MEDICAID REFORM TASKS

		Staff	Date
Per Capita cap			
o	Framework Paper -- Expand and clarify	All	9/1
o	Growth Index Paper	Parashar/Holly	8/25
o	Medically Needy as separate class	Kristen	8/24
o	1115		
	- Data Analysis	Meg	8/23
	- Policy Implications/Rationale	Karen	8/30
o	QMB		
	- Description/data	Don	8/30
	- Policy Implications/Rationale	Don	9/1
o	Enforcement		
	- State gaming	Jeanne	8/25
	- Administrative Process	Karen/Miles	8/30
Block Grant			
o	Additional Analysis		
	- Impact of Hospital/workers	no action	
	- Impact of Nursing Home Residents	Jeanne/Urban	8/25
	- Impact of Recession	Jeanne/Urban	9/1
	- Impact of welfare match rate	waiting for Sen. action	
o	Medicaid Briefing Document	OLIGA/ASL	8/22
Flexibility			
o	Flexibility paper	Don/Bill H.	8/25
DSH			
o	Reduce and Re-Target	OMB??	9/1

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 1

To Jennifer Klein | From Jack Ebeler

Dept./Agency | Phone # 690-6870

Fax # | Fax # 401-7321

Medicaid Analyses

Several analyses are being conducted by the Urban Institute. All are based on the Medicaid proposal in the Conference Agreement Budget Resolution, in which total Medicaid expenditures are limited to 7.2% in 1996, 6,8% in 1997, and 4% for all subsequent years.

Under the Republican Proposal:

- Number of aged, disabled, adults and children losing coverage; dollar amounts associated with those losing coverage
- Number of nursing home residents losing coverage
- Number of aged, disabled, adults and children losing coverage if there is an economic downturn; dollar amounts associated with those losing coverage
- Effect of the Senate welfare block grant formula applied to Medicaid:
    - Winners and losers;
    - Aggregate loss if savings if the welfare block grant formula were used;
    - Winners and losers if the proposal were budget neutral.

We are hoping for preliminary estimates for the first two analyses by August 25. The effect of the welfare block grant formula might be best done during or after the Senate floor debate, which is scheduled for the week of September 4, since the current formula will likely change.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

22-Aug-1995 07:44am

TO: (See Below)

FROM: Joseph Minarik
Office of Mgmt and Budget

SUBJECT: RE: Medicare/Medicaid

Your memo looks basically fine. I would explain a bit more how the ultimate bill will probably be a hybrid of some substantive changes (they have cover for at least as much as we do), baseline relief, and formulaic savings from a cap with a sequester. I would add a discussion of the role that "managed care" will play in the final product -- how much CBO will score, how much the Republicans will want to claim, and how that will fit into the formulaic part of the final product. On Medicaid, I think we should figure out how much help they really get if they keep their baseline only so that they can score more savings from our cuts; do they really come out ahead? We should also explore how comfortable the world would be if the deal accepted the different baselines for the two programs.

Distribution:

TO: Barbara C. Chow

CC: Martha Foley
CC: Christopher C. Jennings
CC: Nancy-Ann E. Min
CC: Robert G. Damus
CC: Jennifer L. Klein

MEMORANDUM

TO: Leon Panetta
Pat Griffin
Alice Rivlin
Laura Tyson

FROM: Entitlement Cap Group

DATE: August 21, 1995

This memorandum outlines possible Republican strategies to address Medicare/Medicaid cuts required by the Reconciliation bill.

Medicare Reconciliation Target: $270 billion

I. Hybrid (part process, part substance). The current thinking on Medicare is that the tax writing committees will develop roughly $200 billion in "real" scorable savings and $70 billion in mechanistic reductions. The reasoning behind the relatively high level of substantive savings is the need to assure both the press and Republican freshmen of the credibility of the deficit reduction effort.

The policy based savings could be achieved by the following:

1. Extending the 31.5 percent Part B premium (currently scheduled to drop to xx under current law). Saves $60 billion over 7 years.

2. $100-$130 billion in provider cuts (rely upon Administration policies).

3. Increase premiums by xx for high-income (define) Medicare recipients. Could save up to $20 billion.

The remaining $70 billion in cuts could be achieved through some type of mechanistic "look back" device. The argument will be that the CBO and OMB baselines are overly pessimistic and do not accurately reflect current (lower) medical care growth rates. However, in order to comply with budget resolution requirements, the committees will include a fallback mechanism that insures the baseline is not exceeded. This mechanism could involve one or more of the following:

1. Specific programmatic savings that kick in once specified spending levels are breached.

2. A Gramm Rudman type sequester that automatically reduces

payments if caps are breached.

3. A directive to OMB or HHS to raise premiums, deductibles and copayments and reduce provider payments to keep spending under the limits.

The degree of specificity will depend in large part upon CBO's willingness to score a mechanistic versus substantive set of policies. If the first set of substantive policy decisions prove too difficult to manage politically, the size of the fallback pool could rise accordingly.

II. Baseline Shifts

Should a serious effort to reduce Medicare largely through programmatic savings fail, it is our expectation that the Republicans could partially achieve their health care savings by shifting baselines. The most profitable avenue would involve acceptance of the OMB baseline for Medicare but retention of the CBO baseline for Medicaid. Describe numerical differences. Under this scenario, the tax writing committees could shift to a more favorable baseline either through directed scorekeeping or in negotiation with the Administration.

