May 15, 1994

To: Mike O'Grady
Fr: Mary Beth Fiske
Re: Benefits - Another Question !!!

Home Health and Extended Care

Why does it cost us anything to cover these services after an illness, injury, disorder or other health condition? The limiting factor should be the fact that these services are provided only as an alternative to hospitalization. So we should actually save money on this or at least break even since people with congenital conditions would otherwise remain in the hospital at a greater cost without this change.

Has the base issue been clarified yet?

cc: Ed Hustead

cc: Jennifer Klein - White House

456 2878

Section 1114

STDs

.7 = .5 → men .2 → women

Amend section 1114 in appropriate subsections to cover all STD screenings (separate estimates for men and women). -- Annual screening for sexually transmitted diseases for sexually active persons, voluntary HIV screening and counseling. As far as I know, we have only given this as a single estimate.

1% or .11%

Family planning services - Amend Section 1116 to be clear that drugs and counseling are part of the covered services. Also clarify that no co-payments would be required for family planning services. **As amended the section should read:**

Wait on this for clarification

The services described in this section are the following items and services:

(1) Voluntary comprehensive family planning services, including family planning counseling and education

Don't you want ... ?

(2) Contraceptive drugs and prescription devices, subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act.

(3) Services for pregnant women

... over ... benefit ... over ... them.

Section 1122

Outpatient Prescription Drugs and Biologics

(a) (pp. 67-69) inserting after page 68, line 21 of S1757, the following:

Syringes → no cost .01%

"(3) Accesories and supplies that are used directly with drugs or biologics to achieve the therapeutic benefits of such drugs or biologics."

Other Sections:

.05%

PKU - Amend Section _____ to clarify that certain medical foods (protein-modified products) essential to people with inborn errors of metablism are covered (as drugs or medical foods?).

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

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

Date:

From: Sharman Stephens To: Jennifer Klein

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

Number of Pages (Including Cover): 8

Comments: metabolic foods

NOTE TO JENNIFER KLEIN, KEN THORPE, ROSE CHU

Medical Foods and Insurance Coverage

- The primary inherited metabolic disorders are:
  - PKU - 1 / 10,000 to 1 / 25,000 live births (1990 CORN data is 1:13,000)*
  - Galactosemia - 1 / 42,000 LB (1990 CORN data)* to 1 in 80,000
  - Tyrosinemia - 1 / 20,000 to 1 / 160,000 (CORN data)* LB
  - Glutaric Acidemia - 1 / 30,000 [in Sweden] LB*
  - Homocystinuria - 1 / 50,000 to 1 / 155,000 LB (latter is 1990 CORN data)*
  - Biotinidase - 1 / 61,000 to 72,000 (1990 data from 14 states' screening progs.)*
  - Maple Syrup Urine Disease - 1 / 250,000 to 1 / 300,000 LB*
  - Methylmalonic Aciduria - 1 / 20,000 to 1 / 50,000 (1990 CORN data)* LB
- Using numbers provided by Holly Wolf (attached) there are between 972 and 1,389 live births each year with one of these conditions.
- PKU has been estimated to make up 1/4 of all inborn errors and has a patient population of about 15,000.
- PKU treatment programs are now recommending keeping children/adults with inherited metabolic disorders be kept on supplemental diets for LIFE.
- Medical foods or formulas are usually used to provide supplemental calories and nutrients to make up for the often very restrictive diets that these patients must follow in order to ensure that children grow and thrive.
- 1988 survey of state treatment programs for PKU and selected other inherited metabolic diseases showed:
  - family health insurance has grown as a source of coverage for families from 37% in 1982 to 56% in 1988;
  - discussions with treatment program staff in California reveal that they are usually able to get insurance coverage for formulas;
  - State health departments' children with special health care needs programs (Title V programs) also cover formula for lower income children, or when insurance denies.
- At least 14 States have mandated coverage for PKU. All of these include coverage of the medical food in their mandate.
- Attached are data from both Holly Wolf (PKU Network) and an analysis by one of the companies that produces these medical foods. It is not clear how accurate either of these estimates are but they should provide a range for estimation. The numbers provided by SHS are wholesale and could include a 10% to 150% markup for a retail price.

Children's PKU Network

10515 Vista Sorrento Pkwy.
San Diego, California 92121
Phone (619) 587-9421
Fax (619) 450-5034

Holly Howard Wolf
Founder and President

FAX TRANSMITTAL

To: Asst. Secretary of Health Office — From: Holly H. Wolf

Reference: Medical Food Tvtmt. Cost

Attn: Dr. Lisa Simpson, Senior Hlth Policy Analyst — Date: April 15, 1994

Time:

Fax: (202) 690 5432 — # of Pages Sent: 5

Remarks:

Dear Dr. Simpson:

It was a pleasure speaking with you yesterday. I apologize for the delay.

First of next week I can supply you with additional information as needed. Please contact Bobby Silverstein of Senator Tom Harkin's office and Bill Schultz of Congressman Waxman's as well as Faye Drummond of Senate Finance Committee. I think this would be a prudent thing to keep all abreast of activities.

Look forward to working with you.

Sincerely,

Holly H. Wolf
President, Founder

P.S. I failed to include Dr. Duna and Dr. Marty Seig- both staff on Labor, Human Resources Committee

Children's KU Network

A non-profit organization

10515 Vista Sorrento Pkwy.
San Diego, California 92121
Phone (619) 587-9421
Fax (619) 450-5034

April 14, 1994

To Whom It May Concern:

The following schedule lists some of the inborn errors of metabolism which are medically dependent upon medical foods for their optimum health and survival. Incidence of these diseases are generally low, ranging from 1 per 300,000 live births for maple syrup urine disease to 1 per 10-25,000 with phenylketonuria. Incidence and cost of treatment for a 40 year life span is included. Children and adults with these diseases cannot metabolize one or more amino acids, the building blocks of proteins. Untreated, these inherited diseases can lead to untimely death, dementia, and institutionalization costing society in excess of $3,000,000 per affected over a lifetime.

These medical formulas provide up to 70% of the required nutriture for affected individuals, without treatment serious consequences will ensue. The modified phenylalanine product cost, which are supplemental to PKU's medical dietary treatment are included, however they are pending under F.D.A. review process for consideration as a medical food. Costs are based on 40% markup of wholesale prices of commercially available formulas.

These numbers are only estimates and should be regarded as such. For further questions, please do not hesitate to contact me at (619) 587-9421.

