (5000 enrollees for urban areas and 1500 enrollees for rural areas). However, in meeting these requirements, PSOs could "count" as enrollees individuals for whom they are at substantial financial risk. In addition, the Secretary would have broad authority to waive both requirements based on criteria that the Secretary would develop.

Need federal quality stds bec. I stop shopping.

2 issues
1. provider v. entity
2. substantial risk

- **POS OPTION**. PSOs would be prohibited from offering enrollees a point-of-service (POS) option to Medicare enrollees.

Feds do this until states are deemed in 2000.

- **CERTIFICATION AND MONITORING**. Until 1999, the Medicare certification and monitoring standards for eligible organizations (including PSOs) would be federal standards, administered by approved States or by the Secretary of HHS. The Secretary would approve State certification and monitoring programs if (1) the State's standards are substantially equivalent to Federal standards; (2) the State has the ability and sufficient resources to carry out the certification function; and (3) the State has the ability and

or same?

Blue Dogs - identical for solvency
- Subst. equiv. for non-solvency

sufficient resources to carry out the monitoring function. For plans in States that have not been approved, the certification and monitoring process would continue to be conducted by the Secretary of HHS.

Beginning in 1999, States could impose more stringent requirements on Medicare health plans (including PSOs), as long as these requirements would be imposed on all health plans in a non-discriminatory manner. States would be required to obtain Secretarial approval before imposing more stringent standards on plans.

G:\MEDPARTB\DRAFT\DASCHLE.SUM
January 23, 1996

THE WHITE HOUSE

WASHINGTON

OFFICE OF THE FIRST LADY

TO Bob Potter

FROM Jennifer Klein

FAX # 514-9082

PHONE #

OF PAGES (including cover)

COMMENTS Attached please find the language on provider ~~sponsored~~ sponsored organizations for your review.

services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

"(d) PREFERRED PROVIDER ORGANIZATION (PPO).—

"(1) IN GENERAL.—For purposes of this part, the term 'preferred provider organization' means an entity that meets the following requirements:

"(A) MINIMUM SERVICES TO ALL MEMBERS.—The entity provides at least physicians' services performed by physicians (as defined in section 1861(r)(1)).

"(B) PROVISION OF PHYSICIAN SERVICES; FISCAL SOUNDNESS.—The entity meets the requirements of subparagraphs (B) and (E) of subsection (c)(1).

"(C) ASSUMPTION OF RISK.—The entity meets the requirements of subsection (c)(1)(D) with respect to members enrolled with the organization under this part.

"(2) DETERMINATION OF PRIVATE MEMBERSHIP.—In applying the provisions of sections 1851E(g) and 1851F(e)(1)(B)(i) and (f)(1)(B)(i) (concerning minimum private enrollment) to an organization that meets the requirements of paragraph (1), individuals for whom the organization has assumed substantial financial risk shall be considered to be members of the organization.

"(e) PROVIDER SPONSORED ORGANIZATION (PSO).—

"(1) IN GENERAL.—For purposes of this part, the term 'provider sponsored organization' means an entity that meets the following requirements:

"(A) TYPE OF ENTITY.—The entity is a hospital, a group of affiliated hospitals, or an affiliated group consisting of a hospital or hospitals and physicians (as defined in section 1861(r)(1)).

"(B) MINIMUM SERVICES TO ALL MEMBERS.—The entity provides at least physicians' services performed by physicians (as defined in section 1861(r)(1)) and inpatient hospital services.

"(C) DIRECT PROVISION OF SERVICES.—The entity provides directly a substantial portion of the services covered under this title (as determined by the Secretary, which may vary for rural or under served areas).

"(D) ASSUMPTION OF RISK.—The entity meets the requirements of subsection (c)(1)(D) with respect to members enrolled with the organization under this part.

"(E) FISCAL SOUNDNESS; PROVISION AGAINST INSOLVENCY.—The entity meets requirements for fiscal soundness and provision against insolvency developed by the Secretary.

