FACSIMILE TRANSMISSION REQUEST

ADDRESSEE: (Name, Organization, Address)	FROM: (Name, Organization, Address)
Jennifer Klein Phone:	Tom Ault Phone: 690-7314

TOTAL PAGES: (Without Cover)	ADDRESSEE'S FAX MACHINE PHONE NUMBER: (If Known)	DATE:
5	456-2878	7/22/94

REMARKS:

"As discussed"

IF FAX MACHINE RETRANSMISSION IS NECESSARY PLEASE CALL:

_____ AT: _____
(Name) (Phone)

REQUESTOR'S INSTRUCTIONS TO RECEIVER:

____ Please call: _____ at _____ for pick-up
(Name) (Phone)

____ Mail copies to: _____

Location: _____

_____

____ Retain copies in files.

"WARNING: Many fax machines produce copies on thermal paper. The image produced is highly unstable and will deteriorate significantly in a few years. It should be copied on a plain paper copier prior to filing as a FEDERAL RECORD."

6/20/94

HR 3600 HEALTH SECURITY ACT (per HWM)

Creates new GUARANTEED NATIONAL BENEFITS PACKAGE in the form of Medicare Part C.

Changes Medicare Part A:

No limit on number of inpatient hospital days, but copay structure remains, linked to spell of illness

Inpatient psychiatric limits replaced by 60-day-per-year limit, regardless of type of hospital (see above for copay), definition of inpatient psychiatric hospital services deleted

New benefit added for intensive (mental health) residential services, up to 120 days per year (possibly more), in qualified centers, apparently without copay

Changes Medicare Part B:

New benefit added for prescription drugs --

Converts most existing drug coverage, including incident to practitioners & thru DME or prosthetic, to new benefit

Includes insulin

Includes home iv & PEN, also in hosp or SNF if day not covered under Part A (can include other cost-effective settings)

Does not change current coverage for:
incident to for hospital outpatient, or partial hospitalization
dialysis drugs
immunosuppressives
immunizations
CORF drugs

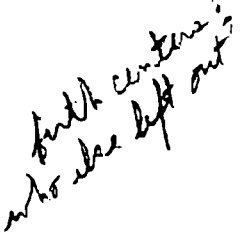
Includes medical food for certain conditions

Off-label use aproved per compendia

New benefit for Home Infusion Drug Therapy Services --

Limited to new qualified provider of services

Physician plan & certification required



Includes nursing, pharmacy, related services & supplies, but not drugs themselves

Available in institution if day not covered under Part A

DME & prosthetic device amended to exclude this equipment & covered outpatient drugs

New benefits added for infants & children, up to age 19 (technical changes to lab authority included in this)

New benefits added & existing ones revised for preventive services, including --

immunizations for ages 19-64

mammography screening

pap smear & pelvic exam screening

colorectral screening

sexually transmitted disease screening for women ages 13-49

New benefits added for pregnancy & family planning

New benefits added for mental health services --

Outpatient psych limit revised, first 5 sessions exempt

Intensive community services, including:

unlimited days of case management for seriously mentally ill, as defined by Secretary

180 days per year for under 19

90 days per year for all other, including rehabilitation, "in home" care, & detox

Expanded chiropractic coverage to include related x-rays

The revised Medicare Parts A & B benefits would be available in a new "Medicare Part C" to individuals not currently eligible. Many of the changes to Parts A & B obviously are targeted to people neither aged nor disabled.

The benefits would be the same as A & B, but the copay structure would be different. Some other differences include:

Coverage for investigational treatment in approved research

Special mental health benefits under managed care

Authority to modify screening/preventive coverage

POTENTIAL TECHNICAL PROBLEMS IN HR 3600

3101 - Outpatient prescription drugs

Not all current Part B coverage for drugs has been subsumed by this.

Drugs included in dialysis coverage remain under 1862(s)(2)(F) -- this is not a problem, so long as it is recognized that non-dialysis drugs would be covered separately under the new benefit.

Vaccines for immunizations remain under 1861(s)(10) -- not a problem if recognized that other vaccines denied coverage on the basis of "not reasonable & necessary."

Immunosuppresive drugs remain under 1861(s)(2)(J) -- question of whether coverage is available under new benefit when requirements not met for the current one, or after time limit expires.

Coverage for non-self-administerable drugs furnished incident to physicians' services to hospital outpatients, including psychiatric partial hospitalization patients, remains under 1861(s)(2)(B) -- creates problem of different claims processing and different payment levels for same drugs depending on source; also creates two different systems for hospitals to bill drugs, depending on whether self-administerable; susceptible to gaming and confusion.

Coverage of non-self-administerable drugs remains part of partial hospitalization benefit in 1861(ff)(1)(D) --same problems as hospitals, noted above.

Coverage for non-self-administerable drugs remains part of CORF benefit in 1861(cc)(1)(F) -- same problems as hospitals, noted above.

3106 - Home Infusion Drug Therapy Services

Since this can be provided to hospital or SNF inpatients on days not covered by Part A, not clear whether hospital or SNF can qualify to provide it to its own inpatients. Potential problems if they cannot, but other problems if they can -- e.g., overlaping/redundant provider identity for survey & certification, payment methodology differences.

3113 - Infants & children benefits

The conforming amendments to the 1862 exclusions, in 3113(b)(2), do not go quite far enough. 1862(a)(7) seems to require a blanket exception for [the new] 1861(oo) in order to not exclude routine exams, hearing exams, and hearing aids. Also 1862(a)(12) would require an exception for dental care.

3114 - Preventive services

The text we have does not contain any references to the expanded immunization coverage.

3115 - Family planning

3115(a)(3), which adds new 1861(s)(20), refers to contraceptive devices but not drugs. Presumably the drugs are covered under this benefit rather than the outpatient drug benefit, which needs to be made clear.

An exception to 1862(a)(1) needs to be added for this category of services.

SHARMAN'S LIST

Issues List - Benefits

1. Home-based respiratory therapy services

2. Durable medical equipment
   -- requirement that it be for in home use (e.g., motorized wheelchairs for disabled worker)
   -- assistive technology versus DME

3. Rehabilitative services - Physical, speech, occupational therapy
   -- requirement that the patient will improve significantly in a reasonalbe and generally predictable period of time
   -- question for HCFA while establishment of maintenance program is covered, is continuing professional oversight and periodic reevaluation and revision of maintenance program covered?

4. Chiropractic services only for subluxation of spine

5. Abortion - what is Medicare policy

6. Needles for administration of insulin and insulin pumps (need to check with Peter Hickman to see if Ways and Means drug benefit did anything on needles)

7. Adult routine office visits, and adult tetanus vaccine

8. ~~In vitro fertilization~~ and other ~~assistive reproductive~~ technology -- what is Medicare policy

9. Hospice -- waiver of therapeutic benefits

10. Balance billing and using your own money to purchase covered benefits

HEALTH SECURITY ACT (HSA) REFERENCES TO MEDICARE PROVISIONS IN TITLE XVIII OF THE SOCIAL SECURITY ACT

HSA §1111(c)(1) defines hospital by reference to §1861(e) and HSA §1115(f)(3) defines psychiatric hospital by reference to §1861(f), which in turn refers back to §1861(e).

> §1861(e) contains several specific references to "physicians," which would restrict the role of nonphysician practitioners. It requires utilization review, discharge planning, and institutional planning as defined elsewhere in title XVIII. It also contains numerous other references to detailed provisions in title XVIII that are irrelevant to HSA. It includes Christian Science Sanatoria, but excludes rural primary care hospitals.

HSA §§1111(c)(2) and 1115(c)(1) define "inpatient hospital services" and "inpatient and residential mental health and substance abuse treatment" by reference to §1861(b)(1)-(3).

> This includes an artificial, and troublesome, distinction between services <u>furnished by</u> a hospital and <u>furnished by others under arrangements</u>. It is both simpler and more flexible to refer to all the services as being <u>provided by</u> the hospital, without the distinction that depends on defining the term "arrangements." Thus, it would be more direct to create a new definition for HSA rather than use a cross-referral.

HSA §1117 describes hospice care by referring to portions of §1861(dd).

> This includes several references to the attending physician (effectively limited to an M.D. or D.O.), physician supervision, and physicians' services. Is this consistent with the general recognition of practitioners elsewhere in HSA?
>
> By avoiding the detail in §1861(dd)(2)(A)(iii), the result will be to recognize <u>inpatient</u> programs -- if that is not intended, some restriction on the extent of inpatient care is needed.

HSA §1118(a)(1) links home health care coverage to §1861(m).

> This requires each patient to be under the care of a physician, and that there be a plan of care established and reviewed by a physician. Is that restriction consistent with the general recognition of various practitioners elsewhere in HSA?
>
> HSA does not refer to Medicare's definition of "home health agency." Some or all of §§1861(o) and 1891(a) could be adopted for this purpose.

HSA §1118(a)(2) describes home infusion drug therapy services by referral to §1861(11), as added by HSA §2005.

This requires each patient to be under the care of a physician, and that there be a plan of care established and reviewed by a physician. Is that restriction consistent with the general recognition of various practitioners elsewhere in HSA?

HSA §1119(a) describes extended care services by referral to §1861(h).

This includes an artificial, and troublesome, distinction between services furnished by a skilled nursing facility and furnished by others under arrangements. It is both simpler and more flexible to refer to all the services as being provided by the skilled nursing facility, without the distinction that depends on defining the term "arrangements."

It also includes a Medicare-unique distinction for services obtained from a hospital with a transfer agreement. This has led to controversy for Medicare and should be avoided in HSA.

The distinction between what is "ordinarily furnished" and what is "routinely provided" continues to invite disputes of interpretation, as well as leave gaps in coverage.

Recognition of rehabilitation facilities is at odds with the Medicare reference to skilled nursing facilities.

In view of all these differences, it would be far simpler to develop a new definition for HSA rather than a cross-referral.

HSA §1122(a)(1) describes covered outpatient drugs by referral to §1861(t) as amended by HSA §2001(b), with certain exceptions.

The terms currently used in the existing statutory language in paragraph (1) of §1861(t) that refer to the compendia are outdated, e.g. there is no National Formulary currently published. In addition, paragraph (1) as it currently reads has the unintended consequence of allowing individual hospitals to define what is meant by the term "drugs and biologicals."

This definition excludes, at §1861(t)(3), drugs furnished as part of, or incident to, another item or service, as well as certain drugs not covered under Medicaid and/or Medicare. These exclusions may not be appropriate for HSA purposes.

HSA §1124(c) describes "durable medical equipment" by referral to §1861(n).

> Use of the term "durable" would limit coverage of this benefit, as it does under Medicare, to medical equipment that is durable in nature, as opposed to disposable equipment. However, in some instances, disposable medical equipment may be more cost-effective than comparable durable equipment. For example, disposable infusion pumps ($5-10) for a brief course of therapy could prove to be more cost-effective than durable infusion pumps which currently have a payment range of approximately $240 - $285 per month. On the other hand, coverage would be expanded to include many items that exist only in disposable forms. Neither the HSA nor the Medicare program recognize disposable equipment used in lieu of more expensive durable medical equipment.

LIST OF ASSOCIATED MEDICARE REGULATIONS

HSA SECTION	TITLE XVIII SECTION	42 CFR REFERENCE
1111(c)(1)	1861(e)	Part 482
1111(c)(2) & 1115(c)(1)	1861(b)(1)-(3)	409.10-.14, & .16
1115(f)(3)	1861(f)	Part 482
1117	1861(dd)[in part]	Part 418
1118(a)(1)	1861(m)	409.40-.42
1118(a)(2)	new 1861(11)	none
1119(a)	1861(h)	409.20-.27
1122(a)(1)	1861(t)[amended]	410.29
1122(c)	1861(s)(2)(I)	410.63(b)
1122(a)(1)(B)	new 1862(a)(18)	none
1124(c)	1861(n)	410.38

BENEFITS

- Medical equipment is covered only in the home under Medicare. Education and Labor adopted our definition of durable medical equipment which is intended to cover equipment used outside of the home (e.g., in school).