Sincerely,

Holly Howard Wolf
President

SUMMARY OF SELECTED INBORN ERRORS OF METABOLISM

DISORDER	ANNUAL INCIDENCE
INBORN ERRORS OF AMINO ACID METABOLISM	
Glutaric aciduria, type I (glutaryl-CoA dehydrogenase)	135 live births
Glutaric aciduria, type II (electron transfer flavoprotein or electron transfer flavoprotein ubiquinone oxidoreductase)	Unknown (rare)
Homocystinuria, nonresponsive	27-81 live births
3-Hydroxy-3-methylglutaric aciduria (3-hydroxy-3-methylglutaryl-CoA lyase)	Unknown (rare)
Isovaleric acidemia (isovaleryl-CoA dehydrogenase)	Unknown (rare)
Maple syrup urine disease branched- chain ketoacid dehydrogenase complex)	14-41 live births
3-Methylcrotonyl-glycinuria (3-methylcrotonyl-CoA carboxylase)	Unknown (rare)
3-Methylglutaconic aciduria (3-methylglutaconyl-CoA hydratase)	Unknown (rare)
Methylmalonic acidemia (cobalamin reductase; adenosyltransferase)	Unknown (rare)
Methylmalonic aciduria (methylmalonyl-CoA mutase or mutase)	203 live births
Phenylketonuria (PKU) (phenylalanine hydroxylase)	162-405 live births

cont. pg 2

PKU because of tetrahydrobiopterin deficiency (guanosine triphosphate cyclo-hydrolase;6-pyruvoyl-tetrahydrobiopterin synthetase;dihydropteridine reductase)	16-41 live births
Propionic acidemia (propionyl-CoA Carboxylase)	Unknown (rare)
Tyrosinemia type I (fumarylacetoacetate hydrolyase)	203 live births
Tyrosinemia type II (tyrosine aminotransferase)	Unknown (rare)

INBORN ERRORS OF CAROBHYDRATE METABOLISM

Pyruvate dehydrogenase E1a or E1b	< 16 live births

INBORN ERRORS OF MINERAL AND VITAMIN METABOLISM

Hypercalcemia (Williams syndrome) idiopathic infantile hypercalcemia; carbonic anhydrase II deficiency	Unknown (rare)

INBORN ERRORS OF NITROGEN METABOLISM

N-Acetylglutamate synthetase deficiency	Unknown (rare)
Argininemia (arginase deficiency)	< 32 live births
Argininosuccinic aciduria (argininosuccinate lyase)	41-58 live births
Carbamyl phosphate synthetase deficiency	41-58 live births
Citrullinemia (argininosuccinate synthetase)	41-58 live births
Ornithine transcarbamylase deficiency	41-58 live births

‹dical : for	Additional cost of modified low phenylalanine dietary products per year per person	Total annual cost of **low phenylalanine dietary products for all U.S. individuals with disease	Total annual medical food treatment and low phenyl-alanine dietary product cost over 40 year life span
	$2700	$17,496,000- $43,740,000	$46,656,000- 134,865,000
			$74,256,000- 196,465,000 ($74 million - $196 million)

193 and "Summary of
Selected Inborn Errors

through August, 1993.
)50,000

Inc. cost comp

Disease	Number of live births in U.S. with disease(a)	Number of individuals in U.S. with disease assuming 40 year life span	*Medical food treatment cost per person per year over a 40 year life span(b)	Medical food treatment cost in dollars per individual over 40 year life span	National annual food treatment c all individuals w disease
Phenylketonuria(PKU)	162-405	6480-16,200			
female	est.		$4500-5000	$180,000-200,000	$29,160,000-
male			$5000-5625	$200,000-225,000	91,125,000
Glutaric Aciduria	135	5,400			
female			$4750-7500	$190,000-300,000	$25,650,000-
male			$5625-8750	$225,000-350,000	47,250,000
Maple Syrup Urine Disease	13-41	520-1640			
female			$3750-7500	$150,000-300,000	$1,950,000-
male			$4500-8750	$180,000-350,000	14,350,000
Methylmalonic acidemia/ propionic acidemia	Unknown				
female			$3500-7500	$140,000-300,000	Unknown
male			$4250-8750	$170,000-350,000	
Homocystinuria/ Hypermethioninemia	Unknown				
female			$3500-7500	$140,000-300,000	Unknown
male			$4000-8750	$160,000-350,000	
					$56,760,000- 152,725,000 ($56.7 million- $152.7 million)

*Medical Foods- prescribed by a physician, these are commercially designed complete elemental ingredients specifically for the treatment of inborn errors of metabolism.

**Low phenylalanine dietary products -these modified products are supplemental to the medical dietary treatment and are recommended by a physician.

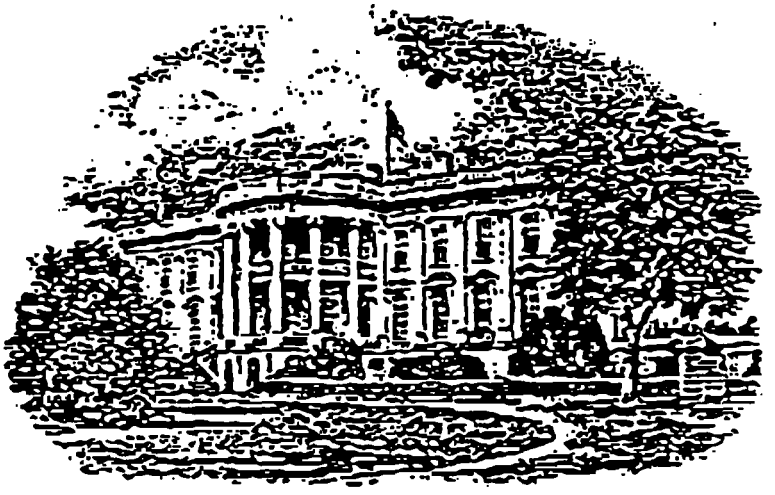
(a)Based upon census bureau estimates of total live births fo
Selected Inborn Errors of Metabolism" from *A Practioner's Guid*
of Metabolism, 1992 Ross Laboratories
1993 total live births were estimated at 2,700,000 for the eight mo
This estimate is extrapolated to estimate total 1993 live births

(b) Cost estimates extrapolated from Scie Hospital Supp
report.

DATE: 4/21
TIME: 10:30 am

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Jennifer Kline

PHONE: ( ) 456 -2599

FAX: ( ) 456 ~~2599~~ 2878

FROM: Chris Jennings

PHONE: (202) 456- 5560

PAGES FOLLOWING COVER SHEET: 7

To: Jennifer Kline

From: Chris Jennings

Date: April 21, 1994

Here you go Jen. As you will note, the difference of savings between model 1 and model 2 is $50 billion over ten years-all of which is directly attributed to a 5% reduction in premiums. Please note however that one, the numbers are preliminary and two, John Hilley down sized the numbers in order to get Mitchell some room for last minute negotiations. Since this was given to them at the retreat, we will keep it consistent. If you have any questions, please page me at 668-2764.

Presentation of 4 Illustrative Models

- Now that we've gone through some of the pieces in the Health Security Act, I'm going to walk you through three models which illustrate how modifications to the HSA can:
  - achieve deficit reduction;
  - better target employer subsidies to low and moderate wage workers;
  - protect small businesses; but, on the downside,
  - substantielly increase subsidies if premiums are unconstrained.
- Before we start looking at the illustrative models, let me again walk through the major points of the Health Security Act, so you can see how these models differ from the HSA.

HEALTH SECURITY ACT:

- EMPLOYER/EMPLOYEE SHARE. BEFORE SUBSIDIES, EMPLOYERS PAY 80 PERCENT OF AVERAGE PREMIUM. FAMILIES PAY NO MORE THAN 20 PERCENT OF AVERAGE PLAN.

- EMPLOYER/INDIVIDUAL SUBSIDIES. SUBSIDIES MAY REDUCE PREMIUM PAYMENTS. FIRMS UNDER 5,000 PAY NO MORE THAN 7.9 PERCENT OF TOTAL PAYROLL. SUBSIDIES LOWER AVERAGE EMPLOYER PAYMENTS TO 68 PERCENT OF PREMIUMS. HOUSEHOLDS PAY NO MORE THAN 3.9 PERCENT OF INCOME.