Medicare Baselines

1996 1997 1998 1999 2000 2001 2002

OMB
CBO

Medicaid Baselines

OMB
CBO

Medicaid Reconciliation Target: $181 billion

I. Block grants. Medicaid savings will most likely be achieved through a block grant to states based upon extremely low out year medical care growth rates (e.g. 4% by 1998).

II. Per Capita cap. The Administration assumes that Medicaid savings will be achieved through a per capita cap on spending. Describe how this would work.

MEDICAID REFORM: RECOMMENDATIONS ON PER CAPITA GROWTH LIMITS POLICY

FRAMEWORK

In an effort to 1) provide incentives to states to control the growth of Medicaid per capita spending and 2) achieve federal Medicaid savings without endangering coverage, the President's balanced budget plan includes a proposal to limit the rate of growth in federal Medicaid spending on a per recipient per capita basis.

The application of federal growth limits on per capita spending is different from the aggregate Federal cap in Congressional block grant proposals in that it takes enrollment out of the cost containment equation, promoting efficiency rather than coverage reduction as the means of reducing costs. The policy preserves critical aspects of the current Medicaid program, including: existing Medicaid eligibility rules; provision of so-called "mandatory" services such as inpatient hospital and physician services, as well as state flexibility to cover optional benefits; and the current matching approach to spending. None of these would be guaranteed under a block grant.

MAJOR ISSUES

Expenditures Under the Per Capita Growth Limit

Multiple expenditure groups would be established, corresponding to broad Medicaid eligibility categories -- specifically, the aged, disabled, adults and children. These expenditure groups will be the basis of the growth limits (e.g., a limit of $1,250 per adult recipient; $2,500 per aged recipient; etc.).

Staff discussed and will work to resolve an issue concerning whether high-cost users within these broad expenditure categories should be treated separately.

Expenditures for disproportionate share hospital payments, the Vaccines for Children program, Indian Health Service providers, and Medicare cost-sharing paid on behalf of certain Medicaid- eligible individuals would be excluded when calculating per capita limits. (Please note that a separate DSH policy is being developed.) However, per capita limits would include expenditures for administration and undocumented immigrants.

Base Year and the Frequency of Rebasing

One year, specifically FY 1995, would be used to calculate limits for the first year under the per capita cap. These limits would not be rebased subsequently every year but would grow at a specified growth rate.

The per capita limits would be based on each state's total computable expenditures (Federal and state spending for Medicaid) by expenditure category in the chosen base year.

Growth Rates

The growth rate would be a nationally uniform rate applied to each expenditure category. However, if desired, this national rate could be adjusted to allow a different growth rate for each expenditure group.

Staff are reviewing the relative strengths and weaknesses of different indices (CPI, GDP, etc.) and will prepare a working paper and recommend an approach.

Transition and Implementation

Per capita limits would become effective October 1, 1995, with the cap effective in FY 1996 but not enforced until FY 1997 to accommodate differences in states' abilities to change their Medicaid laws and regulations.

The existing Medicaid payment mechanism by which states receive Federal matching payments would be retained.

Section 1115 Demonstrations

Staff must conduct further review to assess how states with waivers would be affected by per capita caps on growth. Pending that research, a recommendation will be made.

SPECIFICATIONS FOR A PROGRAM OF HEALTH INSURANCE FOR THE TEMPORARILY UNEMPLOYED

I. Grants to States

The Federal Government would provide annual grants to states which choose to participate to operate a health insurance program for unemployed individuals who meet the criteria set out below. The grants would be administered by HHS. If a State chooses not to participate, the Secretary of HHS will determine how a system would operate in that State. HHS would have the authority to contract out.

Health Insurance for the Unemployed will be a capped entitlement to the state. Funds will be "appropriated until expended", a budget classification which permits excess funds to be carried over at the end of the year to the next year. This will permit funds to be appropriated at a relatively level cost over the course of a business cycle.

States would be provided with funds adequate to pay for the actuarial value of the basic benefit package (modelled on the FEHP BC/BS Standard option) based on estimates of unemployed persons and their dependents that would meet the eligibility criteria. The total amount of the grant would be based on the number of eligible individuals (see below) who collected unemployment insurance (UI) benefits in the state in the prior year. Allocations would be adjusted to reflect variation in health costs among states. State administrative costs for the program would be paid out of a state's allocation and may not exceed limits set by the Secretary of HHS.

As a condition of the grant, States would have to demonstrate that recipients have access to an insurance product equivalent to the BC/BS standard option plan. Coverage could be through 1) COBRA coverage from their prior employer; 2) an insurance product in the private market; or 3) an alternative means of coverage (e.g., state high risk pools, medicaid buy-in, a special plan for the temporarily unemployed, etc.). The Secretary would have the discretion to vary the content of the benefit package within certain parameters to adjust for varying availability of insurance products at the average cost level assigned to the State. A state could make adjustments in its benefits package, with the approval of the Secretary of HHS, if allocated funds are inadequate to meet actual costs. States would also have the option of extending eligibility periods or providing a more generous package using state funds.

HHS would have the authority to require the states to provide the information necessary to support a grant, such as information on UI eligible populations, benefit take-up experience and actual enrollment.