- Ways and Means does not change the definition of medical necessity under Medicare, which has been interpreted quite narrowly and does not include treatments that facilitate development and functioning. It is therefore less appropriate for a broader population.

- Well-child services are covered only to age 19 rather than age 21 as under Medicaid EPSDT. Why?

- Ways and Means states that no State could require a health plan to reimburse a class of providers other than those defined under Title XVIII of the Social Security Act. Qualified health plans (other than Medicare Part C) would not be prohibited from covering other legally authorized providers. Education and Labor did not specify eligible providers. This provision may limit the ability of some providers to get access to plans and may therefore be volatile.

TRANSMITTAL

Date: 7.8.94

To: Suzanne Stobert/

Location: Jen Klein/ Margie Ross

Phone Number:

Fax Number:

From:

Total Number of Pages Transmitted (Including fax cover sheet): 5

Message: Here are comments on W+M.

NRC Library
2101 Constitution Ave, NW
Washington, DC 20418

Main Library
Phone: (202) 334-2125
Fax: (202) 334-1651

Harris Building Annex
Phone: (202) 334-2022
Fax: (202) 334-2398

Foundry Building Annex
Phone: (202) 334-3957
Fax: (202) 334-1742

- Med nec.
- Get agu right
- preventive dental
- Must risk adjust capitated mental health plans.
- Why preventive services must be cost effective

Comments on Ways and Means Report on Benefits

Subtitle A

Section 1 - present law -

Page 1

The Federal HMO Act does have a defined benefit package and it includes preventive services, and Federal law also establishes a very clear benefit package under Medicaid, particularly for children with EPSDT.

ERISA does determine whether particular benefits are in or out of ERISA provisions re: compensation.

Page 2

Medicare does not cover routine clinician visits for preventive services for adults, only tests and immunizations. In addition, Medicare also covers influenza vaccine.

The beneficiary is liable for 100% of charges unless under assignment.

Other services not covered under Medicare include respiratory therapy, audiology services, speech-language services [as opposed to speech pathology services], and medical equipment used outside the home.

The medical necessity definition under Medicare is extremely limited and based on a medical, biological construct. It fails to recognize needs related to development and functioning and is therefore out of date for adults but especially problematic for children and persons with disabilities.

In general many of the provisions in the Medicare benefits package raises problems for non-elderly populations.

Page 3

Will indexing take into account regional adjustments and different labor markets?

Is all hospital and SNF care without cost sharing? This is good for children but could be costly incentive to use hospitals. This is particularly problematic for children where alternatives to hospitalization are usually preferred for developmental outcomes. Sets in stone out of date service delivery settings approach.

Why not index growth to part C growth only, as parts A & B will have much faster growth?

The out of pocket caps are huge and well beyond the means of most "middle class" working families, also bankrupting many poor working families through illness. Little "security seems afforded through this. It would also only be met by those with severe health care needs.

The copayment levels for HMO's seem very high. Already, the level of $10 of copay is higher than 70% of what plans now offer (see Foster Higgins 1993 survey in last edition of Health Affairs).

Why are well child services only covered to age 19. This was not specified in earlier drafts and is contrary to existing precedent in Medicaid with EPSDT going to 21 or 22.

Page 4

Preventive dental care for kids - why are specifications so limited? Should include fluoride applications, dental sealants, oral examinations, oral hygiene, i.e. all the services specified under prevention in Health Security Act, as these come at very little cost and great benefit to children.

The mention of routine lab tests should include reference to age and risk appropriate lab tests.

Coverage of outpatient rehabilitation services for children should include speech **language**, respiratory therapy, and audiology services. What does "provided other current law requirements are met" mean? What about specifying that these services should be coordinated with other benefits and agencies, including services under IDEA, ADA, and mental health and child welfare services. The need for coordination across service agencies IS NOT limited to services for mental health and substance abuse. Children with other chronic conditions and disabilities are also very much in need of this.

The requirement that additions or modifications to the clinical peventive services package meet cost effective and premium neutral criteria will result in few, if any, new and effective and clinically appropriate services being added. Cost effectiveness as a criterion, if it is to be applied, should be used for all services, not just preventive services.

Coverage for contraceptives drugs and devices as drafted would include all over the counter devices, including condoms. Is this intended? Alternative language would be to specify that coverage is for FDA approved prescription contraceptive drugs, biologicals, and devices.

The mammography coverage is inconsistent with current science showing that there is no evidence of mortality reduction in population based screening of women under 50.

Page 5

Specifications for STD screening excludes syphilis and HIV - is this intended? Also it is not clear why this begins at age 13 and ends at age 49.

Colorectal screening specifications should be for persons **over 50 only.** Will this be in both parts B and C or only C? (Please check with Doug Kamerow re: the high risk provisions for colonoscopy).

Why are updates on prevention only given to OTA. It should also refer to the work of the USPSTF. Given that the Secretary has authority to modify the package and so does Congress there appears to be duplication.

There appear to be numerous entities listed for the Secretary to consult with on different parts of the preventive services coverage - could these be consolidated or streamlined?

Page 6

Medicare definitions of providers are out of date, are likely to stifle health plan innovation and especially for provisions under Part C would result in mismatch of community provider capacity with reimbursability - i.e. many providers to low income populations, brought in by part C are served by non physician providers who have a restricted range of practice under Medicare.

The provisions for preemption or override of state practice acts are very unclear. Is it intended to override or not?

Page 7 - Mental health and substance abuse services

Page 8 -

The IDEA legislation is the operative one and covers individuals from birth through 21, not age 5 (that is only Part H and Part B).

Page 9 -

It is not clear how intensive community based services relate to health plans.

On outpatient psychotherapy, why use of age 18? Should be consistent throughout and be 21 as in EPSDT. There is no visit limit on these services, correct?

Page 10 -

Again, should be 21 years throughout.

Page 12 -

under (ix), should include developmental and functional outcomes, not just clinical.

Page 13 -

VERY IMPORTANT - capitated payments from plans or Medicare part C to states for managed mental health care should be well risk adjusted as it is likely to be the MOST SEVERE and difficult cases that will be transferred over to the State.

Page 15 -

It is understood that the conscience clause only applies to providers and institutions NOT employers, purchasers, or plans.

Klein

Subtitle B—Coverage of Outpatient Prescription Drugs and Other Changes in Medicare Benefits

PAR T

Peter -
Here's a mock-up of drug language. Anne S.
Karen our comments to Ellen M. Peter

SEC. 3101. (RIPTION

(a) COV AL AND

OTHER HEA (J) (42

U.S.C. 1395x VS:

"(J)

(b) DEFI OUTPATIENT DRUG.—Section 1861(t) (42 U.S.C. 1395x(t)) is amended—

(1) in the heading, by adding at the end the following: "; Covered Outpatient Drugs";

(2) in paragraph (1), by striking "paragraph (2)" and inserting "the succeeding paragraphs of this subsection"; and

(3) by striking paragraph (2) and inserting the following:

"(2) Except as otherwise provided in paragraph (3), the term 'covered outpatient drug' means any of the following products used for a medically accepted indication (as described in paragraph (4)):

cal need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

"(B) A biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product.

"(C) Insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"[*Review:* ~~(D) Parenteral nutrients~~ *given your comments on p. 73 and p. 74, I assume that enterals* (D) enteral nutrients provided as a "covered home infusion drug"

are covered only as home IV drugs (i.e., they're not subject to a rebate or to the out-of-pocket limit) and parenterals are covered as covered outpatient drugs (i.e., they're subject to a rebate and the out-of-pocket limit)].

"(3) The term 'covered outpatient drug' does not include any product—

"(A) which is administered through infusion in a home setting unless the product is a covered home infusion drug (as defined in paragraph (5));

"(B) when furnished as part of, or as incident to, any other item or service ~~[*Review:* (~~other than physicians' services~~)~~, for which payment may be made under this title; or

"(C) which is listed under paragraph (2) of section 1927(d) (other than subparagraph (B), (I), or (J) of such subparagraph) as a drug which may be excluded from coverage under a State plan under title XIX and which the Secretary elects to exclude from coverage under part B.

"(4) For purposes of paragraph (2), the term 'medically accepted indication', with respect to the use of an outpatient drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

drug or an enteral nutrient dispensed to an individual that—

"(i) is administered intravenously, subcutaneously, or epidurally, using an access device that is inserted in to the body and an infusion device [(or through other means determined by the Secretary)] of administration to control the rate of flow of the drug;

"(ii) is administered—

"(I) in the individual's home (including an institution used as the individual's home, other than a hospital under subsection (e) or a skilled nursing facility that meets the requirements of section 1819(a)), or during a day that is covered under Title 18.

"[*Review: (Crane amendment)*] (II) in a facility other than the individual's home if the administration of the drug at the facility is determined by the Secretary to be cost-effective (in accordance with such criteria as the Secretary may establish); and

"(iii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or the indication to which the drug is applied, that the drug cannot generally be administered safely and effectively [*Review effect of Crane amendment (if any):*] in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug or the indication to which the drug is applied, that the drug can generally be administered safely and effectively [*Review (see above):* in a home setting].

"(B) Not later than January 1, 1998, (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home infusion drugs, with respect to which home infusion drug therapy may be provided under this title.".

(c) CONFORMING AMENDMENTS REPEALING SEPARATE COVERAGE OF CERTAIN DRUGS AND PRODUCTS.—(1) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (A), by ~~inserting ", but not including covered outpatient drugs" after "self-administered"~~, deleting "(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)"

(B) by striking subparagraphs (G) and (I);

(C) by adding "and" at the end of subparagraph (M); and

(D) by striking subparagraphs (O), (P), and (Q).

(2) Section 1861 (42 U.S.C. 1395x) is amended by striking the subsection (jj) added by section 4156(a)(2) of OBRA–1990.

(3) Section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in the first sentence of paragraph (1)—

(i) by striking ", (B)" and inserting ", and (B)", and

(ii) by striking ", and (C)" and all that follows and inserting a period;

(B) in paragraph (11)—

(i) by striking "(11)(A)" and inserting "(11)", and

(ii) by striking subparagraphs (B) and (C).

(4) Sec. 1861(t)(1) is amended by adding "used for a medically accepted indication described in par. (4)" after "respectively".

SEC. 3102. PAYMENT RULES AND RELATED REQUIREMENTS FOR COVERED OUTPATIENT DRUGS.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

"(d) PAYMENT FOR AND CERTAIN REQUIREMENTS CONCERNING COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Payment shall be made under paragraph (2) only for expenses incurred by an individual for a covered outpatient drug during a calendar year after the individual has incurred expenses in the year for such drugs (during a period in which the individual

is entitled to benefits under this part) equal to the deductible amount for that year.

"(B) DEDUCTIBLE AMOUNT.—

"(i) For purposes of subparagraph (A), the deductible amount is—

"(I) for 1998, an amount equal to $500, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year and by the percentage increase computed under section 8206(b) of the Health Security Act for 1998; and

What does this mean?

"(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Health Security Act for that succeeding year.

"(ii) The Secretary shall promulgate the deductible amount for 1998 and each

succeeding year not later than October 1 of the previous year.

"(C) SPECIAL RULE FOR DETERMINATION OF EXPENSES INCURRED.—In determining the amount of expenses incurred by an individual for covered outpatient drugs during a year for purposes of subparagraph (A), there shall not be included any expenses incurred with respect to a drug to the extent such expenses exceed the payment basis for such drug under paragraph (3).

Not necessary

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the deductible established under paragraph (1), the amount payable under this part for a covered outpatient drug furnished to an individual during a calendar year shall be equal to—

"(i) 80 percent of the payment basis described in paragraph (3), in the case of an individual who has not incurred expenses for covered outpatient drugs during the year (including the deductible imposed under paragraph (1)) in excess of the out-of-pocket limit for the year under subparagraph (B); and

"(ii) 100 percent of the payment basis described in paragraph (3), in the case of any other individual.