- SMALL BUSINESS. SMALL FIRMS (UNDER 75) RECEIVE ADDITIONAL SUBSIDIES, PAYING NO MORE THAN 3.5 PERCENT TO 7.9 PERCENT OF PAYROLL, DEPENDING ON FIRM SIZE AND AVERAGE WAGE.

- LARGE FIRMS. FIRMS WITH MORE THAN 5,000 EMPLOYEES WHICH ARE OUTSIDE THE ALLIANCE PAY 1 PERCENT OF PAYROLL ASSESSMENT.

Model 1

- Caps employer subsidies at 12 percent of each worker's individual wage, rather than 7.9 percent of average firm payroll as under HSA.

- Reduces firm threshold for community rating (alliances) from 5,000 to 1,000 and assesses all 1,000+ firms 1 percent of payroll. All firms eligible for employer subsidies.

	HSA	Model 1
Avg. employer premium payment per family . . .	$2,152	$2,187
Avg. family premium payment	$563	$583
Deficit reduction relative to baseline	NA	$45-55

Implications:

- Relative to the HSA, average family payments rise slightly.

- Model 1's individual wage cap better targets employer subsidies to lower wage workers, which results in slightly higher average employer payments per family.

- As under HSA, small businesses in all four models receive additional subsidies to lower their costs.

- Total federal subsidy are reduced relative to the HSA.

Model 2

- Identical to Model 1, except that it reduces the value of the benefit package by 5 percent.

	HSA	Model 2
Avg. employer premium payment per family . . .	$2,152	$2,108
Avg. family payment	$563	$555
Deficit reduction relative to baseline	NA	$100–115

Implications:

- Relative to the HSA, average family and employer payments decline slightly, due to the lower cost of the benefit package. This could, however, increase families' out of pocket costs.

- As in Model 1, an individual wage cap better targets employer subsidies to lower and moderate wage workers.

- Better targeted employer subsidies and lower benefit package reduce total federal subsidies relative to the HSA.

Model 3

- Reduces employer share from 80 percent to 50 percent. Increases individual share from 20 percent to 50 percent.
- Lowers value of benefit package by 5 percent.
- Reduces firm threshold for community rating (alliances) to 1,000. 1,000+ firms assessed 1 percent of payroll and eligible for employer subsidies.
- Employer share capped at 7.9 percent of individual wages and household payments capped at 6 percent of income. Small businesses capped at 3.5–7.9 percent of individuals' wages.

	HSA	Model 3
Avg. employer premium payment per family . . .	$2,152	$1,814
Avg. family premium payment	$563	$831
Deficit reduction relative to baseline	NA	$150–165

Implications:

- Relative to the HSA, Model 3 reduces burden on businesses and increases burden on individuals.
- Because the individual wage cap better targets employer subsidies to lower wage workers, it reduces total subsidies relative to the HSA.

Model 4

- Identical to Model 1. except that it allows the first year premiums for the first year the program is in place to give the uncompensated care windfall to the health industry.

Implications:

- Just making that one change -- even if growth rates are constrained after the first year -- increases the federal deficit by $455-470 billion to over 1996-2004.

To: Distribution

From: Chris Jennings

Re: Senate and Human Resources Committee draft of options

Date: April 21, 1994

Pat Griffin
Judy Feder
Jerry Klepner
Jennifer Kline
Greg Lawler
Ira Magaziner
Lynn Margherio
Nancy Ann Min
Karen Pollitz
Steve Ricchetti

Attached for your information is the current draft of options the Senate and Human Resources Committee is considering. There's little question that there will be mini-modifications to this draft over the next several weeks, but I thought it'd be useful to get a sense of their current thoughts.

AGENDA

1. Administration presentation on impact of the Health Security Act on Small Business

2. Discussion of three variants on Health Security Act

3. Committee treatment of program financing

4. Bi-partisan meeting

Model 1

- Caps employer subsidies at 12 percent of each worker's individual wage, rather than 7.9 percent of average firm payroll, as under HSA.

- Reduces firm threshold for community rating (alliances) from 5,000 to 1,000 and assesses all 1,000 + firms 1 percent of payroll. All firms eligible for employer subsidies.

	HSA	Model 1
Avg. employer premium payment per family	$ 2,152	$ 2,187
Avg. family premium payment	$ 563	$ 583
Deficit reduction relative to baseline	N/A	$ 45-55-75

Distribution of Federal Subsidies to Employers by Income of Workers

(1994 $ in billions, as if fully phased-in)

Percent of Poverty **	Health Security Act/ Subsidy Based on Average Payroll	Subsidy Based on 12% Individual Wage Cap*
<50%	1.1	2.5
50-100%	3.1	5.1
100-200%	9.2	11.0
200-300%	8.5	6.7
300-400%	6.6	4.3
400-500%	4.8	2.4
500+	9.4	3.0
Total	42.7	35.0

* Lower cap level for small firms

** 1994 Federal poverty level is $7,360 for an individual and $14,800 for a family of four.

Model 2

- Identical to Model 1, except that it reduces the value of the benefit package by 5 percent.

	HSA	Model 2
Avg. employer premium payment per family .	$2,152	$2,108
Avg. family payment	$563	$555
Deficit reduction relative to baseline	NA	$100-115

BENEFITS

Option for Saving 5% on the Benefits Package

-- Keep the annual family out-of-pocket limit at $3,000. Increase the out-of-pocket limit for individuals from $1,500 per year to $2,500 per year. In practice, individuals in low-cost sharing plans would not be affected by this change.

-- For the low-cost sharing plan, keep no deductibles for physician visits. Add a $250 hospital deductible to the low-cost sharing plan, with protections for low-income individuals.

-- Increase the prescription drug co-payment from $5 to $10 in the low cost-sharing plan. Keep provisions that reduce co-pays for Medicaid welfare eligibles to 20% of the co-payment required of everyone else.

-- These changes in the benefit package would save approximately $28 billion over 5 years, exclusive of additional protection for low-income.

Selected Potential Benefit Improvements and Cost

--Provide better benefits to women, children, and people with disabilities, including better home health, extended care, and outpatient rehabilitation services, additional preventive services, and hearing aids for children

-- The total five year costs in increased Federal subsidies would be approximately $16 billion. (NOTE: This does not include estimates for mental health expansions.)

Increased Subsidies for Low-Income

--All people up to 100% of poverty would pay $1 per prescription and $2 per physician visit. All people between 100% and 200% of poverty would would pay $2 per prescription and $4 per physician visit.

-- This would increase Federal subsidy costs by about $10 billion over 5 years.

SELECTED POTENTIAL BENEFIT IMPROVEMENTS

For children

- Cover hearing aids for children under 18. The Health Security Act specifically excludes coverage of hearing aids for people of all ages.

- Make the periodicity schedule for children's preventive services consistent with the latest recommendations of Bright Futures, a group that includes the American Academy of Pediatrics and the Public Health Service. The Health Security Act provides fewer physician visits and a slightly different periodicity schedule for some tests.

For women

- Eliminate co-payments for family planning services, drugs, and devices to make the consistent with coverage of other preventive services. The Health Security Act does not classify family planning services, drugs, or devices as preventive services – these services would be subject to co-payments.

- Cover pap smears more frequently in the preventive services schedule for women (annually unless three years of negative pap smears or other risk factors). For women of certain ages, the Health Security Act covers pap smears every three years unless a women has an irregular pap smear or other risk factors.