"(2) DETERMINATION OF PRIVATE MEMBERSHIP.—In applying the provisions of sections 1851E(g) and 1851F(e)(1)(B)(i) and (f)(1)(B)(i) (concerning minimum private enrollment) to an organization that meets the requirements of paragraph (1), individuals for whom the organization has assumed

substantial financial risk shall be considered to be members of the organization.

"(3) LIMITED PREEMPTION OF STATE LAW.—Except as otherwise provided in the next sentence, an organization that meets the requirements of paragraph (1) may provide health benefits to individuals enrolled with the organization under this part without regard to any State law that imposes requirements different from those under paragraph (1)(E)) (concerning fiscal soundness and provision against insolvency), or that imposes requirements (in other respects) that differ from those imposed on other organizations which provide health care benefits only through (or preferentially through) certain entities. If the Secretary determines that a State has licensing standards which are substantially equivalent to the requirements of such paragraph (1)(E), that the State has a process for issuing licenses on a timely basis, and that the State does not impose requirements (in other respects) that differ from those imposed on other organizations which provide health care benefits only through (or preferentially through) certain entities, the Secretary shall require the organization to obtain a license from the State.

"SEC. 1851B. ENROLLMENT AND DISENROLLMENT.

"(a) IN GENERAL.—

"(1) SECRETARY'S RESPONSIBILITY.—The Secretary shall carry out enrollment and termination of enrollment of individuals with eligible organizations.

"(2) INDIVIDUAL OPTIONS.—An individual may, as prescribed by regulations—

"(A) enroll under this part with an eligible organization; and

"(B) terminate enrollment with such organization—

"(i) as of the beginning of the first calendar month following the date on which the request is made for such termination;

"(ii) as of the date determined in accordance with regulations, in the case of financial insolvency of the organization; and

"(iii) retroactively to the date of enrollment, in such special circumstances as the Secretary may designate.

"(b) INFORMATION CONCERNING ENROLLMENT.—

"(1) STANDARDIZED COMPARATIVE MATERIALS.—The Secretary shall develop and distribute standardized comparative materials about eligible organizations and medicare supplemental policies (as defined in section 1882(g)(1)) to enable individuals to compare benefits, costs, and quality indicators.

"(2) COST-SHARING BY PARTICIPATING ORGANIZATIONS.—Each eligible organization with a contract under this part shall

pay the Secretary for its pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out the requirements of the preceding sentence, the first sentence of subsection (a)(1), and section 4360 of the Omnibus Reconciliation Act of 1990. Those payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

"(2) REVIEW OF MARKETING MATERIALS.—The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may furnish information about the organization to enrollees and individuals eligible to enroll under this part. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) such individuals unless at least 45 days before its distribution, the organization has submitted the material to the Secretary for review, and the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(c) PERIODS OF ENROLLMENT.—

"(1) STANDARD ENROLLMENT OPPORTUNITIES.—Subject to the provisions of this section, an organization with a contract under this part shall permit enrollment under this part by any individual—

"(A) during the month of each year specified by the Secretary for all eligible organizations;

"(B) during the individual's initial enrollment period in the program under part B (as described in section 1837(d));

"(C) during a special enrollment period in the program under part B (for individuals formerly electing employment-based coverage) described in section 1837(i)(3); and

"(D) during the 90-day period beginning 30 days before the date the individual takes up residence in the service area of the organization.

"(2) SPECIAL ENROLLMENT PERIOD FOR INDIVIDUALS LOSING COVERAGE BY ANOTHER ORGANIZATION.—

"(A) IN GENERAL.—Subject to other provisions of this section, if a contract with an organization under this part is not renewed or otherwise terminated, or is renewed in a manner that discontinues coverage for individuals residing in part of the service area, each other organization with a contract under this part shall permit enrollment under this part by affected individuals enrolled with such other organization on

the effective date of such termination or discontinuation of coverage.