"(B) OUT-OF-POCKET LIMIT DESCRIBED.—

"(i) For purposes of subparagraph (A), the out-of-pocket limit for a year is equal to—

"(I) for 1998, $1000, increased by the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year and by the percentage increase computed under section 8206(b) of the Health Security Act for 1998; and

"(II) for any succeeding year, the amount applicable under this subparagraph for the previous year, increased by the percentage increase computed under section 8206(b) of the Health Security Act for that succeeding year.

What for? 23 years?

"(ii) The Secretary shall promulgate the out-of-pocket limit for 1998 and each succeeding year not later than October 1 of the previous year.

"(C) SPECIAL RULE FOR DETERMINATION OF EXPENSES INCURRED.—In determining the amount of expenses incurred by an individual for covered outpatient drugs during a year for purposes of subparagraph (A), there shall not be included any expenses incurred with respect to a drug to the extent such expenses exceed the payment basis for such drug under paragraph (3).

Not necessary

"(3) PAYMENT BASIS.—For purposes of paragraph (2), the payment basis is the lesser of—

"(A) the actual charge for a covered outpatient drug, or

"(B) the applicable payment limit established under paragraph (4).

"(4) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR SINGLE SOURCE DRUGS AND MULTIPLE SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a covered outpatient drug that is a multiple source drug which has a restrictive prescription,

or that is single source drug, the payment limit for a payment calculation period is equal to—

"(i) the 90th percentile of the actual charges (computed on the geographic basis specified by the Secretary) for the drug product for the second previous payment calculation period, or

"(ii) the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the per unit estimated acquisition cost for the drug product (determined under subparagraph (C)) for the period,

whichever is less.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug which does not have a restrictive prescription, the payment limit for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (5)) plus the product of the number of dosage units dispensed and the unweighted median of the unit estimated acqui-

sition cost (determined under subparagraph (C)) for the drug products for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) INITIAL PAYMENT CALCULATION PERIOD.—Subject to clause (ii), the Secretary shall determine, for the dispensing of a covered outpatient drug product in the payment calculation period beginning January 1, 1998, the estimated acquisition cost for the drug product, based upon—

"(I) in the case of a single source drug or multiple source drug with a restrictive prescription, based upon information from the period beginning in 1994 updated (in a compound manner) by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 4 12-month periods ending with June 1997; or

"(II) in the case of a multiple source drug without a restrictive prescription, based upon information from the most recent year for which data is available.

"(ii) LIMITATION.—With respect to any covered outpatient drug product, the estimated acquisition cost in the payment calculation period described in clause (i) may not exceed 93 percent of the published average wholesale price for the drug ~~during~~ as determined One month prior to the beginning of the ~~the previous~~ payment calculation period.

"(iii) SUBSEQUENT PERIODS.—The estimated acquisition cost for a covered outpatient drug product applicable under this subparagraph for the dispensing of a drug product in a payment calculation period beginning in January of each year (beginning with 1999) shall be equal to the estimated acq. cost for the product determined under this subparagraph for the period ending in January of the previous year, increased by the uniform percentage increase determined under section 8206(a) for the class of services that includes prescription drugs for the year involved. Notwithstanding the previous sentence, with respect to any covered outpatient drug product, such cost may not exceed 93 percent of the published

average wholesale price for the drug ~~during~~ as determined one month prior to the beg. of the ~~the previous~~ payment calculation period.

"(iv) COMPLIANCE WITH REQUEST FOR INFORMATION.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide price information requested to carry out clauses (i), (ii), or (iii), or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as they apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to clause (i), (ii), or (ii) shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part or to enable the Comptroller General to review the information.

"(D) UPDATES TO PAYMENT LIMITS.—Notwithstanding any other provision of this paragraph, the payment limit determined under this paragraph with respect to a payment calculation period may not exceed the payment limit for the preceding year, increased by the [*Review: (should be same as index used for cost-sharing)* percentage increase computed under section 8206(b) of the Health Security Act].

"(5) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the administrative allowance established under this paragraph is—

"(i) for 1998, an amount equal to $5, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 4 12-month periods ending with June 1997; and

"(ii) for each succeeding year, the amount for the previous year, adjusted by the percentage change in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that previous year.

"(B) REDUCTION FOR MAIL ORDER PHARMACIES.—The Secretary may, after consulting with representatives of pharmacists, individuals enrolled under this part, and of private insurers, reduce the administrative allowances established under subparagraph (A) for any covered outpatient drug dispensed by a mail order pharmacy, based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(C) NO DISPENSING FEE FOR CERTAIN DRUGS AND PRODUCTS.—No administrative allowance may be provided under this paragraph with respect to any of the following covered outpatient drugs:

"(i) Erythropoietin. furnished by a provider or supplier to a [illegible] patient

"(ii) Antigens [*Review:* furnished by a physician--*what's the difference between this and an antigen furnished as an incident to a physician's service?*].

"(iii) Drugs and biologicals provided as an incident to a physician's service (PA, NP, CNS, NM-W

"(iv) Covered home infusion drugs.

"(6) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

"(iii) ADDITIONAL DUTIES.—In carrying out this subparagraph, the Secretary shall—

"(I) develop public domain software which could be used by pharmacies to provide the on-line prospective review; and

"(II) study the feasibility and desirability of requiring patient diagnosis codes on prescriptions and the feasibility of expanding the prospective review program to include the identification of drug-disease contraindications, interactions with over-the-counter drugs, and drug-allergy interactions.

"(C) COUNSELING.—[*Review: Is there anything left here, especially given (B)(ii) above?*]

"(D) PRIOR AUTHORIZATION.—

"(i) DEVELOPMENT OF LIST OF MISUSED DRUGS.—The Secretary shall develop (and periodically) update a list of covered outpatient drugs which the Secretary has determined, based on data collected, may be subject to misuse or inappropriate use. The Secretary shall provide a means for

manufacturers to appeal an initial decision to include a drug on the list.

"(ii) PRIOR AUTHORIZATION FOR DRUGS ON LIST.—The Secretary shall establish a process under which (subject to clause (iii)) the Secretary [*Review:* may--*is this optional or mandatory?*] require advance approval for any covered outpatient drug included on the list developed under clause (i).

"(iii) RESTRICTIONS ON DENIAL OF APPROVAL.—The Secretary may not deny the approval of a drug under the process established under clause (ii) before its dispensing the process—

"(I) provides responses by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(II) provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in emergency situations.

"(iv) STUDY OF EXPANSION TO OTHER DRUGS.—The Secretary shall study

(1) in the heading—

(A) by striking "PHYSICIAN", and

(B) by inserting "BY PHYSICIANS AND SUPPLIERS" after "CLAIMS",

(2) in the matter in subparagraph (A) preceding clause (i)—

(A) by striking "For services furnished on or after September 1, 1990, within 1 year" and inserting "Within 1 year (or 90 days in the case of covered outpatient drugs)",

(B) by striking "a service" and inserting "an item or service", and

(C) by inserting "or of providing a covered outpatient drug," after "basis," and

(3) in subparagraph (A)(i), by inserting "item or" before "service".

(c) SPECIAL RULES FOR CARRIERS.—

(1) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

"(D) With respect to activities related to covered outpatient drugs, the Secretary may enter into contracts with carriers under this section to perform the activities on a regional basis.".

and operate (and for related functions with respect to) the electronic system established under section 1834(d)(8)(B) for covered outpatient drugs under this part;".

(3) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(A) by inserting "(i)" after "(c)(1)(A)",

(B) in the first sentence, by inserting ", except as otherwise provided in clause (ii)," after "under this part, and", and

(C) by adding at the end the following:

"(ii) To the extent that a contract under this section provides for activities related to covered outpatient drugs, the Secretary may provide for payment for those activities based on any method of payment determined by the Secretary to be appropriate.".

(4) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (4), each";

(B) by adding at the end the following new paragraph:

"(ii) in the case of a non-innovator multiple source drug or insulin furnished [*Review: (what does this mean?)* over-the-counter], 10 percent of the average manufacturer retail price.

"(2) DEPOSIT OF REBATES.—The Secretary shall deposit rebates under this section in the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"(d) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a manufacturer under this section is confidential and shall not be disclosed by the Secretary (or a carrier), except—

"(A) as the Secretary determines to be necessary to carry out this section,

"(B) to permit the Comptroller General to review the information provided, and

"(C) to permit the Director of the Congressional Budget Office to review the information provided.

"(e) AGREEMENT TO GIVE EQUAL ACCESS TO DISCOUNTS.—An agreement under this subsection by a manufacturer of covered outpatient drugs shall guarantee that the manufacturer will offer, to each wholesaler or retailer

(or other purchaser representing a group of such wholesalers or retailers) that purchases such drugs on substantially the same terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing the manufacturer's costs) as any other purchaser (including any institutional purchaser) the same price for such drugs as is offered to such other purchaser. In determining a manufacturer's compliance with the previous sentence, there shall not be taken into account terms offered to the Department of Veterans Affairs, the Department of Defense, or any public program.

"(f) DEFINITIONS.—For purposes of this section—

"(1) AVERAGE MANUFACTURER RETAIL PRICE.—The term 'average manufacturer retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price (inclusive of discounts for cash payment, prompt payment, volume purchases, and rebates (other than rebates under this section), but exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacy class of trade.

the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month, that is attributable to covered outpatient drugs.".

SEC. 3106. COVERAGE OF HOME INFUSION DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home infusion drug therapy services" before the semicolon.

(b) HOME INFUSION DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by redesignating the subsection (jj) inserted by section 4156(a)(2) of the Omnibus Budget Reconciliation Act of 1990 as subsection (kk); and

(2) by inserting after such subsection the following new subsection:

"Home Infusion Drug Therapy Services

"(ll)(1) The term 'home infusion drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as the individual's home, (including an institution used as the individ's home, other than a hospital under subsec. (d) or SNF described in sec. 1819 (a) during a day that is covered under Title 18).

"(B) by a qualified home infusion drug therapy provider (as defined in paragraph (3)) or by others

under arrangements with them made by that provider, and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively a drug regimen through use of a covered home infusion drug (as defined in subsection (t)(5)), but do not include such covered home infusion drugs.

"(3) The term 'qualified home infusion drug therapy provider' means any entity that the Secretary determines meets the following requirements:

Except as provided in par. (4)

"(A) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home infusion drugs.

"(B) The entity maintains clinical records on all patients.

"(C) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(D) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(E) The entity coordinates all service with the patient's physician.

"(F) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(G) The entity assures that only trained personnel provide covered home infusion drugs (and any other service for which training is required to provide the service safely).

"(H) The entity assumes responsibility for the quality of services provided by others under arrangements with the entity.

"(I) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, the entity (i) is licensed pursuant to such law, or (ii) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(J) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home infusion drug therapy services and the efficient administration of the home infusion drug therapy benefit.".

(c) PAYMENT.—

(4) The Sec. shall determine which of the reqs. described in par. (3) shall apply to HHAs meetings the reqs. of sec. 1891 and to an entity that furnishes only enteral nutrition therapy services.

the actual charges for such services or the fee schedule established under paragraph (2).

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of 1998 and each succeeding year a fee schedule for home infusion drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis."

(3) PROHIBITION ON CERTAIN REFERRALS.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following:

"(L) Home infusion drug therapy services.".

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (E),

(2) by striking the period at the end of subparagraph (F) and inserting "; and", and

(3) by inserting after subparagraph (F) the following:

"(G) in the case of home infusion drug therapy services, (i) such services are or were required because the individual needed such

is amended by adding at the end the following new subsection:

"(k) With respect to carrying out functions relating to payment for home infusion drug therapy services and covered home infusion drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

(g) CONFORMING AMENDMENTS RELATING TO COVERAGE OF ENTERAL AND PARENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—(1) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by striking ", except that" and all that follows through "equipment".

(2) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after "dental" the following: "devices or enteral and parenteral nutrients, supplies, and equipment".

(3) Sec. 1861(n) is amended by adding at end of 1st sentence and does not include ~~including~~ equipment + supplies associated with home infusion drug therapy services described in 1861(lll)(2) or any drug used in conjunction with DME.