- Cover mammogram screening more frequently for older women if scientifically supported. The Health Security Act covers mammograms every 2 years for women over age 50. Other groups have recommended mammograms every 2 years for women between 40 and 50 and annually for women over 50.

For people with disabilities

- Make home health services, extended care services, and outpatient rehabilitation available as an alternative to hospitalization for people with congenital conditions. The Health Security Act limits these services only to individuals that need them as a result of illness or injury.

- Continue periodic outpatient rehabilitation for people that need it to maintain function and prevent deterioration. The Health Security Act limits outpatient rehabilitation services only to those individuals that continue to show improvement.

Model 3

- Reduces employer share from 80 percent to 50 percent. Increases individual share from 20 percent to 50 percent.
- Lowers value of benefit package by 5 percent.
- Reduces firm threshold for community rating (alliances) to 1,000. 1,000+ firms assessed 1 percent of payroll and eligible for employer subsidies.
- Employer share capped at 7.9 percent of individual wages and household payments capped at 6 percent. Small businesses capped at 3.5-7.9 percent.

	HSA	Model 3
Avg. employer premium payment per family .	$2,152	$1,814
Avg. family premium payment	$563	$831
Deficit reduction relative to baseline	NA	$150-165

IMPACT OF 50-50 EMPLOYER-EMPLOYEE SHARE OF PREMIUMS UNDER DIFFERENT MAXIMUM PERCENT OF INCOME CAP FOR EMPLOYEE SHARE

	3.9%*	6%*
5 YEAR DEFICIT IMPACT ($ IN BILLIONS)	- -	-105
IMPACT ON FAMILIES RELATIVE TO HSA	Little impact-- families subsidized to $70,000	Little impact on poor-- substantial cost increases for moderate income families
ALTERNATIVES	Sliding scale subsidies for upper middle income	More progessive schedule rising to 6 % cap

Affordability of Insurance for Working Families Under Different Reform Proposals

Average premiums as a percentage of pre-tax income for a family of four.

	100% Poverty ($14,800)	150% Poverty ($22,200)	200% Poverty ($29,600)	240% Poverty ($35,520)	300% Poverty ($44,400)
Clinton	3.0%	3.9%	3.8%	3.1%	2.5%
Chafee	0.0%	9.0%	13.4%	15.7%	12.5%
Cooper	0.0%	12.5%	18.8%	15.7%	12.5%
Nickles	5.0%	13.8%	11.9%	10.3%	8.8%

Based on CBO premium estimtes for the Health Security Act and the 1994 Federal poverty level.

TREATMENT OF HEALTH SECURITY ACT FINANCING BY THE LABOR COMMITTEE

Before the Health Security Act goes to the Senate floor, changes will need to be made to the program to assure at least budget neutrality. Currently, CBO projects that the program will add $64 billion to the deficit from 1995-1999 and $125 billion from 1995-2004.

In addition, our Committee will want to make some changes in the bill that will increase Federal costs, such as better benefits for women, children and the disabled; assurance of adequate investment in public health; protection for academic health centers and increased spending for biomedical research; and better cost-sharing protection for the low income.

Offsetting changes to pay for these increases, as well as to eliminate the CBO projected shortfall can be made partially within our committee's jurisdiction, but others will require actions in the jurisdiction of the Senate Finance Committee.

Options for the Labor Committee include:

1. Do not include provisions to achieve deficit neutrality within the legislation reported by our committee. State that adjustments will be made in the bill prior to its going to the floor, taking into account the work of Finance and other committees.

2. Do not include provisions to achieve deficit neutrality within the legislation reported by our committee. Provide press materials describing options for additional steps that could be taken prior to the legislation's being taken up on the floor which would achieve deficit neutrality.

3. Include in legislation reported by the Committee provisions to achieve deficit neutrality that are within our jurisdiction; also include a sense of the Committee resolution indicating the additional changes the Committee recommends in legislation to be brought to the floor that will achieve deficit neutrality, e.g., "The Committee recommends that measures to achieve the aggregate savings and revenues achieved by the portions of the Health Security Act not within the jurisdiction of the Labor and Human Resources Committee be included in legislation to achieve comprehensive health care reform considered by the full Senate, along with the following

additional measures to assure that the program does not add to the deficit:

1. An increase in the cigarette tax of $1.25 per pack

2. An increase of the State Maintenance of Effort payments required under Section __ of the Health Security Act of 10 percent per year."

3. Include in the bill reported by the committee specific legislative language providing for all changes necessary to achieve budget neutrality, including changes not in our jurisdiction.

TO: Ken Thorpe
FROM: Jennifer Klein
DATE: 4/4/94
RE: Benefit Estimates

I have been asked by the Senate Finance Committee staff and Senator Wellstone's staff for estimates of the following benefit changes:

1. Pap smears every year for sexually active women
2. Screening for sexually transmitted diseases for men
3. Requiring health plans to offer health education classes with and without cost sharing
4. Endodontic services for individuals 18 years or older after 2001
5. Attached changes to DME

They would like these estimates as soon as possible.

QUESTIONS FOR ADMINISTRATION RE: TITLE I

THE HEALTH SECURITY ACT S. 1757

Senator Wellstone

	Page	Topic	Issue/Question
Jen	44	prevention	covers annual screening for chlamydia and gonorrhea for females at risk for fertility related infectious illnesses. Are screens for sexually transmitted diseases also covered for men? If not, why not?
Jen	57	"	Outpatient services are received only if --- designated by a health professional designated by the health plan, based on criteria that the plan may choose to employ. What is the impact on single payer states? How should this be amended to accomodate these states? What makes health plans expert in designating criteria? (Criteria must be uniform to avoid risk shifting.)
Jen	72	Dental	After 2001, endodontic services still not covered for individuals 18 y.o. or older. Why not?
Jen	73	"	(3) Space Maintenance. (C) Excludes space maintainer placed within 6 mos. of the expected eruption of the permanent posterior tooth concerned. Why?
Jen	73-4	Hlth ed.	Sec. 1127. Health education classes. (b) A health plan may offer education & training classes at its discretion. Why at discretion of the plan? What is the impact on single payer states

that have no health plans?

/ Jen 74 Invest.tx — Sec. 1128. Investigational Treatments. (b) Discretion of plan. A health plan may cover an investigational treatment described in subsection (a) at its discretion.

Risk problem.

/ Jen 80 Cost share — Sec. 1132. Lower Cost Sharing. Seems to define coinsurance as payment made at point of service rather than as individual share of the premium: (POS): (3) (A) Lower cost sharing plan shall prohibit payment of any coinsurance (except as defined in paragraph (4) - coinsurance is required for an out-of-network item or service, if it would be subject to coinsurance under the higher cost sharing schedule described in sec. 1133. Or does this mean no premium contribution?

✓ Jen 85 POS — Definition of coinsurance: (b) (2) prohibits payment of any coinsurance in POS plan, but (3) (on p. 86) requires pmt of a copayment in accordance with the lower cost sharing schedule.

✓ Jen 90 Exclu — Sec. 1141 - does "medically necessary and appropriate" mean that only those abortions that are considered medically necessary and appropriate will be covered?