II. Eligibility for Coverage

As a condition for receiving the grant, the Governor must certify that funds will only be spent for health coverage under the following conditions:

- o Recipients must be in active unemployment insurance claims status.
- o Coverage would not exceed 6 months. (The cost of any extension would be borne fully by the state.)
- o Individuals must have had health insurance coverage through the previous employer. The definition of what constitutes "coverage" (e.g., potential exclusion of certain catastrophic plans) would be made determined by the Secretary of HHS.
- o A full subsidy is provided up to 100% of the poverty level for family income and phased out at 240% of the poverty level (determined on a monthly basis).
- o An employed spouse has no health insurance coverage or, if covered, the employer contributes less than 50% of the premium.
- o The individual/family is not ~~enrolled in~~ eligible for Medicaid or Medicare.
- o Individuals will be eligible based on their place of work, rather than their place of residence.
- o No reduction can be made in the duration or amount of unemployment benefits as the result of an individual participating in the health care coverage program.

but don't require people to apply to Medicaid & determine they are not eligible. But, Medicaid is based on where you live; UI is where you work.

Can you use this to cover COBRA? Part of state option

III. Administration

Administration of the program would be the responsibility of the Governor, but must meet the following basic criteria:

- o The state must conduct all eligibility determinations subject to the oversight of HHS. The state has the option of contracting out eligibility and enrollment. However, the state may not contract with an entity that is engaged in underwriting insurance contracts for any part of the enrolled population or has any financial interest in any entity that does so.
- o Eligibility determinations and appeals would be handled in a manner consistent with procedures established by HHS.
- o Any reduction in either the duration or extent of health coverage benefits would have to be approved by the Secretary.
- o Unemployment claimants are informed of possible coverage eligibility at the time that an eligibility determination for UI benefits is made.

- Recipients must be informed that program funds are capped, which could result in reduction or elimination of benefits if funds become exhausted.

- Funds from the grant will take the form of letters of credit to the states.

- Governor will ensure that program information and applications are available in every local unemployment office/one-stop office.

- Appropriate arrangements, taking into account confidentiality and other requirements, will be made to permit the state employment security agency to share current benefit recipient tapes with the state health insurance agency/service provider on a monthly basis in order to make eligibility determinations.

% contribution on a national level to account for downturns/ unemp. cycles → states could use w/out recapture (or maybe some if give too much)

(More Specifics) (Purchasing Coop)

PROVIDING GREATER ACCESS TO SMALL EMPLOYERS THROUGH COOPS

The Clinton Administration proposal would assist small businesses realize the cost savings and choice of plans of larger employers by encouraging states to establish geographically-based purchasing cooperatives for small employers.

The cooperatives would:

- accept all employers (50 or fewer employees) residing within the area served by the cooperative on a first-come, first-served basis [note: we are considering permitting cooperatives to choose to enroll individuals as well, which would be consistent with the Kassebaum/Kennedy bill] ;

- not discriminate against an employee on the basis of their health status, medical history, disability, or claims experience [this language is consistent with the Kassebaum/Kennedy bill] ;

- guarantee renewability of health benefits at rates that are consistent with state premium rate laws; and

- offer a choice of plans (health maintenance organizations, fee-for-service, preferred provider organizations, etc.).

[Note: Consideration is being given to making funds, perhaps $25-$50 million, available to assist coops with start-up costs. The Administration is also studying the tax status of purchasing cooperatives and considering whether legislative clarification may be appropriate.]

If a state does not provide for group purchasing options for small employers, a state that has enacted insurance market and premium rate reforms may request the federal government to make group purchasing available to small employers through the Federal Employees Health Benefits Program (FEHBP).

The small employer FEHBP purchasing option would operate generally as follows:

- All carriers participating in FEHBP for federal employees that also provide coverage outside of FEHBP (eg., not including union plans specific to federal employees) would be required to offer coverage through the small employer FEHBP purchasing option.

- Small employers in each state would be pooled together and would be charged rates that are competitive and consistent with each state's insurance laws.

- Administrative costs associated with the small employer FEHBP purchasing option would be supported through membership fees paid by participating small employers.

- After experience with enrolling small employers, FEHBP, in consultation with states and interested parties would prepare a report examining the feasibility of enrolling individual purchaser (eg., the self-employed and unemployed).

INSURANCE REFORMS

We have consistently said that the President opposes cuts in Medicare and Medicaid outside the context of health care reform. Reductions in these programs will produce cost-shifting to private payers, particularly smaller businesses that have relatively little power in the health care marketplace. Insurance reforms can improve the efficiency and fairness of the health insurance market and cushion the effects of cost-shifting.

The reforms discussed below can be broken into three categories: (I) portability; (II) availability and affordability of coverage; (III) encouraging competition.

- Changes that assure that people can retain the coverage they have (often referred to as "portability") as well as reforms that make insurance more available and affordable will increase coverage by limiting people being dropped and barriers to access (thereby reducing uncompensated care). Less uncompensated care lowers the burden on providers and makes them better able to absorb cuts in public programs.

- Reforms that improve the availability and affordability of insurance will also improve the overall efficiency of the market by forcing insurers to compete based on price and service, rather than trying to insure only healthier people as they can today. Price and service competition should reduce overall premiums over time which will offset the effects of cost-shifting from cuts in Medicaid and Medicare.

- Promoting purchasing cooperatives also will help to improve market efficiency, both by organizing and expanding the insurance choices available to small business and by giving them a mechanism to pool their bargaining power.

I. PORTABILITY: Measures to improve the ability of the currently insured to maintain coverage.

A. Group Market

1. Prohibit insurers from imposing new pre-existing condition exclusions for new enrollees who were previously insured.

2. Require insurers to renew coverage to small employer groups regardless of health status.

3. Guarantee access to insurance for new employees in businesses that offer coverage at the group's average rate.

4. Treat the self-employed as a "group".

5. Prohibit insurers (and self-insured employer plans) from imposing caps on benefits for

specific diseases.