QUESTIONS AND ANSWERS ABOUT THE WAYS AND MEANS HEALTH REFORM PROPOSAL

On June 30, 1994 the Ways and Means Committee approved a substitute to the President's proposed health reform plan. The legislation approved by the Committee is based on the health reform plan passed by the Ways and Means Health Subcommittee, and includes key improvements made by the full Ways and Means Committee.

This plan offers a simple and logical way of achieving the President's goals of universal coverage and cost containment that:

- **Minimizes disruption to our current health care system and to the 85% of Americans who already have health care insurance**
- **Guarantees unrestricted choice of doctors and hospitals for all Americans -- regardless of income**
- **Is affordable to all**
- **Ensures and improves the quality of care**
- **Creates no new bureaucracies**
- **Creates no new broad-based taxes**

Under the plan, every American will be covered by the comprehensive set of health care benefits by January 1998 and, by the year 2001, health care inflation will be brought in line with the rest of the economy.

Question: [redacted]

Answer: The Ways and Means plan includes three steps that, together, provide a concrete path to health security for all.

The plan will build on our existing employer-based system to ensure coverage for everyone who is connected to the work force. Today, the majority of Americans who have health insurance get their insurance through their employer or the employer of someone in their family. The plan will expand on this system by requiring that all employers pay a share of the premium for their workers. Because more than 80 percent of those without insurance are connected to the work force, this simple step will provide health insurance to the majority of people who are currently uninsured.

The plan will create a new safety-net program to ensure coverage for those who do not have access to an employer-sponsored plan. Although expanding our employer-based system will get us most of the way there, it is necessary to make sure that people not connected to the work force have a health plan to join. The Ways and Means plan will establish a new federal safety-net program -- modeled after the popular Medicare program -- to ensure that there is always an easy-to-join and affordable health plan available to those without access to an employer-sponsored or other private health plan.

The plan will reform our insurance system to make sure that no one will lose or be denied coverage . Under the Ways and Means plan, health plans will not be allowed to deny coverage to anyone, to cancel a person's coverage, to exclude coverage for pre-existing conditions, or to charge higher premiums to people because they are older or have worse medical histories. These changes will ensure that everyone who has coverage can keep it -- and that all those who have been denied coverage or canceled from coverage can get it.

Question: ***How will the plan control health care costs?***

Answer:: The Ways and Means plan will slow the rate of growth in health costs so a greater portion of our personal -- and national -- incomes are not consumed by health care each year.

Under a new national cost containment system, the rate of growth in health spending will be brought in line with increases in the rest of the economy. The total amount of money we currently spend on health care will not be decreased, but the rate at which this amount is growing will be gradually slowed down.

Under the plan, national "estimated rates of growth" for health spending will be set each year. For the first several years of the program, the estimated rate of growth will be gradually reduced until it is brought in line with growth in the rest of the economy.

Through insurance reforms and other provisions, the Ways and Means bill will allow the private sector to control private sector costs by encouraging greater competition in the health care market. If after five years, these market forces fail to control costs, a system of cost containment would go into effect.

In those states where where market reforms and other state strategies don't work, a national "fee schedule" system -- or an alternative system proposed by a new national cost containment commission (which will be adopted, rejected, or changed by the Congress in 2000) -- will be applied. Under the fee schedule system, maximum payment rates for medical services would be set, and each year, these rates would be increased at levels that would keep spending within the target.

Like they are now, these "fee schedule" rates would be used to pay doctors and hospitals who provide care under the Medicare programs.

By controlling costs in this way, the Ways and Means plan will give the private market a fair chance to control costs, will keep fee-for-service medicine affordable, and will maintain the kind of delivery system that most patients and providers prefer.

Question: ***What benefits will be included in the standard package?***

Answer: Every American will be guaranteed a health insurance package that covers a comprehensive set of medical benefits, including prescription drugs, mental health and substance abuse services, and preventive care. Covered minimum benefits will include:

Service	Cost-Sharing Schedule: Fee-for-Service	Managed Care
Inpatient hospital services	no cost sharing	no cost sharing
Outpatient hospital services	20% co-pay	$15.00
Physician and other health professional visits	20% co-pay	$15.00
Medical and other health services including services and supplies provided as part of a physician's care, diagnostic , laboratory and other tests, surgical dressings, splints and casts, durable medical equipment, ambulance services, prosthetic devices, hearing aids for children, physical, occupational and speech therapy services, nurse mid-wife services	20% co-pay except no co-pay for diagnostic tests	$15.00
Outpatient prescription drugs /biologicals	20% co-pay	$10.00
Mental health and substance abuse services , including intensive residential and community services	20% psychotherapy co-pay for children; 20% psychotherapy co-pay for first 5 adult	$25.00 adult psycho-therapy; $25.00 child psychotherapy; $30 intensive non-

In those states where where market reforms and other state strategies don't work, a national "fee schedule" system -- or an alternative system proposed by a new national cost containment commission (which will be adopted, rejected, or changed by the Congress in 2000) -- will be applied. Under the fee schedule system, maximum payment rates for medical services would be set, and each year, these rates would be increased at levels that would keep spending within the target.

Like they are now, these "fee schedule" rates would be used to pay doctors and hospitals who provide care under the Medicare programs.

By controlling costs in this way, the Ways and Means plan will give the private market a fair chance to control costs, will keep fee-for-service medicine affordable, and will maintain the kind of delivery system that most patients and providers prefer.

Question: ***What benefits will be included in the standard package?***

Answer: Every American will be guaranteed a health insurance package that covers a comprehensive set of medical benefits, including prescription drugs, mental health and substance abuse services, and preventive care. Covered minimum benefits will include:

Service	Cost-Sharing Schedule	
	Fee-for-Service	Managed Care
Inpatient hospital services	no cost sharing	no cost sharing
Outpatient hospital services	20% co-pay	$15.00
Physician and other health professional visits	20% co-pay	$15.00
Medical and other health services including services and supplies provided as part of a physician's care, diagnostic , laboratory and other tests, surgical dressings, splints and casts, durable medical equipment, ambulance services, prosthetic devices, hearing aids for children, physical, occupational and speech therapy services, nurse mid-wife services	20% co-pay except no co-pay for diagnostic tests	$15.00
Outpatient prescription drugs /biologicals	20% co-pay	$10.00
Mental health and substance abuse services , including intensive residential and community services	20% psychotherapy co-pay for children; 20% psychotherapy co-pay for first 5 adult	$25.00 adult psycho-therapy; $25.00 child psychotherapy; $30 intensive non-

	Fee-for-Service	Managed Care
Mental Health and Substance Abuse Services, cont	visits, 50% thereafter; 20% co-pay for community services	residential services; $15.00 brief outpatient visits
Outpatient ambulatory services	20% co-pay	$15.00
Outpatient rehabilitation facility services	20% co-pay	no cost sharing
Rural and community health clinic services	no cost sharing	no cost sharing
Post-hospital in-patient nursing facility Services	no cost sharing	no cost sharing
Home health care	20% co-pay	no cost sharing
Hospice care	approximate 5% hospice-provided outpatient drug co-pay	no cost sharing
Newborn, well-baby care, well-child care	no cost sharing	no cost sharing
Preventive care, including adult immunizations, mammograms, pap smears, and colorectal screening	20% co-pay	$15.00
Pregnancy-related services -- including pre and post natal care -- and all family planning services	20% co-pay all services except no co-pay for prenatal care	no co-pay for prenatal care; $15.00 all other services

- Under the fee-for-service cost-sharing schedule there would be a general deductible of $500 per year for individuals and $750 per year for families (with inpatient hospital services and post-hospital nursing care exempted from the deductible). The prescription drug benefit would also include a separate $500 deductible, and a $1000 out-of-pocket expense limit. The prescription drug deductible for managed care cost-sharing will be set by the Secretary of HHS.

- There will be an overall cap on out-of-pocket personal expenditures of $5,500 per year for individuals and $11,000 for families beginning in the year 2003.

Question: *What happens if I want additional benefits to those covered in the standard benefit package?*

Answer: The Ways and Means plan does not in any way limit the amount or kind of additional benefits that people can buy.

The Secretary of Health and Human Services will define ten standard supplemental insurance packages that insurers can offer. Any individual who wants to purchase supplemental insurance or additional benefits -- either to cover services not included in the basic benefit package, or to cover co-pays and deductibles -- may purchase these benefits. And, any employer who wants to provide benefits that exceed those covered by the standard package can do so, so long as they provide the extra benefits to all of their employees equally.

By establishing a set of standardized supplemental packages, the plan will help consumers make meaningful comparisons among supplemental packages, and will ensure that consumers are not being offered supplemental insurance for benefits already provided in the nationally guaranteed package.

Question: ***In general, how does this plan change the current health care system?***

Answer: One of the main objectives of the Ways and Means plan is to fix what is wrong with our current system while making as few changes as possible to existing relationships among insurers, employers, providers, and consumers, and to the way people already purchase, pay for, and get their health care. As a result, there will in general be little disruption -- and few changes -- to the current system.

Most people will continue to receive their health insurance through private plans provided through their employers; employers will retain their role as negotiators on behalf of their employees; employees will continue to contribute to their coverage through deductions from their paychecks; employers will continue to make premium payments directly to insurers; and all the options which currently exist for health care delivery -- including fee-for-service and managed care -- will continue. In addition, employers may choose to offer their employees and contribute to a high deductible medical savings account.

Question: ***How will this plan affect me, and what kind of changes will I see?***

Answer: There are several basic and important benefits to everyone. Everyone will see a reduction in the rate at which their health premiums increase. No one will be denied coverage or lose their coverage when they change jobs. Over time, as the cost to employers of providing coverage decreases, workers should also see an increase in their wages.

For most people, the specific changes they will experience in their current health care arrangements will be minimal.

People Who Currently Have Private Health Insurance -- People who currently have coverage under an employer-sponsored or other private

health plan will see few or no changes. If their employer is not currently contributing at least 80% of the cost of the plan, the employer will be required to do so. For people whose current benefit package does not at least equal the guaranteed national benefit package, they will see an improvement in their package to meet these standards. Employers who currently provide benefits that exceed the guaranteed national benefit package will be required to provide these benefits for another five years.

Medicare Beneficiaries -- People who currently receive coverage through the Medicare program will see no changes, except for an enhancement of the Medicare benefit package to include coverage of outpatient prescription drugs, colorectal screenings, an improved mamography benefit, and more expansive mental health benefits. To help pay for these new benefits, a 20% co-pay added for home health services.

Uninsured Workers -- Uninsured people who work, or who are dependent family members of workers, will receive coverage either through a private plan offered by their employer, or through the Medicare Part C program. Employers will be required to cover at least 80% of the cost of their full-time workers' health insurance, and to contribute to the cost of coverage for their part-time workers on a per-hour worked basis.

Uninsured, Not Connected to Work force -- People who are uninsured and not connected to the work force will be covered under either Medicare Part C or a private plan.

Medicaid beneficiaries -- People who currently get their health care through the Medicaid program and are connected to the work force will get coverage either through an employer-sponsored private plan, or through the new Medicare Part C program. Medicaid beneficiaries who are not connected to the work force will, in general, enroll in Medicare Part C. Most Medicaid beneficiaries will see no change in their benefits. Many Medicaid beneficiaries who are in managed care plans now, and who do not have free choice of doctors, will be able to join a plan that allows this choice.

Active and retired military in Champus and Eligible Veterans -- People who receive their care under the CHAMPUS and Veteran's Administration programs will see no change in their current arrangements.

Question: ***How much will health coverage cost individuals?***

Answer: In general, the maximum amount most people will pay for health insurance will be limited to 20 percent of the cost of their insurance. Employers will pay 80 percent of the cost of the package for their full-time employees, and will contribute for their part-time workers based upon the number of hours worked.

Under the Ways and Means plan, every insurer will be required to offer the guaranteed benefit package for three basic "classes" of enrollment: individual, single-parent, and couple with children. Couples without children may choose to purchase two "individual" policies.

The table below illustrates the estimated cost of the guaranteed benefit package, along with the approximate amount that full-time workers will pay each year.