Gary/Larry 111 Single payer — Title I, Subtitle C, Part 2- REQUIREMENTS FOR STATE SINGLE-PAYER SYSTEMS. Sec. 1222. GENERAL REQUIREMENTS FOR SINGLE-PAYER SYSTEMS. (4) DIRECT PAYMENT TO PROVIDERS. The State shall make payments directly to providers who furnish items and services included in the comprehensive benefit package, and assume (subject to subparagraph (B)) all financial risk associated with making such payments. (Presume this means states are at risk for all health payments, not just for administrative costs.)

Gary/Larry 112 Single payer — (B) CAPITATED PAYMENTS PERMITTED. Nothing in subparagraph (A) shall be construed to prohibit providers furnishing items and services under the system from receiving payments from the plan on a capitated, at-risk basis based on prospectively determined

rates.

What plan? health plan? How does this affect single payer systems?

112 " (5) PROVISION OF COMPREHENSIVE BENEFIT PACKAGE. (B) IMPOSITION OF REDUCED COST SHARING. The system may decrease the cost sharing otherwise provided in the comprehensive benefit package...so long as the system does not increase the cost sharing otherwise imposed with respect to any other class of individuals or services. **Can decrease on outpt mental health and increase inpt mental health? what is limit of "class of services?"** Services or class of individuals

112-3 " (6) COST CONTAINMENT. The system shall provide for mechanisms to ensure, in a manner satisfactory to the Board, that - (A) per capita expenditures for items and services in the comprehensive benefit package under the system for a year (beginning with the first year) do not exceed an amount equivalent to the regional alliance per capita premium target that is determined under section 6003...for the year.

What if the system offers more benefits than the alliance system? If it offers additional benefits, how wd. determine % of expenditures for alliance package and % due to extra benefits?

114 " Sec. 1223. SPECIAL RULES FOR STATES OPERATING STATE-WIDE SINGLE-PAYER SYSTEM. (c)ASSUMPTION BY STATE OF CERTAIN REQUIREMENTS APPLICABLE TO REGIONAL ALLIANCES. (4) ANTI-DISCRIMINATION; COORDINATION. The requirements of section 1328 shall apply to the State in the same manner as such requirements apply with respect to a regional alliance.

Sec. 1328 says alliances can't discriminate against health plans. What role do alliances play in single-payer systems?

115 s.p S.p. state has to keep wkrs comp & auto ins. separate - why? implications?

116 s.p. (d)FINANCING. (1) IN GENERAL. State has to

financing provide for the financing of a system using a payroll-based financing system that requires employers to pay at least the amount that the employers would be required to pay if the employers were subject to the requirement of subtitle B of title VI.

Which standard? 80% of premium or 7.9% of payroll? What if 80% of premium is less than 7.9% of payroll? Does state still have to impose 7.9% payroll tax? Can it be less?

Gary 117 s.p. Sec. 1224. SPECIAL RULES FOR ALLIANCE-SPECIFIC SINGLE PAYER SYSTEMS.

WHAT IS THIS?

Gary 121 " Sec. 1311. (b) ELIGIBLE SPONSORS (1) IN GENERAL (B) PLAN SPONSOR OF A MULTIEMPLOYER PLAN (ii) has more than 5,000 active participants in the United States.

Could lead to very small units in an area negotiating for rates. A group of 5,000 in a region is problematic because it will skew the Alliance pool, but that will be a problem anyway. Some national companies have offices of 25 or fewer employees scattered around the country. Rural electrical coops definitely have this kind of distribution. How is this envisioned to work?

Gary 129 " Sec. 1313. TIMING OF ELECTIONS (whether to join regional alliance or remain independent). (a) FOR LARGE EMPLOYERS.(1) CURRENT LARGE EMPLOYERS (B) DEADLINE FOR NOTICE. Jan. 1 of the second year preceding the general effective date (1996?) or, in the case of a State that elects to become a participating State before the general effective date, not later than one month later than the date specified for States under section 1202 (a) (2).

States to establish plan by March 1 of previous year to be recognized.

This means election by April 1997 at the latest?

Jan 133-4 " (B) REASONABLE RESTRICTIONS DESCRIBED. The

reasonable restrictions on coverage permitted under a fee-for-service plan (as specified by the National Health Board) are as follows: (ii) Prior approval for specified services. Clause ii shall not be construed as permitting a plan to require prior approval for non-primary health care services through a gatekeeper or other process.

Means prior approval other than gatekeeper

BUT that is what clause ii does.

138 FFS

Larry

(3) If State or regional alliance established the fee schedule for FFS plans under prospective budget, payment for all services provided by FFS plans in the alliance or State shall be determined on such basis.

HHS: What is the projection of how many states are likely to do this?

145-6 enroll

Larry

(d) (2) DISENROLLMENT FOR CAUSE. Regional alliance to establish procedures so that individuals may disenroll from their plan for good cause at any time during a year.

Is moving out of the area good cause? What if someone just doesn't like the services?

QUESTIONS FOR ADMINISTRATION RE: TITLE III

THE HEALTH SECURITY ACT S. 1757

Senator Wellstone

	Page	Topic	Issue/question
Gary	582	single payer	Health plans eligible to receive grants as Qualified Community Health Plans are defined in Sec. 3421 (b) (2) as "a participant in one or more health alliances." How is this intended to work in single payer states, where community health centers, e.g., may exist and should be eligible for funding, but are not part of a health alliance?
Gary	583-5	p.h.grantees	defined as meeting 2 or more of the criteria in paragraphs (1) - (8): (1) provide health services to shortage or underserved area and not providing svcs thru any of the other programs listed in para's (2)-(8); (2) - (8) include: current providers under 329, 330, 340, 340A, sec.1001 or title XXIII of PHS Act, title V of SSA (MCH), Indian health svcs, or state or local pub health agencies Consortia eligible to get grant to develop qualified community practice networks include any health plan that participates in one or more health alliances, without regard to whether the health plan is a qualified community health plan. How is this meant to apply to single payer states? What is the rationale for using such broad criteria?
Sara	589	loan waivers	sec.(2) allows subordination or

waiver of capital loans if such will further the objectives of this part.

None -- maybe bar from gaming town

Are there any limits on this power of the Secretary? What would limit potential abuse of this section by for-profit health plans?

Jen

622-4	MH/Pub hlth	sec.3511(b) (8) requires state to submit plan to Secretary specifying how it will integrate state & local services with the benefit package under Title I, including "conditions under which the integration of MH & SA abuse providers into regional and corporate alliances can be achieved, and identification of changes in participation and certification requirements that are needed to achieve the integration of such programs & providers into health plans."

(No)

How is this meant to affect single payer states?

626	MH integr.	sec. 3521 wd. establish pilot programs to demonstrate model methods of achieving the integration of the MH & SA svcs of the States with the MH & SA svcs under Title I.

Jen

Sara

p. 616 - Shld reserve these funds in set aside.

What is the funding for these programs?

Should be $ subtitle

QUESTIONS FOR ADMINISTRATION RE: TITLE VI

THE HEALTH SECURITY ACT S. 1757

Senator Wellstone

	Page	Topic	Issue/Question
Larry	992	Baseline	See p. 992 - ADDITION OF PROJECTED EXPENDITURES FOR UNINSURED AND UNDERINSURED INDIVIDUALS. Adjustment based on estimated average cost for such services in 1993 (not on private payment rates). Estimated amount of uncompensated care in 1993 shall be removed and will not include adjustments to offset payments below costs by public programs. **Why? What is the intent of this section?**
Larry	1016	Rates	see line 3-8. (A) NET PREVIOUS YEAR ACCEPTED BID FOR PLAN. The accepted bid for the previous year (not taking into account any voluntary reduction under section 6004(e)) minus the amount of any plan payment reduction for the plan for that year. **Why not? What is intention of this section?**

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

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

Date:

From: Cliff Gaw

To: Jennifer Klein

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

Phone: _____

Fax: _____

Number of Pages (Including Cover): 3

Comments:

Single payer question (P. 111):

Presumption is correct; State is responsible for all health care costs.