Discussion: Portability (initiatives 1 and 2, and to a lesser extent 3) is the primary focus of Republican proposals in this Congress. Generally, assuring portability for people changing jobs would be relatively noncontroversial (over 40 states have done so for small groups). Initiative 4 is consistent with the NAIC model legislation but many insurers may object on the grounds that verifying "self-employment" is difficult and burdensome.

Initiative 5 would be more controversial because it would prohibit self-funded groups from excluding coverage for specific high-cost diseases, such as AIDS. States commonly prohibit insurers from excluding certain high-cost diseases, but the federal government generally does not regulate the content of self-funded health plans. Senator Jeffords included such restrictions in his bill (S. 1065). Jeffords did not offer this provision as an amendment to the Kennedy/Kassebaum bill mark-up but said he would offer it on the floor.

B. Individual Market

1. Require insurers offering individual coverage to provide coverage (at their average price for an insured with the same characteristics and without pre-existing condition exclusions) to applicants in certain circumstances who had prior insurance coverage. To protect the market from substantial adverse selection, the provision would be limited to circumstances such as loss of employment, divorce, or changes of residence, and the change would have to have occurred within a limited time period. (Representative Johnson's proposal is similar to this.)

12 mo. waiting period?

→ 60 days

2. Guarantee renewability at the same rate as people with similar characteristics and without regard to health status.

Discussion: Extension of portability provisions to these situations extends protection to many people who lose coverage because of extenuating circumstances, similar to what currently exists under COBRA. The problem of people simply entering the market when they become sick would be minimized by limiting the circumstances and time period. Insurers will argue that even a limited extension of portability provisions to include individual coverage would increase individual premiums substantially, but with the time and circumstances restrictions, the numbers potentially affected would be too small to significantly effect the insurance market.

Guaranteed renewability would prevent people from being "dumped" by insurers if they began to incur significant medical claims.

II. ACCESS AND AFFORDABILITY: Measures to expand access to coverage and to limit variations in premiums.

Group Market

1. Require insurers to make coverage available to everyone, regardless of health status (generally referred to as "guaranteed issue").

2. Limit premium variations for small businesses by phasing in adjusted community rating over five years. 1.5/2 to 1

Discussion: To improve the insurance market, guaranteed issue and limits on premium rate variations should be done together, and indeed, most states have done both to some degree. Without limits on rate variations, insurers could easily circumvent guaranteed issue by simply charging very high rates to high risk people. The purpose of Federal action would be to insure greater equity by establishing a minimum standard that surpasses what many states have done to date. States would, however, be permitted to establish more stringent standards.

Federal legislation in these areas would be potentially controversial for four reasons, however. First, even though most states have enacted them, there is considerable variation among the states, reflecting local markets and practices. Second, Federal standards, unless set at the most stringent levels, could undermine what the better states have already accomplished, and the insurance industry and some Republicans in Congress may be anxious to reverse what some states have done. Third, Federal legislation raises difficult issues about applicability to self-insured plans and MEWAs that states laws cannot address because of ERISA. And finally, Federal legislation would represent a significant intrusion in an area that has been primarily a state responsibility for nearly 50 years.

During the last Congress, a number of Republicans (including Senator Dole) supported comprehensive access and rating reforms. The current Republican proposals (e.g., bills by Representatives Thomas and Johnson), however, are limited to portability. The Kennedy/Kassebaum bill, which was recently marked-up, included portability provisions similar to those above, but it did not include any restrictions on premium variations.

III. ENCOURAGE COMPETITION: Measures to restructure the market to promote competition among insurers based on efficiency and service, and to reduce opportunities for risk selection by insurers.

Promote the establishment of purchasing cooperatives for small businesses, including:

a. Providing administrative funding and technical assistance

b. Establishing standards for cooperatives (e.g., cannot bear any insurance risk, must be geographically based, non-profits, rating rules applicable within coops, etc).

c. Making FEHBP -- the federal employee health program -- available to small businesses in states that do not establish purchasing cooperatives (i.e., carriers selling insurance outside the FEHBP program would have to offer appropriate insurance plans to small businesses through the FEHBP, but such plans would be rated separately from those offered to Federal employees).

Discussion: State governments and private organizations are already working to form voluntary small business purchasing cooperatives. Facilitating these initiatives would likely attract broad support (but requiring their establishment or enacting uniform standards might be perceived as overly regulatory). Establishing appropriate standards for cooperatives would be extremely important, however; without such standards the cooperatives could become a variation of a MEWA, which could exacerbate problems in the market rather than improve them.

The idea of using FEHBP as a purchasing mechanism for small businesses had broad, bipartisan support in the last Congress. However, opening up FEHBP without insurance reforms in the rest of the market providing for guaranteed access to coverage and limitations could result in mainly sicker people joining the FEHBP, which in turn could lead to significant premium increases.

Shld they be allowed to experience rate?

THE HEALTH PLAN CONSUMER BILL OF RIGHTS

I. Overview: Pursuant to Federal legislation, the Secretary of HHS and the Secretary of Labor develop/adopt minimum standards for consumer information, quality, privacy and confidentiality, and grievance procedures (as listed below). Non-ERISA and ERISA covered plans adopt the Consumer Bill of Rights.

- The Department of HHS monitors and enforces with respect to non-ERISA plans (via states).
- The Department of Labor monitors and enforces with respect to ERISA plans, and seeks amendments to ERISA as required.