Estimated Cost of Guaranteed National Benefit Package under the Ways and Means Plan

	Individual	Employer	Total
Individual	$428 (.21/hr)	$1,712 (.84/hr)	$2,140 (1.05/hr)
Single Parent	$834 (.41/hr)	$3,336(1.63/hr)	$4,170(2.04/hr)
Couple with Children	$1,134(.56/hr)	$4,536 (2.22/hr)	$5,670 (2.78/hr)

In general, although premiums will vary somewhat across insurers, coverage for a comprehensive set of medical benefits will be available to every person -- depending upon family status -- for between about $35 and $95 a month. For those whose employers choose to contribute more than the required amount, or for those whose employers offer an alternative "high-deductible medical savings account" plan, these amounts may be even less.

Question: ***What about low-income people who cannot afford to pay?***

Answer: The plan would make sure that <u>every</u> person can afford to purchase the health insurance to which they are entitled, and to use the services covered by the guaranteed benefit package.

Everyone who has an income below 240 percent of poverty (approximately $16,800 for an individual, and $24,000 for a family of three) will receive help paying their premiums. Some low-income people -- including AFDC and SSI recipients and people with incomes below the poverty level -- will not have to pay anything towards their premiums.

In addition, people with incomes below the federal poverty level, as well as pregnant women and children below 200 percent of poverty and AFDC or SSI recipients, will not be required to pay co-payments or deductibles.

Question: ***Will I have unrestricted choice of doctors and hospitals?***

Answer: *YES!* Everyone, regardless of income level, will be able to choose a plan that gives them free choice of doctors and hospitals. People who already have a doctor and want to keep that doctor will be able to, and people who currently don't have this kind of choice will get it.

Under the Ways and Means plan, real choice of doctors and hospitals will be guaranteed: employers who offer private insurance will be required to make available to their employees a plan that allows unlimited choice of doctors, managed care plans will be required to allow members to go "out-of-network" to get care, and everyone who receives coverage under the Medicare C program - a fee for service program -- will have free choice.

To make sure that access to an affordable free-choice plan is available to all, unemployed low-income people and low income people working for small employers will be able to enroll in the Medicare C program.

Question: ***How will this plan affect the quality of care?***

Answer: The quality of health care provided to us all will be improved.

Under the Ways and Means Committee plan, the current uneven regulation and evaluation of health plans and providers will be replaced by uniform quality standards, evaluation, and reporting.

Every health plan will have to meet a set of basic national standards that includes establishing a quality assurance program, having a grievance and appeals process in place, and not operating physician incentive programs designed to reduce the number of medically necessary services provided.

A new national quality assessment program will evaluate the quality of care actually provided by health plans and providers. Health plans will be assessed to measure the access to health services among their enrollees, the appropriateness and outcomes of the services provided, and patients' overall satisfaction with their care. States will be required to provide the results of these assessments to consumers at least once each year, and to take steps to fix any problems that are found.

As added assurance that people do not "get stuck" in health plans that are not meeting their needs, the proposal will ensure that every individual is able to change health plans at any time during their first year of enrollment in a plan (individuals could make such a change once within the year).

Question: ***What will be done to ensure access to care for people living in underserved rural and inner city areas?***

Answer: People living in rural and inner-city communities often face special barriers to obtaining health care that others don't face. These barriers include a shortage of doctors and other health care providers, inadequate medical facilities, and an insufficient number of health plans serving these areas.

The Ways and Means plan includes four initiatives to eliminate these barriers and to make access to health care a reality for people in inner-city and rural areas.

- Grants will be available to all fifty states to help them develop health care networks in rural areas.

- A new program of grants will be made available to local governments and health care facilities to help them expand or establish primary and acute care networks in underserved areas.

- Financial assistance will be provided through a new federal trust fund to inner city and rural medical facilities to help them meet their capital financing needs.

- The number of primary care doctors practicing in urban and rural areas will be increased by paying Medicare bonuses, and by providing tax incentives to primary care doctors in these areas.

Question: ***Will the tax treatment of health benefits be changed?***

Answer: For most people, the way their health coverage is treated for tax purposes will remain the same. Just like now, employer contributions to health insurance will not be counted as taxable income for individuals, and employers will be able to deduct the full cost of contributions made to their workers' coverage.

For those people who are self-employed, however, the tax treatment of health insurance will be changed: whereas these individuals are currently able to deduct only 25 percent of the cost of their health coverage, under the the Ways and Means proposal, self-employed people will be able to deduct 80 percent cost of the cost of their coverage beginning in 1998.

Question: ***How will doctors and hospitals be affected by the plan?***

Answer:

- Hospitals that are currently overburdened by indigent care and other unreimbursed costs will see a dramatic reduction in these costs.

- Those hospitals that are already making innovative changes in the delivery system will be able to continue pursuing these innovations.

- Doctors who want to continue practicing in a fee-for-service setting will be able to, and opportunities for those who prefer to practice in high quality managed care settings will be increased.

- Burdensome billing and administrative procedures will be eliminated for both doctors and hospitals by the use of uniform electronic claims, medical records, and entitlement verification systems.

- Doctors and hospitals who currently serve Medicaid patients will see a significant increase in reimbursement for care provided to these patients as they are brought into private plans and the new Medicare Part C program.

- Hospitals that serve the vital function of training our nation's doctors will receive needed assistance in meeting the costs associated with providing this service

Question: ***How will small employers be able to afford to pay?***

Answer: More than half of all employers with fewer than 100 employees already contribute to the cost of health coverage for their workers. Among small employers who do help pay, the average contribution in 1992 was about $2,300 -- approximately the same amount, on average, that medium and large firms contributed (EBRI, *Sources of Health Insurance and Characteristics of the Uninsured*, 1994). For these firms, and particularly for those that currently offer this level of coverage to all their employees, providing coverage under the Ways and Means Committee plan will result in minimal if any additional payments.

Those small businesses which are currently least likely to help pay for their employees health coverage are low-wage businesses with fewer than 50 employees. The Ways and Means plan will help low-wage small

businesses who would otherwise have a difficult time making their required contributions in several ways.

Subsidies will be provided to small, low-wage businesses to reduce the amount they must contribute toward their workers' premiums: firms with 25 or fewer employees would be eligible for a maximum subsidy of 50 percent, and firms with 26-50 employees would be eligible for a maximum subsidy of 37.5 percent. For companies with 25 or fewer employees, the subsidy will reduce the employer obligation for an individual premium from about $.85 per hour to about $.42 per hour. For companies with 26-50 employees, the subsidy will reduce the obligation to about $.53 per hour.

The new Medicare Part C program will offer small employers a simple and affordable way of providing high quality coverage for their employees.

Question: ***How will states be affected by the plan?***

Answer: Under the Ways and Means Committee plan, states will have broad flexibility to create the kind of health system that best meets the needs and desires of their citizens -- so long as the system meets the national goals of universal coverage and cost containment. Those states who have already started reforming their systems will be able to continue with these reforms, and those who would like to establish their own system -- including single payer, managed competition, or employer mandate systems -- will be able to.

States may also see a significant reduction in their health care spending under the proposal. As their uninsured residents are brought into the health care system, the increasingly large share of state and county resources being consumed by uncompensated hospital care and indigent health care programs should be reduced.

Question: ***What does the plan do about long-term care?***

Answer: Meeting the long-term care needs of disabled and elderly individuals is one of the most important challenges we face. This requires both ensuring the well-being of existing long-term care programs, and creating new programs to serve those who don't qualify for these programs.

The Ways and Means plan will significantly expand the availability of long-term care for disabled individuals. Under the plan, a new federal program will provide home and community based services -- including personal assistance services, home modifications, and home health services -- to people with severe disabilities, regardless of their age or income. The plan

will also preserve Medicaid's existing long-term care program for low-income Americans.

Question: ***How will the plan be paid for? And how will it affect the deficit?***

Answer: Most of the cost of the program will be covered by contributions from employers and individuals. Additional funds will be required to pay for improvements to the current Medicare program, the new long-term care program, subsidies for low income individuals and small, low-wage companies, and assistance to academic medical centers. Funds to cover these costs will be raised in four sensible and fair ways: savings from slowing the rate of growth in Medicare and Medicaid costs; a gradual and moderate increase in the tax on tobacco products; eliminating the tax subsidy for health benefits provided through cafeteria plans; and a 2 percent tax on private health insurance premiums.

As reported by the Committee, the plan will reduce the deficit by about $2 billion in the first five years of the program, and will provide additional long term savings to reduce the federal deficit.

Question: ***Are fee schedules for medical services "price controls" and don't they have the same problems as price controls?***

Answer: **No!** Fee schedules for medical services and supplies are not price controls, and the four common concerns raised about price controls do not apply to limits on medical fees.

The first concern is that price controls require a large bureaucracy in order to communicate prices to millions of buyers and sellers, and to make sure everyone is charging and paying the right amounts. Fee schedules for medical services, however, do not require any "bureaucracy" beyond the few payers -- public and private insurers -- themselves. Each of these payers has a strong incentive to know and pay only the right price, and each of the sellers -- doctors and hospitals -- has strong incentive not to jeopardize a relationship that probably pays the bills for hundreds of patients. In fact, the vast majority of private insurers already use some form of fee schedule to establish the amounts they will pay for each service

The second concern is that price controls make the buying and selling of goods more complicated. Fee schedules, however, actually *simplify* the administrative aspects of "selling" and "purchasing" health care. In a system without fee schedules, doctors and hospitals have to figure out what different insurers will pay for their services, insurers have to figure out providers' "charges", and disagreements have to be fought over and resolved. With fee

schedules, everyone knows what they can charge and what they will be expected to pay.

The third is that price controls only hold costs down temporariiy, and that when the controls are removed, inflation comes back at even higher levels than before. Fee schedules for medical services, however -- although updated and revised -- are never removed. As a result, there is no danger of a bout of post-control inflation

The fourth concern is that price controls lead to "waiting lists" or "shortages". Fee schedules for doctors and hospitals, however, do not impose any kind of constraint or limit on a medical system's capacity to provide needed care. There are no cut-off points after which doctors and hospitals will not be paid, and there are no incentives to not provide needed care. Under the Ways and Means plan, if spending exceeds the "spending target" in a particular year, the fees paid to providers the next year will simply be allowed to rise less.

Question: ***Will fee schedules work to control costs ?***

Answer: Some argue that fee schedules will not provide an effective means of controlling costs because providers will increase the number of services they provide to make up for lost revenues.

Evidence from this country's Medicare program -- and from the five other countries which use fee schedules -- makes clear that while the volume of certain services may increase some, fee schedules provide an extremely effective way of controlling costs. There are two reasons why this is the case.

The first is that there are several factors that "naturally" limit how much the volume of services and goods will increase. While physicians may well be able to tell a patient to come back in for an "extra office visit", other providers who do not "prescribe what they provide" -- like hospitals and drug companies -- are not so easily able to create extra demand for their services. Even among those providers who can "induce demand" though, *the majority* would not choose, for financial reasons, to do unnecessary procedures and tests.

The second is that most fee schedule systems -- like the system in the Ways and Means Committee proposal -- have a mechanism built in to adjust fees to volume so that the total cost stays within the target. Under the Ways and Means plan, as in other effective fee schedule systems, if the volume of services rises more than expected in a particular year, increases in the fees paid for these services will be allowed to rise less.

Committee on Ways and Means

Recommended Substitute for H.R. 3600: The Health Security Act

as ordered favorably reported June 30, 1994

==========

This proposal, as recommended by the Committee on Ways and Means, achieves the goals of:

- **universal coverage**
- **cost containment**
- **a fair way to share these costs**

By drawing on the best of the President's bill, and building upon what works in our current system, the Committee recommendation offers a simple, affordable, and logical way to create a better American health care system.