Single payer question (P. 112):

The "plan" refers to the single payer plan (e.g., the state). The concept is that of the Medicare risk contracts, where an HMO (or similar arrangement can agree to provide covered services in exchange for a per capita or per family capitiation payment from the single payer system (i.e., Medicare).

Cost Containment (112-3):

Intent appears to be that single-payer can only reduce cost-sharing (within the financing structure); appear that must stay within caps even if less cost-sharing).

Single payer question (P. 115):

This provision requires single payer states to meet the requirements of Title X as to workers compensation and automobile insurance.

Single payer (P. 116)

Bill not specific; appears answer should be that employers pay the same aggregate amount -- look at the combined.

Single payer question (P. 117):

These provisions apply if a state sets up a singe payer system for one alliance area (but not statewide), assuming that a state has more than one alliance area. This may largely apply in rural areas, where we do not expect many competing health plans.

Multiemployer plan sponsor question (P. 121):

We let out these types of plans because they have traditionally been exempt from state regulation under ERISA. For the multis and rural coops, they can join the regional alliances at community rates with no penalties. So, if they cannot negotiate a reasonable deal outside, they can come in.

At one point, we had a provisions that would allow corporate alliances to enroll (all of) their smaller enterprises into regional alliances at community rates (no penalties). This was removed but could be returned.

Election to be a corporate alliance.

Yes.

FFS (P. 138):

There is no projection; this is here to assure that State have flexibility and that an affordable method of FFS is available everywhere.

Single payer question (P. 582):

Single payer state is presumed to have one alliance for other purposes of bill.

Calculating target (P. 992):

The intent of the section is to establish premium targets consistent with covering the current uninsured and underinsured at average costs.

Rates (P. 1016):

Net accepted bid already takes into account the reduction); counting the reduction would take it into account twice. Bill not as clear as it should be.

PAUL D. WELLSTONE
MINNESOTA

456 2878

United States Senate

WASHINGTON, DC 20510-2303

FROM THE OFFICE OF SENATOR PAUL DAVID WELLSTONE

FAX COVER SHEET

TO: JENNIFER KLEIN

FROM: ELLEN SHAFFER

DATE: 4/15

MESSAGE: PROPOSED AMDTS. TO S. 1779, FY1, AS DISCUSSED

COVER SHEET + 1 PAGES = 2 TOTAL PAGES

QUESTIONS/PROBLEMS, PLEASE CALL 202-224-5641
FAX 202-224-8438

AMENDMENT 4/15/94

Page	Issue	Amendment
36-42	prevention	Sec. 1114. Add, for each section on individuals over the age of 13: screening for gonorrhea and chlamydia and other sexually transmitted diseases as determined by the National Health Board (ii) annually for females (add: and males) at risk for fertility related add: or sexually transmitted infectious illnesses. Sec. 1114. Add, in section (f) and section (g): (D) For women at high risk for breast cancer, mammograms annually or every 2 years as determined by the women and their clinicians. Sec. 1114. Add, in section (h) and (i):(2)(B): Mammograms for females every 2 years, or annually for women at high risk for breast cancer.

TO: Ira, Judy, Nancy Ann, Ken T., Jen Kleine.

FROM: Chris Jennings

Attached is a list of cost out requests from the Senate Labor and Human Resources Committee – specifically David Nexon. Let's plan on discussing it briefly Monday evening.

1. Additions to Clinton plan protections for low-income

a. add global limit on proportion of income spent on premium

b. provide cost-sharing protection for low-income, non-cash assistance recipients

c. provide wrap-around services for additional low-income individuals

2. Benefit changes

a. in vitro fertilization

b. hearing aids for children

c. care for congenital conditions under home health and extended care benefit

d. children's preventive health revisions

e. medical costs associated with clinical trial

f. mental health

g. outpatient rehabilitation services

h. family planning services as preventive benefits

i. mammograms and pap smears

j. additional services for children

3. Cost voluntary nursing home insurance program (S. 1833)

1. ADDITIONAL PROTECTIONS FOR LOW-INCOME

a. Add global limit on proportion of income paid for premiums

i) Extend 3.9 percent cap on individual liability for 20% of premium to people of all incomes, (i.e., eliminate the $40,000 cut-off now in HSA.)

ii) Create a new per cent of income cap on overall individual premium liability (mainly to benefit non-workers, self-employed, and part-time workers that are responsible for more than 20% of the premium). This would be in addition to rather than substituting for the current subsidy program in the bill. Test several different levels, including a sliding scale option that would set the per cent lower for the poor and near poor.

iii) For persons disabled according to Americans with Disabilities Act of 1990 definition of disabled, provide with additional premium subsidies to assure access to a fee-for-service plan at no more than cost of the average cost plan.

b. Provide additional cost-sharing protection for low-income, non-cash assistance individuals

i) For all persons below 100% of poverty provide addtional co-pay and deductible subsidies, (i.e., they would only be liable for 20% of the co-pay schedule for the low cost sharing plan - $1 drug and $2 office visit). (**note:** we are assuming that these benefits are already assumed for low-income children through the wrap-around program--section 4222--in your current costing. Please advise us if this is not the case).

ii) For people between 100-200% of poverty: provide additional co-pay and deductible subsidies so that they pay no more than 40 percent of the out-of-pocket costs of the low cost sharing plan (i.e. $2 drug and $4 office visit).

c. Provide wrap-around services for additional low-income individuals

i) require States to offer wrap around benefits to hold harmless current non-categorical Medicaid recipients (for as long as they continue

to meet the Medicaid eligibility criteria that was in effect in 1993.) Offer same Federal matching as current Medicaid for these wrap around benefits.

ii) for non-cash individuals below 100 per cent of poverty, provide Medicaid wrap-around services on the same terms as cash recipients.

iii) Provide wrap-around services for non-cash pregnant women up to 185 per cent of poverty.