Most standards would be mandatory for health plans; certain standards regarding quality and performance measures would be encouraged but not mandated (see part B., below).

Implementing regulations could be developed in either of two ways: (1) the HHS and DoL develop regulations, in consultation with all interested parties; (2) NAIC, NCQA or other relevant entity develops the regulations, which are then adopted as formal regulations by the relevant agencies (i.e., the MediGap regulation model). [**NOTE**: DoL opposes the second option as applied to them.][1]

II. Federal legislation would impose the following (except where specified, the following apply to both Non-ERISA and ERISA plans):

A. Consumer Information

1. All health plans provide to consumers, at the time of enrollment and upon request, the following information:

- Basic descriptions, including covered benefits and exclusions, premiums, cost sharing, "lock-ins" by HMOs, and disenrollment rights.
- The identity, locations, specialties, and availability of participating providers.
- A summary description (not including proprietary information) of the procedures used to control utilization of services and expenditures, the practice guidelines used by the plan, and the financial incentives used by the plan (i.e., the amount of risk assigned to participating physicians).

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[1] This document describes a system of minimum standards which would be imposed on health plans, to protect consumers. It would also be possible to take a "voluntary certification" approach to these standards, using the Baucus Amendment model for development of MediGap standards. Under this model, the standards would be voluntary. States could adopt the standards as their regulations; in this case, all health plans in the state would be automatically certified. In states that do not adopt the standards, a health plan could seek individual certification as meeting the standards and could advertise that status. In effect, the standards would function as a "good housekeeping seal of approval." HHS would undertake consumer education efforts to explain the meaning of the certification. [**NOTE**: DoL opposes applying this "voluntary certification" approach to ERISA plans.]

- Applicable appeals or grievance procedures, including phone numbers for designated staff and independent ombudsman offices in that service area.
- The plan's self-measurement against the performance measures established under point III.B., below. [**NOTE**: DoL would apply this requirement to ERISA plans on a voluntary basis, but opposes applying this requirement to ERISA plans on a mandatory basis.]

2. Non-ERISA plans also provide this information at least once annually.

3. ERISA plans are subject to the following disclosure requirements:

- Health plan sponsors provide updated summary plan description (SPDs) for employee health plans every 5 years to DoL.
- Plans cannot charge copying fees for providing copies of the current SPD and all summaries of material modifications (SMMs) to date to a participant of beneficiary who has requested such material and who has not received such materials previously in the same plan year.
- The plan administrators provide notice (either as an SMM of some other notice) to each covered individual at least 30 days before the effective date of any change to the health benefit plan (e.g. change in benefits, coverage, and cost-sharing requirements).
- Health plan sponsors distribute SMMs for all other changes at least 30 days before the earlier of the end of the plan year or the first date participants and beneficiaries may choose to decline coverage (open season). Examples of such amendments include a decision to self-insure a plan that previously was insured without reducing benefits, or a change in plan administrator.
- Insurance companies can not lapse individuals' coverage under insured employee health plans lapse due to the plan administrator's nonpayment of premium, unless the insurer notifies these individuals at least 15 days before the coverage is to lapse.
- Plan sponsors make the following disclosures to enrollees regarding their rights and remedies under an ERISA plan:
  - -- If a benefit claim is denied, any rights and remedies beyond the administrative appeal process come under federal law (ERISA), not state law.
  - -- Under federal law, the remedies available are generally limited to recovery of the benefits due under the terms of the plan, and at the court's discretion, reasonable attorneys' fees and costs of action but not expert witness costs.
  - -- Enrollees may generally not recover compensatory consequential or punitive damages under state law (e.g., out of pocket expenses and other costs incurred such as lost wages, pain and suffering and emotional damages).
- Plan sponsors inform enrollees whether their health coverage is provided through insurance or from the general funds of the plan sponsor.

-- Disclosure For Self-Insured Plans. The health benefits are provided by the plan sponsor (name) and not by an insurance company (the third party administrator could be named). The TPA is a claims processor and does not underwrite or insure any benefits under the plan. If the plan sponsor becomes generally unable to pay its bills, participants and beneficiaries may be responsible for outstanding bills. Because no insurance company underwrites the benefits, such unpaid claims are generally not eligible for reimbursement from a state guarantee fund that normally protects claims of failed insurance companies.

-- Disclosure For Fully-Insured Plans. The health benefits are underwritten by the (name) insurance company. Should this insurance company experience financial difficulties, unpaid benefits may be eligible for reimbursement through a fund established by the state, sometimes called a guarantee fund. Your rights, however, will vary from state to state and you should consult with your state insurance commissioner for further information.

B. Quality

1. Department of HHS adopts standards for health plan quality/performance and requires health plans to provide to consumers information about how the plan performs against these standards, so consumers can evaluate competing health plans. [NOTE: DoL would apply this requirement to ERISA plans on a voluntary basis, but opposes applying this requirement to ERISA plans on a mandatory basis.]

- Department of HHS adopts performance measures, in connection with existing market-driven health plan evaluation efforts such as HEDIS.
- Health plans report their performance on these measures, and furnish information about their performance to consumers.

2. Department of HHS develops mandatory minimum national standards for utilization review procedures.

3. HHS and DoL, for non-ERISA and ERISA plans respectively, adopt civil and criminal penalties for falsification of information.

C. Privacy and Confidentiality: The Federal legislation would establish uniform confidentiality safeguards for all medical records, regardless of the form (paper or electronic).