Universal Coverage

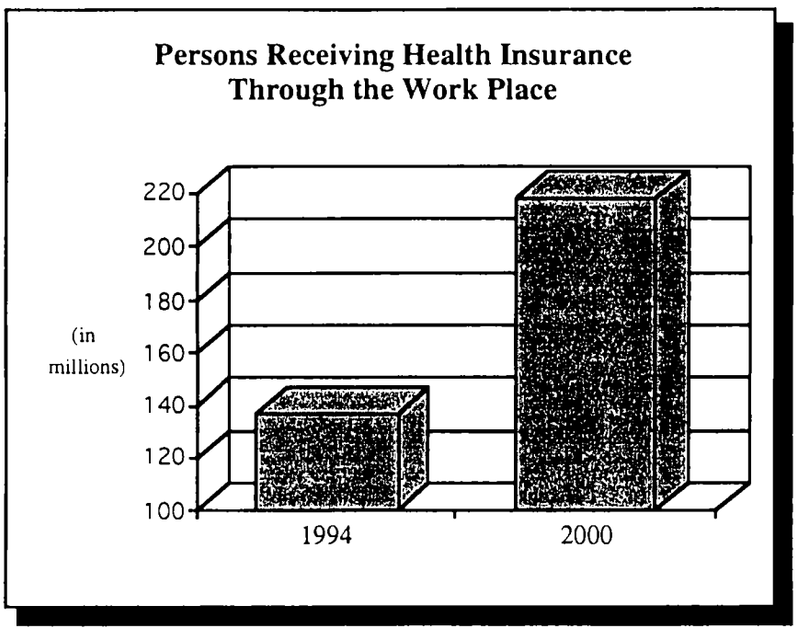
By January 1, 1998, every American would be assured coverage through a health insurance plan that provides at least the national standard set of benefits.

Universal coverage would be achieved through shared responsibility: a requirement that individuals purchase health insurance, employers contribute to the cost for their employees and their dependents, and the government provide subsidies for low-income families who cannot afford health insurance on their own. States would be given broad flexibility to develop alternative approaches to achieving universal coverage.

Expansion of Employer-Based System

Universal coverage would be achieved by building on the current health insurance system. Today, two thirds of Americans receive health insurance coverage through their employer or the employer of a family member. For half of the 38 million Americans currently uninsured who work full time or are dependents of full-time workers, the employer-based system simply would be expanded to include them. Small employers would be eligible for subsidies up to fifty percent of their health insurance obligation.

For the great majority of Americans who are insured today, including Medicare beneficiaries, the Committee proposal would make few visible changes in how they get their coverage or their health care. If they like their doctors, they could still freely choose to see them, or they could choose to find a new doctor. And compared to proposals that mandate participation in purchasing cooperatives, this proposal causes minimal disruption to current insurance purchasing arrangements.



Source: Congressional Budget Office, June, 1994.

For those not connected to the work force and for part-time and seasonal workers, a new Medicare Part C would be created. Employers with 100 or fewer employees also would be able to insure their workers by enrolling in Part C. Those eligible would not have this as their only option, but the creation of Medicare Part C would ensure that *all* Americans have access to an affordable health insurance plan. The premium would be set at a level sufficient to cover the cost of the Part C plan (i.e., without general revenue subsidies).

Employers would offer employees a choice of health plans that cover the guaranteed national benefit package: a managed care plan and a plan that offers an unlimited choice of providers. In addition, employers could offer employees a high deductible plan combined with a tax-preferred medical savings account. This plan would encourage employees to be more cost conscious in using health care services.

Market Reforms and Cost Containment

Under the Ways and Means proposal, the insurance market would be reformed, eliminating cherry-picking, pre-existing condition exclusions, and arbitrary limits on certain illnesses and disabilities. Community rating -- without adjustment for age or illness -- would apply to plans sold to individuals and to employers of 100 or less. Administrative simplification would reduce the paperwork for doctors and hospitals.

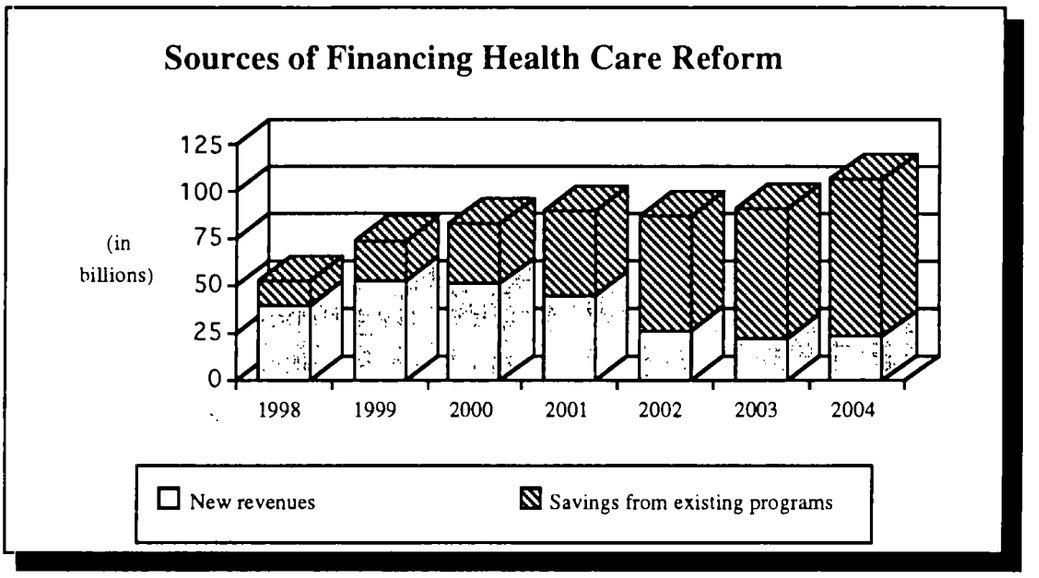
The creation of a standard benefit package and supplemental insurance policies will allow consumers to more easily compare plans. With universal coverage, premium growth would be slowed due to reduced cost shifting and from slowing the overall growth rate in health care costs.

A National Health Cost Commission would be formed and charged with recommending to Congress whether the system of private sector cost

containment in the Committee proposal would go into effect January 1, 2001 or would be modified. The Commission's recommendations would be given 'fast track' review by Congress. If the Congress did not decide to do otherwise, and if expenditures in a State were in excess of target rates of growth, the back-up cost containment provisions in this proposal would be applied in those States not meeting the expenditure targets.

Financing Health Care Reform

In addition to the contributions made by employers and employees to cover their shared responsibilities for health insurance coverage, the resources necessary to finance health care reform -- and subsidize low-income individuals and small, low-wage firms -- would be generated from two areas.



Source: Ways and Means Committee, June, 1994

New revenues would be raised from increasing the cigarette tax 45 cents a pack by 1999, eliminating the tax subsidy for health benefits provided through cafeteria plans, instituting a two percent tax on health insurance premiums, and temporarily retaining a portion of the funds transferred between "non-enrolling" and "enrolling" employers.

While these new revenues would provide substantial funding, over time the largest source of financing would be generated by slowing the growth in existing government insurance programs. While *no cuts* in government expenditures would occur, the *growth* in the existing Medicaid and Medicare programs would be slowed to the target rates of growth in private sector spending and the growth in the national economy.

Guaranteed Benefits, Freedom of Choice

The guaranteed national benefit package would include the benefits currently provided under Medicare, plus unlimited hospital care, coverage of prescription drugs, preventive services for children without cost-sharing, pregnancy-related services, and comprehensive mental health and substance abuse treatment services. The addition of prescription drug

coverage under Medicare -- with an out-of-pocket maximum of $1,000 -- would ensure that the cost of pharmaceutical products will no longer threaten one's financial health. An out-of-pocket cap for all health services would be added to Medicare and to the standard package beginning in the year 2003.

Individuals would be guaranteed the right to choose their own doctor. Supplemental insurance policies would provide for additional insurance coverage for those who wish to purchase it. And as in current law, individuals would always be free to pay out-of-pocket for any additional health care services they wanted.

New Long-term Care Program

An important first step in providing needed services to individuals with severe disabilities would be included through a new program to cover long-term home and community-based care. Benefits would be provided to individuals without regard to age or income.

Ensuring Quality and Consumer Protection

The quality of health services would be improved by the creation of a national quality improvement program, including standards for utilization review procedures and due process standards for health care providers. Health insurers would be required to produce annual report cards on the quality of care provided and the level of patient satisfaction in their plans. Medical research efforts would be expanded. The Federal government would conduct additional outcomes research, and a clearinghouse for the dissemination of practice guidelines would be created.

An expanded national anti-fraud and abuse program would facilitate the coordination of State, local and Federal efforts to investigate and prosecute fraudulent activities. Patient privacy protections would be established.

Meeting the Challenge of Health Security for All Americans

In October of last year, the President placed before us the challenge of guaranteeing health insurance coverage to all Americans. Eight months of public hearings, community meetings, and discussions among Members of Congress produced this proposal, one that -- while it is less ambitious than the Administration's bill in restructuring the health insurance market -- meets the President's challenge of health security for all Americans by a date certain.

This is a workable, straight-forward, and fully and fairly-financed means of ensuring the health care security of every American, in every corner of our country.

****

(7/1)

General Summary

I. Universal Coverage

All individuals would be guaranteed coverage under a health insurance plan providing at least the national benefit package. Individual choice of provider would be guaranteed. Health insurance coverage would be provided under private plans, and most Americans would continue to receive coverage with little change. A new public, self-financing insurance program similar to Medicare would be created as a safety net for those not served under the present system.

II. Individual and Employer Responsibilities

In general, employers would be required to contribute toward the cost of health insurance coverage for their employees and their employee's dependents. The minimum employer contribution for a full-time worker would be equal to 80 percent of the premium of the plan chosen based on the family status of enrollment elected by the employee. Employers could provide additional benefits. Employers would be required to make contributions for part-time, seasonal, and temporary workers on a per-hour worked basis.

Employers with 50 or fewer employees and an average full-time equivalent salary of $26,000 or less would be eligible for a tax credit which would reduce their liability for health premiums. The maximum credit for firms with 25 or fewer employees would be 50 percent. The maximum credit for firms with 26 -50 employees would be 37.5 percent.

Individuals would be responsible for paying the full premium of the health plan in which they enroll, minus their employers' contributions. When the program is fully phased-in, low-income families with income below 240 percent of poverty ($24,000 for a family of three) would be eligible for an income-related subsidy for their premium obligation. Individual and employer responsibilities would be enforced through the Internal Revenue Code.

III. Benefits

The national guaranteed benefit package would include the benefits currently covered under Medicare, plus the following enhancements: (1) a single deductible of $500 per individual/$750 per family, (2) inpatient hospital services without a separate hospital deductible and without co-insurance, (3) coverage of prescription drugs with a separate $500 deductible, 20 percent cost-sharing, and $1,000 out-of-pocket annual limit, (4) preventive services for children without cost-sharing, (5) pregnancy-related services, (6) family planning services, and (7) expanded mental health and substance abuse treatment services. Beginning in the year 2000, a new Federally financed, State administered program would be created

covering long-term home and community-based care services for individuals with severe disabilities.

Medicare benefits also would be enhanced and would include identical drug benefits. Beginning in 2003, a cap on out-of-pocket expenditures would be added to the standard benefit package and to the Medicare program. Families below the poverty level, pregnant women and children up to age 18 with family income below 200 percent of the poverty level, and AFDC and SSI recipients would receive additional "wrap-around" coverage comparable to the scope of benefits now covered under Medicaid.

IV. State Flexibility

States would have broad flexibility to establish their own health reform plans. States could adopt any type of plan, including single-payer or pure managed competition, as long as the plan guaranteed universal coverage and controlled health care costs within the State. States could not require multi-state employers with at least 5,000 employees nationally to participate in a State benefit management program. After a three-year trial period, individuals covered under Medicare could be included under a State system.

V. Insurance Market Reforms, Health Plans and Health Alliances

Broad insurance market reforms would be instituted. Health plans, including self-insured plans, could not deny coverage nor renewal to any eligible group or individual. Pre-existing condition exclusions would be prohibited. Health plans could choose to sell insurance in one or more of five market sectors. Pure community rating would apply to health plans sold to individuals and to employers of 100 or less. Employers with 100 full-time employees or less would be prohibited from self-insuring. Plans would be required to ensure due process protections for health care providers and abide by new utilization review and prior authorization standards.