2. BENEFIT CHANGES

Expand benefits package to include:

a) in vitro fertilization - covered if medically appropriate; Section 1116, Family Planning Services and Services for Pregnant Women, p. 63 add: "(4) in vitro fertilization services." after line 14; and in Section 1141, Exclusions on p.91 delete (b) "(5) In vitro fertilization services." (line 25).

b) hearing aids for children - Cover hearing aids for individuals less than 18 years of age, according to a periodicity schedule established by the Board. In Section 1141, Exclusions on p.91 add "for individuals at least 18 years of age.", after "hearing aids".

c) care for congenital conditions - clarify that home health services and extended care services are available as an alternative to hospitalization for people with congenital conditions. Override 100 day limit on extended care services if cost effective alternative.

a) home health services, Section 1118, p.64, line 14 delete "after an illness or injury"

b) extended care services, Section 1119, p.65, line 7 delete "after an illness or injury"; on line 9, delete the period and insert "unless the need for continued care is re-evaluated by the prescribing health care professional and found to be a cost-effective alternative to necessary inpatient hospitalization."

d) different periodicity schedule for children's preventive services - (section 1114) Make children's preventive health care coverage consistent with the latest recommendations of AAP (**see attachment C**).

e) medical costs associated with a clinical trial
For people in approved clinical trials, require health plans to cover medical care for covered services that are not ordinarily expected to be paid for by alternative sources - pursuant to regulations issued by the Secretary. (Modification of current language under Section 1128 p.74).

f) Mental health. Evaluate options for moving toward a comprehensive benefit before 2001 by selectively eliminating limitations for all individuals or for subgroups. **(see Attachment A)**

g) outpatient rehabilitation services. Eliminate the "result of illness or injury" qualification test for eligibility for such services i.e, clarify that congenital conditions are included. Clarify that coverage continues for maintenance of function and prevention of deterioration. Clarify that outpatient respiratory therapy is covered. Allow for re-evaluation after 60 days **(see Attachment B for greater detail).**

h) Treat family planning services as preventive benefits. Include family planning services, drugs, and supplies in the list of preventive benefits, i.e., no co-payments or deductibles.

i) mammograms and pap smear Clarify the periodicity of these services

j) Provide Additional Services to Children

i) allow all children to buy into the Medicaid children's wrap program, regardless of income or cash assistance status. Have a sliding scale co-insurance schedule similar to the long term care block grant program.

ii) expand eligibility for the long term care program to more children with disabilities by redefining the eligibility categories to include all children under 21 with a special need as evidenced by: qualification for SSI, or receipt of services through Part B or Part H of IDEA, Title V Maternal Child Health Block Grant, or Title IV B or E of SSA. Estimate how much it would cost to fully fund the program, assuming the same phase-in schedule as proposed in the Health Security Act.

Attachment A

WHAT IS THE COST IMPACT OF EACH OF THE FOLLOWING ALTERNATIVES TO THE MENTAL HEALTH / SUBSTANCE ABUSE BENEFIT PROPOSED BY THE CLINTON ADMINISTRATION?

I. Comprehensive/flexible benefits:

A. Immediate implementation. Immediate implementation of 2001 benefits, with defined and legislated quality managed care. In all plans, both high and low cost-sharing, the mental health and substance abuse benefit would include well-designed and appropriate case management services, utilization review for all inpatient care, and enforceable standards to assure appropriate care.

B. Study leading to accelerated implementation. By the end of 1995, the HHS shall analyze and report to Congress the actual costs incurred under the standard benefits package for mental illness and substance abuse treatment, and differentiate between the actual cost of such benefits provided through managed benefit plans and un-managed plans. The study shall further identify the features found in managed mental health and substance abuse plans that are cost effective without limiting access to needed services. The National Health Board shall enhance coverage of mental health and substance abuse services for those plans that adopt the features found by the study to be cost effective while maintaining quality.

II. Comprehensive/flexible benefits: Modifications

A. Immediate implementation of 2001 benefits for children and adolescents:

1) for both high and low cost sharing plans;
2) for the low cost sharing plans only.

B. Immediate implementation of 2001 benefits for adults and children for the low cost sharing plans only.

C. Immediate implementation of 2001 benefits for substance abuse treatment.

III. Other benefit modifications

A. Increase the inpatient benefit to 45 days.

B. Increase the psychotherapy and collateral visit benefit limits to 30 visits each.

C. Removal of the benefit limits on all services except inpatient hospitalization.

D. Expansion of the intensive-nonresidential treatment (INR) category to include residential substance abuse treatment.

E. Removal of the benefit limits on INR while retaining the trade-offs of inpatient hospitalization (i.e., requiring that use of INR diminish availability of inpatient benefit, but not vice versa):

1. Including substance abuse treatment.
2. Excluding substance abuse treatment.

F. Modification of the INR category to allow for differential trade-offs with inpatient care for the various covered services based upon the average costs of such treatment.

IV. Cost sharing

A. Removal of deductibles for high cost sharing plans and reduction of co-pays for low cost sharing plans to the SSI/AFDC level.

B. Removal of provisions excluding contributions to out-of-pocket maximums:

1. including psychotherapy.
2. excluding psychotherapy.

C. Establishment of a separate out-of-pocket maximum for mental health / substance abuse equal to that for medical services.

D. Establishment of specific dollar deductibles for inpatient and INR rather than a one-day deductible.

Attachment C

Current S.1757 | * CBO to cost out

Age	Clinton	AAP/Bright Future/HHS
0-2	8 Clinician Visits 1 Hematocrit 2 Lead # DTP # OPV # HiB # MMR # HBV	11 Clinician Visits 1 Hereditary/Medibolic Screen 2 Hematocrit 2 Lead 2 Urinalysis 1 Tuberculin Test 4 DTP 3 OPV 3-4 Hib 1 MMR 3 HBV
3-5	3 Clinician Visits 1 Urinalysis # DTP # OPV # MMR	3 Clinician Visits 1 Tuberculin 1 DTP 1 OPV
6-12	3 Clinician Visits	5 Clinician Visits 1 Hematocrit 1 Urinalysis 1 MMR
13-21	(13 to 19 years only) 3 Clinician Visits Pap/Pelvic every 3 years or annually depending on risk Chlamydia/Gonorrhea screen for females at risk # Tetanus # Diptheria	9 Clinician Visits Pap/Pelvic as appropriate 1 Hematocrit 1 Tuberculin 1 Urinalysis 1 Tetanus

= age appropriate immunizations - - no specific number is given

December 22, 1993

MEMORANDUM

TO: Paul van de Water, Chuck Seagraves, and Alan Fairbanks

FR: David Nexon

RE: Draft Request for CBO estimates on Potential HSA Changes

We would like to have CBO estimate the costs of a number of options to modify the Health Security Act. The items fall into three categories: benefit changes, long term care program changes, and subsidy/wrap-around changes. We have also discussed benefit package changes with CRS. (Page references are for S.1757, introduced by Senator Mitchell).

Obviously, we welcome information on any of these options as soon as you develop estimates, and we would like you to give us any preliminary information you can, even if final estimates are not complete. We have been working with Wellstone's office on the mental health and substance abuse benefits - an attachment outlines the cost estimates requested in that area. We are still working with Harkin's office on potential changes for rehabilitation services and assistive technologies. We will send you additional requests relating to these and other changes right after the new year. Many thanks for your attention to our requests.

Expand benefits package to include:

1) in vitro fertilization - covered if medically appropriate; Section 1116. Family Planning Services and Services for Pregnant Women, p. 63 add: "(4) in vitro fertilization services." after line 14; and in Section 1141. Exclusions on p.91 delete (b) "(5) In vitro fertilization services." (line 25).

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3) care for congenital conditions - clarify that home health services and extended care services are available as an alternative to hospitalization for people with congenital conditions. Override 100 day limit on extended care services if cost effective alternative.

a) home health services, Section 1118, p.64, line 14 delete "after an illness or injury"

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4) different periodicity schedule - (section 1114) Make children's preventive health care coverage consistent with the latest recommendations of AAP (see attachment 2).

5) medical costs associated with a clinical trial
For people in approved clinical trials, require health plans to cover medical care for covered services that are not ordinarily expected to be paid for by alternative sources - pursuant to regulations issued by the Secretary. (Section 1128 p.74 - eliminate "discretion of plan"; and rewrite).