1. The safeguards allow disclosure for payment of claims, investigation of health care fraud or abuse, and for specified public health reasons or in medical emergencies, by court order, by the subject's consent or to create anonymous aggregate data.

2. The safeguards ensure the individual's right to inspect and modify his or her records in case of an error.

3. Adopt civil and criminal penalties for violations of confidentiality.

D. Consumer Grievance Process: Ensure consumer grievances about claims or covered benefits are addressed quickly and fairly, with access to a neutral dispute resolution system.

1. Non-ERISA Plans.

- Grants to states to establish ombudsman offices and alternative dispute resolution systems, providing independent advice and counsel to consumers encountering difficulty with providers.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right to appeal.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
- Health plans submit an annual report to the ombudsman offices on the number of complaints filed, their allegations, and the dispositions.
- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

2. ERISA Plans.

- [**NOTE**: DoL is deciding among the following options.]
  - -- Status Quo, no legislative changes.
  - -- Expand ERISA remedies to make people whole for economic losses suffered; no pain and suffering or punitive damages.
  - -- Expand ERISA remedies to include economic and non-economic losses (pain and suffering), but not punitive damages.
  - -- Make ERISA plans subject to existing state law remedies.
- Establish pilot demonstration projects in the Department of Labor for mediation of health claims.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right to appeal.
- Permit Secretary of Labor to impose civil penalties for failure to provide plan benefits without any reasonable basis.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

E. Additional Rules for Multiple Employer Welfare Arrangements (MEWAs). MEWAs register with the Department of Labor. The Department then shares the information with states to ensure that MEWAs comply with applicable state laws.

- All MEWAs register initially and annually with DoL. MEWAs could register by submitting copies of their state licenses or through some other means as promulgated in DoL regulations.
- The Department of Labor may charge a registration fee, determine the content of the registration statement and cease the operations of unregistered MEWAs.
- When a MEWA fails to register, a civil penalty may be imposed on either the individual designated by the MEWA as the "administrator" or absent such a designation, on the person responsible for handling plan assets.
- Willful failure to register becomes subject to the criminal penalties under ERISA section 501 and 18 USC section 1027. Under Section 501 individuals face up to a $5,000 fine and/or a year in jail while entities can be fined not more than $100,000
- Amend certain ERISA definitions (e.g., the section 3(40) regulation project on collective bargaining agreements) to prevent MEWAs from avoiding registration requirements.

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- The Department of HHS monitors and enforces with respect to non-ERISA plans (via states).
- The Department of Labor monitors and enforces with respect to ERISA plans, and seeks amendments to ERISA as required.

Most standards would be mandatory for health plans; certain standards regarding quality and performance measures would be encouraged but not mandated (see part B., below).

Implementing regulations could be developed in either of two ways: (1) the HHS and DoL develop regulations, in consultation with all interested parties; (2) NAIC, NCQA or other relevant entity develops the regulations, which are then adopted as formal regulations by the relevant agencies (i.e., the MediGap regulation model). [NOTE: DoL opposes the second option as applied to them.][1]

II. Federal legislation would impose the following (except where specified, the following apply to both Non-ERISA and ERISA plans):

A. Consumer Information

1. All health plans provide to consumers, at the time of enrollment and upon request, with the following information:

- The identity, locations, specialties, and availability of participating providers.
- A summary description (not including proprietary information) of the procedures used to control utilization of services and expenditures, the practice guidelines used by the plan, and the financial incentives used by the plan (i.e., the amount of risk assigned to participating physicians).
- Applicable appeals or grievance procedures, including phone numbers for

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[1] This document describes a system of minimum standards which would be imposed on health plans, to protect consumers. It would also be possible to take a "voluntary certification" approach to these standards, using the Baucus Amendment model for development of MediGap standards. Under this model, the standards would be voluntary. States could adopt the standards as their regulations; in this case, all health plans in the state would be automatically certified. In states that do not adopt the standards, a health plan could seek individual certification as meeting the standards and could advertise that status. In effect, the standards would function as a "good housekeeping seal of approval." HHS would undertake consumer education efforts to explain the meaning of the certification. [NOTE: DoL opposes applying this "voluntary certification" approach to ERISA plans.]

designated staff and independent ombudsman offices in that service area.

- The plan's self-measurement against the performance measures established under point III.B., below. [**NOTE: DOL opposes applying this requirement to ERISA plans.**]

2. Non-ERISA plans also provide this information at least once annually.

3. ERISA plans are subject to the following disclosure requirements:

- Health plan sponsors provide updated summary plan description (SPDs) for employee health plans every 5 years to DOL.
- Plans cannot charge copying fees for providing copies of the current SPD and all summaries of material modifications (SMMs) to date to a participant of beneficiary who has requested such material and who has not received such materials previously in the same plan year.
- The plan administrators provide notice (either as an SMM of some other notice) to each covered individual at least 30 days before the effective date of any change to the health benefit plan (e.g. change in benefits, coverage, and cost-sharing requirements).
- Health plan sponsors distribute SMMs for all other changes at least 30 days before the earlier of the end of the plan year or the first date participants and beneficiaries may choose to decline coverage (open season). Examples of such amendments include a decision to self-insure a plan that previously was insured without reducing benefits, or a change in plan administrator.
- Insurance companies can not lapse individuals' coverage under insured employee health plans lapse due to the plan administrator's nonpayment of premium, unless the insurer notifies these individuals at least 15 days before the coverage is to lapse.
- Plan sponsors make the following disclosures to enrollees regarding their rights and remedies under an ERISA plan:
  - -- If a benefit claim is denied, any rights and remedies beyond the administrative appeal process come under federal law (ERISA), not state law.
  - -- Under federal law, the remedies available are generally limited to recovery of the benefits due under the terms of the plan, and at the court's discretion, reasonable attorneys' fees and costs of action but not expert witness costs.
  - -- Enrollees may generally not recover compensatory consequential or punitive damages under state law (e.g., out of pocket expenses and other costs incurred such as lost wages, pain and suffering and emotional damages).
- Plan sponsors inform enrollees whether their health coverage is provided through insurance or from the general funds of the plan sponsor.
  - -- Disclosure For Self-Insured Plans. The health benefits are provided by the plan sponsor (name) and not by an insurance company (the third party