"(B) ENROLLMENT PERIOD.—The enrollment period required by subparagraph (A) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

"(2) ACCEPTANCE OR DENIAL OF APPLICATION.—An eligible organization shall enroll individuals under this part in the order of application, and may deny enrollment of such an individual only if the enrollment—

"(A) would exceed the limits of the organization's capacity (as determined by the Secretary);

"(B) would result in an enrolled population substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization; or

"(C) would result in the organization's failing to meet the requirements of sections 1851E(g) and 1851F(e)(1)(B((i) and (f)(1)(B)(i) (concerning minimum private enrollment).

"(3) EFFECTIVE DATE OF ENROLLMENT.—An individual's enrollment with an eligible organization under this part shall be effective—

"(3) shall notify each such individual of the requirements of paragraph (1) at the time of the individual's enrollment.

"SEC. 1851C. BENEFITS.

"(a) BASIC BENEFITS.—

"(1) IN GENERAL.—An eligible organization must provide to members enrolled under this part, either directly or through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(A) services covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

"(B) services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization.

"(2) PPO REQUIRED TO AFFORD "POINT OF SERVICE" OPTION.—An eligible organization that contracts as a preferred provider organization under this part, in addition to providing services in accordance with paragraph (1), shall also pay for any service furnished to a member enrolled under this part (in the amounts, if any, that otherwise would be paid under this title) by any entity that may furnish that service under this title (other than an entity through which the organization provides services, or other than a service with respect to which the organization

"(A) in the case of an enrollment under paragraph (1)(A), on the first day of the third month beginning after the end of the enrollment period;

"(B) in the case of an enrollment under paragraph (1)(B), as specified by section 1838(a);

"(C) in the case of an enrollment under paragraph (1)(C), as specified by section 1838(e);

"(D) in the case of an enrollment under paragraph (1)(D), on the first day of the first month following the month in which the individual enrolled; and

"(E) in the case of an enrollment under paragraph (2), 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

"(d) ENROLLMENT OR TERMINATION FOR HEALTH REASONS PROHIBITED.—An eligible organization—

"(1) shall not refuse to enroll, and shall not expel or refuse to re-enroll, any individual eligible to enroll or enrolled with the organization under this part because of the individual's health status or requirements for health care services;

"(2) shall include in any marketing materials a statement of the requirements of paragraph (1); and

is required to provide for reimbursement under subsection (h)(2) (concerning urgently needed services provided outside the organization).

"(3) PSO PROHIBITED FROM AFFORDING "POINT OF SERVICE" OPTION.—An eligible organization that contracts as a provider sponsored organization under this part may not pay for any service described in subsection (d) that is furnished to a member enrolled under this part.

"(b) ADDITIONAL BENEFITS OR OTHER ADJUSTMENT UNDER RISK PLANS.—

"(1) REQUIREMENT WHERE ADJUSTED COMMUNITY RATES BELOW PAYMENT RATES.—Each contract under section 1851F(e) shall provide for adjustment in accordance with this subsection, if—

"(A) the adjusted community rate for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this part with the organization and entitled to benefits under part A and enrolled in part B, or

"(B) the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this part with the organization and entitled to benefits under part B only

Main Justice Building
10th & Constitution Ave., NW
Washington, DC 20530

Date: 12/5/95

FACSIMILE TRANSMISSION

TO: Jennifer Klein

Telephone: 456-2511 Fax: 456-2878

FROM: Robert A. Potter
Chief
Legal Policy Section
Telephone: (202) 514-2512 Fax: (202) 514-9082

COMMENTS: Jennifer,

Please give me a call regarding the enclosed.

Thanks,

Bob

TOTAL NUMBER OF PAGES BEING TRANSMITTED, EXCLUDING COVER: 4

1101 Vermont Avenue, NW 202 789-7400
Washington, DC 20005

December 1, 1995

The Honorable Anne K. Bingaman
Assistant Attorney General
Antitrust Division
Department of Justice
10th and Constitution Avenue, NW - Room 3109
Washington, DC 20530

Dear Anne:

The participation by the Department of Justice in the campaign to oppose modest antitrust relief for provider sponsored networks, are in conflict with President Clinton's views on the subject. The President has stated his strong support for antitrust relief on multiple occasions.