Health plans would be required to offer the national guaranteed benefits as a separate package. Incentives would be provided for expansion of HMOs and rural-based managed care demonstration projects. Standards would be established for private supplemental plans providing coverage beyond the nationally uniform benefits and for private long-term care insurance. States could establish health alliances. If mandatory within a State, the alliances must be part of a State's overall reform plan, guaranteeing universal coverage and controlling costs. Federal grants would be available to support health alliance development.

VI. Federal Responsibilities and Cost Containment

A new, Federal, safety net insurance program -- referred to as Medicare Part C -- would be established for individuals that are not connected to the work force, for part-time and seasonal workers, and for low-income persons

working in firms with under 100 employees. Employers with 100 or fewer employees also would be able to insure their workers through Medicare Part C. The program would, net of subsidies for low-income persons, be fully financed through premiums paid by enrollees and their employers.

A National Health Cost Commission would be formed and charged with issuing annual reports regarding the rate of growth in health care expenditures. By the year 2000, the Commission would recommend whether the system of private sector cost containment in the Committee proposal would go into effect January 1, 2001 or would be modified. The Commission's recommendations would be given 'fast track' review by Congress. If the Congress did not decide to do otherwise, and if expenditures in a State were in excess of target rates of growth, the back-up cost containment provisions of Medicare's payment methods would be applied in those States not meeting the expenditure targets.

VII. Public Health Initiatives

Numerous provisions would strengthen the ability of rural and inner-city communities to address their health care needs, including grants for facility and network development, assistance for telecommunications linkages, incentives for providers locating in underserved areas, and special payments to "essential community providers" serving underserved populations.

A new fund would be created to support the research and training function of academic health centers. A national work force plan would be prepared, and the plan would provide that at least fifty-five percent of all residents would be in primary care specialties.

VIII. Quality and Consumer Protection

A national quality improvement program would be established. Standards for utilization review and provider due process procedures would be created. In addition, Medicare's existing rules regarding health care fraud and abuse would be extended to all payers. The administrative burden on providers would be reduced through implementation of a system of administrative simplification. Privacy standards would apply to the disclosure of protected health information.

IX. Financing Health Care Reform

The cigarette tax would be increased by 45 cents per pack over five years. An excise tax of two percent would apply to health insurance premiums and the expenses of self-insured plans. Health benefits provided through a cafeteria plan or flexible spending arrangement would not be excludable from an employee's income. A portion of the premiums paid by non-enrolling employers to enrolling employers would be retained during a transition period. The current Medicare hospital insurance tax would be extended to all State and local employees.

Withdrawn

AMENDMENT TO
Title III, Benefits
of the Chairman's Mark

Offered by Mr. Thomas

Amendment to Permit Individual and Family Flexibility in Benefits

Modify the benefits package as follows:

The benefits in the guaranteed national benefit package would be subdivided into a core benefits package and an auxiliary benefits package. The core package would include all benefits included in the mark's guaranteed national benefit package other than the benefits listed in the next sentence as options under the auxiliary benefits package. The auxiliary benefits package options would include the following benefits: hearing and vision devices (hearing aids, contact lenses, and eyeglasses); additional adult preventive care; dental care; chiropractic; substance abuse treatment; and infertility, fertility and pregnancy termination services; rehabilitation services, including home health care; and such additional options as may be determined by the Secretary of Health and Human Services.

The total premium for the guaranteed national benefit package will be allocated between the core benefits package and the auxiliary benefits package. Each year, each individual must use $500 per year in actuarially equivalent premium coverage to cover options the individual must select from the list of auxiliary benefits. Families must use $1,000 in actuarially equivalent premium coverage to cover options the family must select from among the list of auxiliary benefits. The remainder of the individual or family premium for the guaranteed national benefit package will be used to pay for the core benefits package.

Explanation:

This amendment would allow individuals and families some degree of flexibility in tailoring the guaranteed national benefit package to their own needs. It would also permit coverage of several benefits which would not otherwise be available under the mark.

AMENDMENT TO
Title III and Title VIII
of the Chairman's Mark

Offered by Mr. Santorum

Sunset of OBRA '93 Vaccine Provisions

Title III, Section 2 (p.21) Guaranteed National Benefit Package
Title III, Section 11 (p. 51) Other Changes in Medicare Benefits
Title VIII, Section 8, (p. 165) Revisions to the Medicaid Program

Add to titles III and VIII:

> "Inclusion of well-baby and well-child services, including immunizations, in the guaranteed national benefit package activates the sunset provisions of the vaccine entitlement created by OBRA '93 effective on the date of enactment.

Explanation

The Chairman's mark (on pages 21 and 51) includes in the guaranteed national benefit package "newborn, well-baby and well-child services." The Chairman's mark specifies that immunizations would be covered in the package.

The Chairman's mark (on page 165) provides that state plans under Medicaid would discontinue coverage for all items and services covered under the guaranteed national benefit package.

In OBRA 93, Congress created a vaccine entitlement program which was added to Title XIX of the Social Security Act. OBRA 93 included a sunset for the vaccine program when broad-based reform of the national health care system provides for immunization services. The Chairman's mark clearly constitutes broad-based reform and clearly includes immunization services for children in the benefit package. This amendment activates the sunset provision in the OBRA 93 program effective upon date of enactment.

When Congress passed OBRA 93, they included a new entitlement program to provide pediatric vaccine for Medicaid-eligible children, American Indians, children without health insurance and children who are uninsured for immunizations who go to a Federally-qualified health center. At the time the Administration presented legislation to Congress, Secretary Shalala justified the need for an entitlement on the basis of an "ineffective " immunization system that resulted in "dismal" vaccination rates.

However, the data used by the Secretary to show that there was a need for the new entitlement was eight years old. The most recent data shows that as of July 1993, we had reached the year 2000 goal of 90% immunization against diphtheria, tetanus, pertussis, and polio and were just a few percentage points short of a 90% rate for measles, mumps, and rubella. Dr. Walter Orenstein of CDC told the Senate Appropriations Committee in May of this year that "immunization levels among preschool children today are the highest ever and disease incidence for most of the vaccine-preventable disease is at, or near, record low levels."

Ironically, "children living below the poverty level were less well vaccinated in 1992 than others." Yet these are the children who already were eligible for free vaccine through Medicaid or the public health system before the OBRA 93 program was established.

Studies just completed by the Centers for Disease Control underscore that outreach and infrastructure are the keys to achieving and maintaining America's immunization goals. More emphasis should be placed on outreach and infrastructure, the real problems in need of resolution.

The OBRA 93 program was financed by this Committee, although this Committee did not have the opportunity to provide input on the need for such an entitlement or the structure of the program. Implementation of the OBRA 93 vaccine for children entitlement is proving logistically difficult and will cost the taxpayers considerably more than was originally scored by CBO.

We are particularly concerned about HHS' plan to use the General Services Administration, through a megawarehouse in Burlington, New Jersey, to store, sort, and distribute up to 80% of the nation's annual vaccine supply. We are concerned about this GSA distribution plan, in light of the fact that the U.S. already has a private vaccine distribution system with demonstrated expertise in delivering pharmaceuticals and vaccines in a safe, efficient, and cost-effective manner. GSA has no experience in distributing vaccines and may place the goal of increasing immunization rates at risk.

The mark must clarify that the sunset provision of the vaccine program is activated. The implementation of this program is troubled.

Well-Baby and Well Child Services Amendment
Expected Questions and Possible Responses

Question: Doesn't this amendment repeal the provision of free vaccine for poor children?

Response: The OBRA 93 vaccine program already contains a sunset provision as Congress expected that immunizations would be addressed in health care reform. The Chairman's mark clearly covers immunizations and therefore the sunset provision should be activated.

We would also note that Medicaid covered immunizations before the OBRA 93 program and will continue to cover immunization services.

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515-6115

FAX COVER SHEET

DATE: 4/6/94

TO: JENNIFER KLEIN

FROM: NANCY DELEW

FAX NUMBER 456 2878

NUMBER OF PAGES (INCLUDING COVER) 8

COMMENTS: _____

If there are any problems with the transmission, please call (202) 225-9037.

COMPARISION OF STARK & CLINTON MH/SA BENEFITS

- inpatient counts toward cap
- outpatient services do not count toward the cap

	STARK: GUARANTEED NATIONAL BENEFIT	CLINTON: TITLE I BENEFIT	ADVOCATES CONSENSUS OPTION
A. Hospital/Residential Services			
1. General hospitals	90 days annually	30 days w/dangerousness, drug adjustment or somatic trmt for addl 30 days.	Stark
2. Psychiatric hospitals	45 days annually 190 day lifetime.	same as general hospitals above.	Stark
3. Other residential services Residential treatment ctrs; therapeutic family homes; therapeutic gp trtmt homes; commun. residential trtmt; residential detox fac; crisis residential; subst abuse recov ctrs.	135 days annually; trade-off 3/1 w/hospitals; trades go both ways. Sec. devl approp stds for mgmt	same as general hospitals above.	Stark
B. Intensive Non-residential Services(INR)			
Psychiatric rehab svcs; day treatment(children); behavioral aide svcs; in-home svces; ambulatory detox svcs;	90 days w/20% copay; Sec dev stds for approp management.	first 60-days w/2-1 trade off w/inp. res. svcs. w/no copay. 2d 60 days has 50% copay.	100 days w/ 20% copay for adults. 180 days (or unlimited) for children.
Partial hospitalization	unlimited w/20% copay.	same as above INR services.	Same as above.
C. Outpatient Services			
1a. Evaluation of mental dis	unlimited w/20% copay.	N/A	
1b. Screening & assessment; diagnosis; crisis svcs.	N/A	unlimited w/20% copayment.	Clinton
2. Medical(medication) management by MD	unlimited w/20% copayment.	unlimited w/20% copayment.	Clinton
3. Somatic treatment	not covered	unlimited w/20% copayment.	Stark
4. Case management	90 days w/20% copay; Sec dev stds for approp management.	unlimited w/no copay. Plan det. need and use.	Clinton

CBO 7000 $2.5B savings if you have a limit

3 inpatient for 1 residential day

private psych want like 190 day limit

20% copay for kids

Inpatient - Stark
Outpatient - Clinton

~7,000 people re. in state mental hosp. 365 days a yr. generally old people

CBO $175 per capita

Admin. $124 per capita

	Stark	Clinton	Recommendation
5. Psychotherapy	Unlimited w/50% copay for adults. Children pay 20%.	30 visits w/50% copay. Addl visits to prevent hosp at 4/1 trade-off	Clinton w/ 20% copay for children
5a. Collateral (family) services	N/A	Within 30 visit psychotherapy ben.	Clinton
6. Substance abuse counseling & relapse prevention	N/A	30 gp therapy visits after inpt/res or INR trmt w/in past yr; 30 addl visits at 4/1 trade-off.	No position. We haven't had time to talk with substance abuse colleagues.
D. EPSDT Wraparound	Unlimited. No ded. or copay to 100% of pov; sliding scale up to 200%	Not in Title I. See Sec. 4222	
E. Residual Medicaid Program	States may cont. svc not or part covered by natl guaranteed benefit.	Not in Title I. Cont'd Medicaid in Title IV.	Clinton
F. Other Considerations			
1. 2001 comp. benefit	N/A	Included as mandated change	Clinton
2. Catastrophic Cap	N/A Dingell —	$2500 for ind; $3000 for family. Only inpt/res cost included in cap.	Include o.p. ded & copays w/in cap
3. State pilot projects	N/A	Included	See attached paper on Comprehensive Mental Health Program
4. Supplemental state program for serious MI/SED	State managed mental hlth prog. for low income serious MI/SED. Elig ind get comp svcs w/o limits & lower copays.	State submit plan by 1998 for integ of pub mh svcs w/comp benefit pkge	
5. Organized Systems of Care	N/A	N/A	See attached specs

psychiatrists don't like psychologists have accepted

they want request to CBO for pricing

200% of poverty & below

8-21,000
such non-profit
community health centers

The Need for Specialty Management and Essential Community Provider Authority Within the Mental Health System

An important goal of healthcare reform is to ensure that all individuals with severe and persistent mental illness obtain needed mental health services. To meet this goal, there is a role--perhaps transitional--for specialized management of the mental health aspects of the new organized systems of care and the need to involve those specialty providers with a demonstrated history of quality services to this population. This specialized mental health management and essential provider status are important for the first 5 years of the transition to national healthcare reform, which should be followed by a reexamination of the issues by national policy makers.