Long Term Care: Change new program assume an open ended entitlement; price as is (3 ADLs, etc.) and then with these options:

1) Decrease ADLs required for eligibility for long term care from 3 to 2;
2) use SSI definition for eligibility for children under 18 (see chart)
3) Limit the cost of LTC services provided to a recipient to 50 percent of the average cost of care in a Medicare SNF.
4) increase co-pay for highest income group from 25 to 35 percent.
5) Out-of-pocket costs for co-payments capped at $1,500 per individual and $3,000 per family per year.
6) provide assessment care plan for all elderly/disabled people (regardless of their eligibility for this LTC program) on sliding scale fee schedule: **free** if < 150 percent of poverty
50 % co-pay for 150-300 percent of poverty
100% for people over 300 percent of poverty

Special Benefits and Subsidies

1) require States to offer wrap around benefits to hold harmless current non-categorical Medicaid recipients (for as long as they continue to meet the Medicaid eligibility criteria that was in effect in 1993.) Offer same Federal matching as current Medicaid for these wrap around benefits.

2) Extend 3.9 percent cap on individual liability for 20% of premium to people of all incomes, (i.e., eliminate the $40,000 cut-off now in HSA.)

3) Create a new cap on overall individual premium liability (mainly to benefit non-workers, self-employed, and part-time workers that are responsible for more than 20% of the premium). Estimate the cap at three different income levels: 5.5%, 7%, and 8.5% of adjusted gross income.

4) For all persons below 100% of poverty provide co-pay and deductible subsidies, and wrap around services equivalent to those provided to Medicaid cash recipients (i.e., only liable for 20% of the co-pay schedule for the low cost sharing plan - $1 drug and $2 office visit - and they are eligible for Medicaid wrap around services.)

5) For people between 100-200% of poverty: provide co-pay and deductible subsidies so that they pay no more than 40 percent of the out-of-pocket costs of the low cost sharing plan (i.e. $2 drug and $4 office visit).

6) Provide disabled Medicaid recipients (regardless of their SSI status) with additional premium subsidies to assure access to a fee-for-service plan if no fee-for-service plan is available at or below weighted average premium.

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Current 5.1757 | * CBO to cost out

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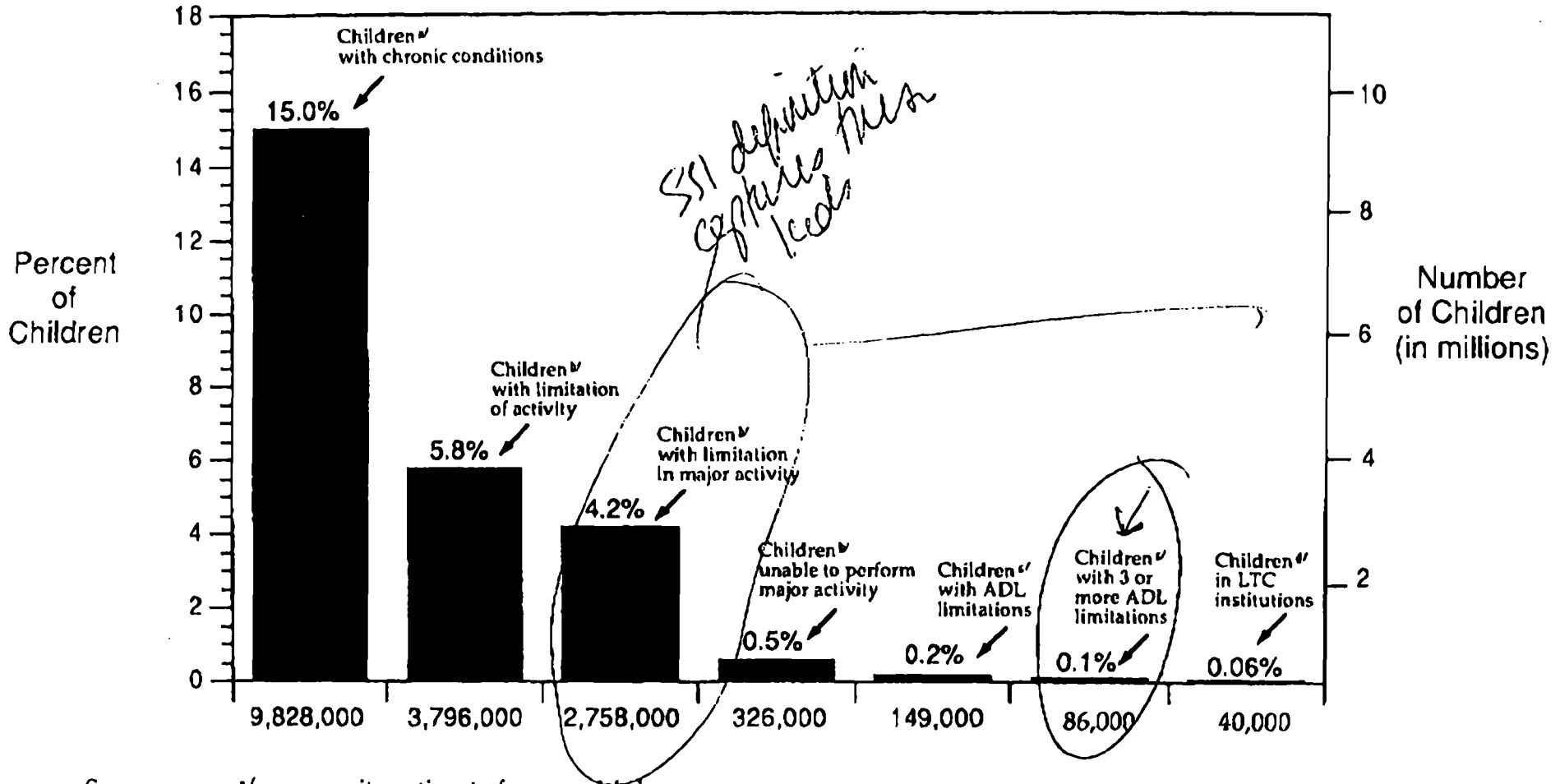
13-21	(13 to 19 years only) 3 Clinician Visits Pap/Pelvic every 3 years or annually depending on risk Chlamydia/Gonorrhea screen for females at risk # Tetanus # Diptheria	9 Clinician Visits Pap/Pelvic as appropriate 1 Hematocrit 1 Tuberculin 1 Urinalysis 1 Tetanus

= age appropriate immunizations - - no specific number is given

DRAFT

Continuum of Chronic Conditions and Disability for Children under 18 Years Old



Sources:
- a/ composite estimate from multiple sources
- b/ original tabulations of the 1991 National Health Interview Survey
- c/ original tabulations of the Home Care Supplement to 1979-80 National Health Interview Survey
- d/ preliminary estimate based on 1990 Census

Person with extensive data & experience with this: Paul Newacheck
U. of Cal. S.F. Institute for Health Policy Studies
415-476-3896

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TELECOPIER COVER MEMORANDUM

TO: Sara Rosenbaum

FAX NUMBER: 296-0025

FROM: Deborah W

DATE AND TIME: 1/3/94

NUMBER OF PAGES: Cover + 7

RETURN FAX NUMBER: (202) 224-3533

If there is trouble receiving this fax, please call (202)224-5880

Jill - please don't share or discuss with others yet.
Hope to see you soon + go over stuff.
Happy New Year .... it's got to get better I think