In response to a question on the need for antitrust relief on November 13, 1995, President Clinton said:

> ...."**I do believe this is one area where we can reach agreement with the Congress. I have long advocated changes in the present law which would permit doctors and hospitals to have the flexibility they need to establish their managed care networks and to provide the most cost-effective direct way to provide these kinds of services to patients. So I do think that in the end, we might be able to get some very good legislation on that, and I am encouraged by that. I do think that we'll have broad agreement on that.**"

Attached is the official transcript issued by the White House Press Secretary.

This is by no means the first time President Clinton has articulated Administration policy supporting antitrust relief. During a satellite teleconference with the California Medical Association on March 23, 1994, President Clinton said:

> ..."**I agree that there must be some changes in the antitrust law so you can clearly get together without fear of legal repercussions. Otherwise, you are cosigned to dealing with a middleman that will only add to the cost of you providing your services and undermine the choice that the consumer gets.**"

The antitrust provisions for Medicare provider sponsored networks will expand patient choices and offer better value. Insurance market analysts have found that HMO

premiums continue to rise despite steady reductions in the share of revenues devoted to patient care. The most successful HMOs spend less than 70% of revenue on patient care. As President Clinton has stated, provider sponsored networks hold great promise for eliminating the insurance middleman and devoting a higher percentage of the premium dollar to patient care. The enclosed paper by Clark Havighurst supports the President's view. Continued application of the per se rule will stifle development of provider sponsored networks. The Department of Justice and the Federal Trade Commission would retain ample authority with the proposed change to rule of reason analysis.

In view of the President's clearly articulated views on the need for antitrust relief, we ask that you recontact Members of Congress and advise them that President Clinton supports antitrust relief to facilitate the development of provider sponsored networks. This is such a high priority for physicians that a similar request has been made to President Clinton (letter enclosed).

Sincerely,

Kirk B. Johnson

Kirk B. Johnson, JD

Enclosures

bcc: Bob Potter

DRAFT

Kirk B. Johnson, Esq.
American Medical Association
1101 Vermont Avenue, N.W.
Washington, DC 20005

Dear Kirk:

Thank you for your letter of December 1, 1995 on antitrust issues in health care reform.

As you know through your participation in numerous meetings with me and our work on the Health Care Enforcement Policy Statements, it is crucial to holding down health care costs for competition to be preserved in the health care industry. The President shares this goal with me.

We became aware through our outreach efforts to the health care industry, that a number of industry participants incorrectly believed that the antitrust laws prevented the formation of efficient networks. As a result, the Department of Justice and the Federal Trade Commission determined to take action to correct that misconception.

We have, through our efforts, including meetings with you and other representatives of the AMA, issued two sets of health care policy statements, the only industry specific statements of their kind, which educate physicians about the options they have, within the current antitrust laws to form physician owned and operated networks. Also, both we and the Federal Trade Commission have issued numerous business review and advisory opinion letters approving proposed physician network joint ventures. Consequently, and as the nonpartisan Congressionally-created Physician Payment Review Commission concluded, current laws and enforcement policies have not deterred the formation of provider networks. The PPRC found no compelling reason for creating exemptions from the antitrust laws for such networks.

The antitrust laws do not pick and choose between and among competitive marketplace entities as long as all adhere to the antitrust laws. Physician networks can and do form under current law and the President and I welcome these competitive options for consumers. They indeed may hold the prospect of offering decreased costs or better service to consumers.

However, your desire to change the antitrust laws to eliminate the incentives for a physician network to hold down costs and provide better services is inconsistent with the thrust of any appropriate health care reform. It likely would result in increased costs to consumers, not lower costs. As a result, we opposed the proposals you offered to reform the antitrust laws in the recent Medicare debate. I have attached the letters written in opposition to these unjustified proposals, so you can see what our specific concerns with your proposals were.

We remain committed to working with you to ensure that appropriately structured physician networks continue to provide consumers competitive options. However, we also remain committed to opposing unjustified antitrust exemptions which will increase health care costs for consumers.

Sincerely,

Anne K. Bingaman

Encs.

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