administrator could be named). The TPA is a claims processor and does not underwrite or insure any benefits under the plan. If the plan sponsor becomes generally unable to pay its bills, participants and beneficiaries may be responsible for outstanding bills. Because no insurance company underwrites the benefits, such unpaid claims are generally not eligible for reimbursement from a state guarantee fund that normally protects claims of failed insurance companies.

-- Disclosure For Fully-Insured Plans. The health benefits are underwritten by the (name) insurance company. Should this insurance company experience financial difficulties, unpaid benefits may be eligible for reimbursement through a fund established by the state, sometimes called a guarantee fund. Your rights, however, will vary from state to state and you should consult with your state insurance commissioner for further information.

B. Quality

1. Department of HHS adopts standards for health plan quality/performance and requires health plans to provide to consumers information about how the plan performs against these standards, so consumers can evaluate competing health plans. [NOTE: DoL opposes applying this requirement to ERISA plans.]

- Department of HHS adopts performance measures, in connection with existing market-driven health plan evaluation efforts such as HEDIS.
- Health plans report their performance on these measures, and furnish information about their performance to consumers.

2. Department of HHS develops mandatory minimum national standards for utilization review procedures.

3. HHS and DoL, for non-ERISA and ERISA plans respectively, adopt civil and criminal penalties for falsification of information.

C. Privacy and Confidentiality: The Federal legislation would establish uniform confidentiality safeguards for all medical records, regardless of the form (paper or electronic).

1. The safeguards allow disclosure for payment of claims, investigation of health care fraud or abuse, and for specified public health reasons or in medical emergencies, by court order, by the subject's consent or to create anonymous aggregate data.

2. The safeguards ensure the individual's right to inspect and modify his or her records in case of an error.

3. Adopt civil and criminal penalties for violations of confidentiality.

D. Consumer Grievance Process: Ensure consumer grievances about claims or covered benefits are addressed quickly and fairly, with access to a neutral dispute resolution system.

1. Non-ERISA Plans.

- Grants to states to establish ombudsman offices and alternative dispute resolution systems, providing independent advice and counsel to consumers encountering difficulty with providers.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right to appeal.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
- Health plans submit an annual report to the ombudsman offices on the number of complaints filed, their allegations, and the dispositions.
- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

2. ERISA Plans.

- [NOTE: DoL is deciding among the following options.]
  - Status Quo; no legislative changes.
  - Expand ERISA remedies to make people whole for economic losses suffered; no pain and suffering or punitive damages.
  - Expand ERISA remedies to include economic and non-economic losses (pain and suffering), but not punitive damages.
  - Make ERISA plans subject to existing state law remedies.
- Establish pilot demonstration projects in the Department of Labor for mediation of health claims.
- Health plans provide prompt notice of denial, delay or reduction in services and of a right to appeal.
- Permit Secretary of Labor to impose civil penalties for failure to provide plan benefits without any reasonable basis.
- Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
- Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

E. Additional Rules for Multiple Employer Welfare Arrangements (MEWAs). MEWAs register with the Department of Labor. The Department then shares the information with states to ensure that MEWAs comply with applicable state laws.

- All MEWAs register initially and annually with DOL. MEWAs could register by submitting copies of their state licenses or through some other means as

promulgated in DOL regulations.

- The Department of Labor may charge a registration fee, determine the content of the registration statement and cease the operations of unregistered MEWAs.
- When a MEWA fails to register, a civil penalty may be imposed on either the individual designated by the MEWA as the "administrator" or absent such a designation, on the person responsible for handling plan assets.
- Willful failure to register becomes subject to the criminal penalties under ERISA section 501 and 18 USC section 1027. Under Section 501 individuals face up to a $5,000 fine and/or a year in jail while entities can be fined not more than $100,000
- Amend certain ERISA definitions (e.g., the section 3(40) regulation project on collective bargaining agreements) to prevent MEWAs from avoiding registration requirements.

August 14, 1995

MEMORANDUM FOR DISTRIBUTION

FROM: CHRIS JENNINGS
JENNIFER KLEIN

SUBJECT: HEALTH CARE REFORM PROVISIONS

As you know, we have schedule a staff meeting for tomorrow (Tuesday, August 15, 4:00 p.m.) to discuss the specifics of our health care plan, which we may release as early as this September. We have called the meeting to see if we can provide an administration-wide staff recommendation to the principals on our non-Medicare/Medicaid health reform provisions.

Attached, for internal review, are the latest summaries/specifications of most of these provisions:

1) insurance reforms
2) purchasing cooperatives; and
3) insurance for the temporarily unemployed.

Please hold this information close, but be prepared to raise any and all suggestions or concerns you may have . We look forward to seeing you on Tuesday, August 15.