Purpose of Essential Community Provider Designation

States have the primary role in organizing and funding the delivery of public mental health services. To meet the President's proposed national goal of the integration of mental health services, it is necessary for states to be given the authority to designate essential community providers. Among the major benefits of state designation are:

- o continued appropriate access to mental health services for the former patients of the public mental health system;
- o provision of the most appropriate mix of mental health services for the needs of the individual;
- o assurance of quality services that meet the needs of consumers;
- o cost-effective delivery of services;
- o improved coordination of mental health providers with other public health and social service providers which are essential to serving the former public population; and
- o assurance that services provided to public mental health clients are "seamless," integrated, and without unnecessary disruption in those instances where limits of plan coverage may be reached but treatment must be continued using state mental health authority and other public resources.

Patients in the Public Sector Need Protection

Today, the public mental health sector's typical patient profile is much different than the private sector's. The public patient is more severely ill with a longer expected duration of illness and is financially impoverished by the consequences of their illness. These patients need more services of a different nature or approach than the patients served in

the private sector. A sudden elimination of public sector providers will leave those patients who are most severely ill with grossly inadequate and inappropriate services available only through the private sector. States need authority to temporarily ensure select public providers remain participants in the reformed delivery system while it builds new service capacity and expertise to serve an expanded population.

Justification for Granting States the Authority

Important considerations exist in selecting those providers which need to be designated as essential community providers. These determinations are best made by the states because of their long history of dominance in the operation, funding and monitoring of public mental health services. Among the major provider selection criteria states can most effectively judge are:

- o provider experience in offering an array of clinical services;
- o whether the provider fills a service need that is an essential part of the service continuum for former public patients that no other provider could realistically perform initially;
- o provider capacity to serve the number and demographic mix of beneficiaries in the service area and to ensure that consumers receive the services most appropriate to their needs; and
- o provider history of controlling costs and ability to begin assuming some risk.

Once designated as an essential community provider, mental health agencies will be accessible from within the service area regardless of the plan chosen by the consumer. This will ensure that current and long-term patients of a particular provider will not be abruptly withdrawn from established clinical relationships.

Merger of the Public and Private Mental Health Sector

Many public mental health providers or delivery systems lack the basic technologies for proceeding with risk-sharing arrangements. In particular, some public programs lack specific health insurance expertise such as benefit management, rapid access intake systems, management information system support, or the financial and actuarial systems essential to compete effectively in these new arrangements. Providers serving the private sector have mastered these functions, because of their earlier experience with private sector insurance and managed care. Despite its health insurance system competencies, the private mental health sector is extremely deficient in the clinical programs and service models necessary to treat persons with severe disorders in the most clinically effective and least restrictive manner.

Healthcare reform will necessitate a major transition and merger of the public and private mental health sectors in order to adapt to an integrated and comprehensive system of mental health services with financing based upon risk-sharing principles. As this transition takes place, a major reduction in the number of service providers will occur. Public sector patients will not be accessing the same provider systems that have served them for many years. The elimination and consolidation of provider capacity has been occurring rapidly within the private sector for the past several years and has begun an expected rapid acceleration within the public sector. While this unprecedented provider elimination and consolidation process takes place, the temporary allowance of state designation of essential providers is necessary to ensure the smooth transition to the merged system of comprehensive mental health services.

2/25/94

NCMHC
NASMPD

Comprehensive Manged Mental Health Program
(To replace Section 3521, Pilot Program, page 626 of Health Security Act

States would be authorized to pool federal and state resources to establish a comprehensive array of mental health services, provided on the basis of medical and psychological necessity, subject to appropriate management to both guard against unnecessary utilization and undertreatment. Flexibility should be provided for the state to negotiate for a planned phase-in of services and eligibility, but at a minimum a state would have to cover individuals with incomes under 200% of poverty and who have serious mental illness or, in the case of children, who have serious emotional disturbance.

In states which choose this approach, the financing of the comprehensive benefit would come from three sources:

- States would be required to contribute the state-share of Medicaid expenditures for acute mental health care to the premium (subject to maintenance of effort requirements for future years), and may also contribute state general revenue funds for acute services for persons with mental illness

- The federal government would then contribute the federal Medicaid for acute care services (subject to maintenance of effort requirement for future years). This would include funds for services over the Plan's limits, as well as any services covered by Medicaid which are not covered in the Health Care Reform package (exactly which services will be covered, and to what extent, will not be known until the legislation is enacted).

- Reformed health care system would be required to continue to fund mental health services from the premium as needed (but state and federal funds would supplement, in order to ensure a comprehensive service package).

Individuals living in states with this option:

- Would enroll in the health plan of their choice: HMO, PPO or fee-for-service (those in fee-for-service plans could be subject to higher copayment requirements).

- Would have access to a fully comprehensive, flexible array of benefits, outlined in federal law and more specifically defined at the state level. These services would be those recommended by the Mental Health Liaison Group and the Mental Health Work Group of the Health Reform Task Force.

- Would access services through their health plan, which would subcontract with agencies providing specialized mental health services which have been licensed and certified by the state.

States which opt for this approach must submit a plan to DHHS for approval. This plan to include:

Section 1115 of HR 3600

Add new section (f); change Other Definitions to (g)

(f) ORGANIZED SYSTEMS OF CARE FOR CHILDREN

(1) DEFINITION. For purposes of this subtitle, the term "organized system of care" means a deliberately organized, community-based service delivery network for children under age 22 with serious or complex mental or substance abuse disorders. Such systems of care have the capacity to:

(A) Involve and coordinate multiple child-serving agencies and providers (including child welfare, education, juvenile justice, health, mental health, and substance abuse).

(B) Involve families of children with mental and substance abuse disorders in treatment planning and service delivery.

(C) Develop individualized treatment plans, through multidisciplinary or multiagency teams, that are recognized and honored across multiple child-serving agencies and providers.

(D) Ensure the delivery and coordination of the array of services needed by children with serious or complex mental or substance abuse disorders.

(E) Manage the individualized treatment plans and respond flexibly to treatment needs as they change over time.

(2) PROVISION OF SYSTEMS OF CARE. Health plans shall ensure that mental health and substance abuse services for children under age 22 who have serious or complex disorders are provided through an organized system of care. Health plans will be deemed to have met this requirement if one of the following conditions is met: The plan has established a system of care for children enrolled; the plan has established linkages with an existing public sector system, or systems, of care in the area, or the health plan is participating in the development or operation of a joint public-private system of care set up with appropriate public agencies in the health plan area.

Developed for George Miller at Ed & Labor

j:\reform\mhmcare.doc

Mental Health Benefits under Medicare Parts A and B

Amendment to be Offered by Mr. Stark

March 16, 1994

I. Medicare Inpatient Psychiatric Benefit

The Medicare Inpatient Psychiatric benefit would be amended to limit inpatient psychiatric hospitalization to a yearly limit of 90 days in general hospitals and 45 days in psychiatric hospitals.

II. Intensive Residential Benefit

Coverage in intensive residential facilities would be provided for up to 135 days with a 3/1 trade-off for hospital days. These services would include (i) residential detoxification centers; (ii) crisis residential programs or mental illness residential treatment programs; (iii) therapeutic family or group treatment homes; (iv) community residential treatment centers; and, (v) recovery centers for substance abuse.

III. Outpatient Mental Health and Substance Abuse Benefits

The outpatient psychotherapy benefit is amended to provide children and adolescents (through age 18) visits with a 20 percent copayment.

IV. Intensive Community-based Services

Additional intensive community services would be covered with a 20 percent copayment and a 90-day annual limit. These services include (i) psychiatric rehabilitation services; (ii) day treatment services for children; (iii) behavioral aide services; (iv) in-home services; (v) case management services; and, (vi) ambulatory detoxification services.

Mental Health and Substance Abuse Package

Amendment to be offered by Mr. Stark

March 16, 1994

The Chairman's Mark would be amended to provide the following additional benefits specific to the needs of individuals with mental illness and substance abuse disorders.

I. Enhanced Benefits

A. Intensive Residential Services

Coverage would be provided in the following residential programs: (i) residential detoxification centers; (ii) crisis residential programs or mental illness residential treatment programs; (iii) therapeutic family or group treatment homes; (iv) community residential treatment centers; and, (v) recovery centers for substance abuse.

These services would be available for up to 135 days per year. Beneficiaries receiving this benefit would have their inpatient psychiatric benefits reduced by one day of inpatient care for every three days of residential services received. The Secretary would be directed to develop standards for the appropriate management of these services.

B. Intensive Community Services

The following intensive community services would be made available: (i) psychiatric rehabilitation services; (ii) day treatment services for children; (iii) behavioral aide services; (iv) in-home services; (v) case management services; and, (vi) ambulatory detoxification services. This benefit would be limited to 90 total days per year and would have a 20 percent copayment. The Secretary would be directed to develop standards for the appropriate management of these services.

C. **Outpatient psychotherapy visits for children and adolescents**

Outpatient psychotherapy visits for children through age 18 would be provided with a 20 percent copayment.

II. **Comprehensive Managed Mental Health Programs**

A. **State flexibility**

Broad flexibility would be available to States to establish comprehensive managed mental health programs. The programs would promote the development of integrated delivery systems for the management of mental health services for low-income adults and children with serious mental illness or emotional disturbance. The programs would allow individuals to continue to receive the services defined in the national guaranteed benefit package for mental health (as amended by this proposal), but without the limits and, at state option, with reduced copayments.

B. **Eligibility**

Eligibility of individuals to participate in comprehensive managed mental health programs would be based on Federal standards, although States would have the ability to define eligibility in greater specificity.

The Federal standards would assure that the State programs focused services on adults with serious mental illness and children with serious emotional disturbance, as evidenced by a need for multiple services (either a past history, or prediction of future needs), and who have a disorder which is expected to last at least one year.

Limitations on benefits would not apply to individuals participating in a comprehensive managed mental health program

C. **State Planning and Other Requirements**

States would be required to submit a plan for a comprehensive managed mental health program which specifies:

1. The management, access and referral structure which the State would use to promote and achieve integration of the basic benefits and other appropriate services which the State intends to integrate under the State's comprehensive managed mental health program

2. The detailed specifications for the program which will assure that eligible individuals have access to each service, as appropriate, in the basic benefit (including current Medicare benefits and the enhanced benefits added by this proposal.)

3. The definition of "serious mental illness for adults" and "severe emotional disturbance in children" within the State's program, based on Federal standards

4. Additional Federal, state, and local funds that the state proposes to integrate in order to finance the program (e.g., Title IV E, A, and Public Education sources).

TECHNICAL AMENDMENTS TO STARK

Over the last three months, the following concerns have been raised by constituency groups regarding our use of Medicare references in the Health Security Act:

- Durable Medical Equipment - restricted to use in home;
- Respiratory therapy - not covered under current Medicare home health;
- Provider types/settings - Medicare contains certain restrictions regarding which providers can practice in which settings;
- Routine physical examinations for adults - not included under Medicare.

TECHNICAL AMENDMENTS TO STARK

Prenatal Services: specify that the no cost-sharing provision applies to clinician visits and associated services related to prenatal care and 1 post-partum visit.

Clarify that coverage for contraceptive drugs and devices is for those dispensed only upon prescription and subject to FDA approval.

Additional Preventive Benefits: consider adding screening for sexually transmitted diseases for high risk individuals.

consider adding cholesterol screening every 5 years.

Clinical trials and investigational treatments: consider adding coverage for routine care associated with clinical trials and coverage for investigational treatments at the plan's discretion.

Exclusions: It appears that three exclusions in the HSA may not be included in current Medicare law. Consider adding these exclusions:

in vitro fertilization
sex change surgery and related services
private duty nursing