HEALTH INSURANCE REFORMS : HELPING INDIVIDUALS AND BUSINESSES IN THE HEALTH CARE MARKET

I. Insurance Market Reforms

Insurance market reforms, based upon proposals supported by both Republicans and Democrats in the 103rd Congress, would build upon state-level initiatives to improve the fairness and efficiency of the insurance marketplace for individuals and small employers. The minimum standards would be in federal law, but would be enforced by states. Where appropriate, standards would also apply to self-funded plans.

- **Assuring Portability and Renewability of Coverage** To protect consumers from losing coverage when they change jobs, move, or get sick, rules in the insurance market would be reformed by:

  - prohibiting health plans from imposing new exclusions for pre-existing medical conditions for people who change insurance.
  - requiring health plans to renew coverage regardless of health status.
  - prohibiting health plans from raising premiums paid by an individual or family because they were sick or used their insurance.

- **Making Coverage more Accessible and Affordable** To expand access to coverage and limit premium and benefits discrimination based on health status, the insurance market would be reformed by:

  - requiring health insurance companies in the small group market to offer coverage to all small employers and their workers, regardless of their health status or claims history.
  - requiring health plans that cover employer groups to cover new employees (and their families) regardless of their health status.
  - prohibiting health plans from imposing caps on benefits for specific diseases and illnesses.
  - limiting the amount by which health plans can vary or increase premiums charged to small employers and individuals based on claims history.

Collectively, these changes would expand insurance coverage and assure a fairer and more equitable insurance market for small businesses and individuals. Many states have already enacted these provisions to some extent, but the Administration believes these standards should be enacted at the federal level to assure fairness to all Americans--these are protections that individuals should have regardless of where they live.

II. Providing Small Businesses with Greater Leverage in the Health Insurance Market

Today, the small business community is at a disadvantage in the health care market because there are few ways in which it can exercise its clout and achieve the discounts that larger employers

are often able to obtain. To enhance the power of small businesses in the health care market, the Clinton Administration would make $25-$50 million available to states to assist them in establishing geographically-based purchasing cooperatives for small employers. The cooperatives would:

- accept all small employers, including the self-employed, on a first-come, first-served basis.
- not discriminate against employees on the basis of their health status.
- guarantee renewability of health benefits at rates that are consistent with state premium rate laws.
- offer a choice of plans (health maintenance organizations, fee-for-service, preferred provider organizations, etc.). Today, most small employers with insurance only offer one option to employees.

If a state does not provide group purchasing options for small employers, then the state may request the federal government to make group purchasing available to small employers through the Federal Employees Health Benefits Program (FEHBP). All carriers covering FEHBP beneficiaries would be required to participate in the small employer purchasing option.

Separately rated

III. Helping the Self-Employed

The tax deductibility of health insurance for the self-employed would be increased to 50 percent.

IV. Increasing Coverage for the Temporarily Unemployed

The Administration's plan would provide support for low income individuals and families who were previously insured under employer provided plan. To be eligible, an individual would:

- be receiving unemployment insurance
- have been receiving health insurance through their previous employer for at least 6 months
- not be eligible for insurance through a working spouse (whose employer pays at least 50 percent of the cost) or medicaid or medicare
- have a current income less than 240 percent of poverty (a full subsidy would be provided for those who have up to 100 percent of poverty; the subsidy would be phased out between 100 and 240 percent of the poverty level)

The program would allocate Congressionally funds to the states based on a formula reflecting unemployment rates and relative health care costs:

- funds would be allocated on the basis of providing recipients a benefit package equivalent to the standard option Blue Cross/Blue Shield Plan available to federal employees through the Federal Employees Health Benefit Plan.
- as a condition for receiving the a federal grant, the state would have to assure qualified individuals access to a plan that would provide these benefits (or their equivalence).

Access could be through the private insurance market, high risk pools, medicaid buy-in, or a special plan for the temporarily unemployed (as Massachusetts has done).

- a state could make adjustments in its benefit package, with the approval of the Secretary of HHS, if allocated funds are inadequate to meet actual costs, or the state could supplement the federal grant with its own money.

Qualified individuals would:

- be informed of the program and eligibility criteria at the time they apply for unemployment insurance
- receive a contribution toward the purchase of COBRA coverage or other private health insurance or be enrolled in a plan designated by the state (e;g., high risk pools, medicaid buy-in, a special plan for the unemployed, etc.)
- not be subject to any reduction in UI benefits as the result of participation in the health care program

V. Enhancing Consumer Information and Protection

To better inform consumers about how their health insurance works, minimum standards would specify the types of information that health plans would be required to provide to enrollees. At enrollment, health plans would provide information about the plan's benefits and limitations; the identity, location and availability of the plan's participating providers; a summary description of the procedures used by the plan to control utilization of services; and how well the plan meets quality standards.

August 16, 1995

TO: Secretary Rubin
Secretary Reich
Secretary Shalala
Director Rivlin

FROM: Chris Jennings
Jennifer Klein

Attached are summaries of the legislative specifications that we are working on to fill in the details of our health reform proposal. Specifically, you will find details on the following initiatives:

1) Insurance Reform and Purchasing Cooperatives

2) Temporarily Unemployed

3) Medicaid Reform.

We have reviewed the specifications at a DPC/NEC/Departmental staff level, and have general -- although not final -- consensus on the provisions. We thought you might like to review this information prior to the meeting tomorrow.

If you have questions prior to the meeting, please don't hesitate to call.

Thanks.

cc: Alicia Munnell
Leslie Loble
Judy Feder
Gene Sperling
Nancy Ann Min

INSURANCE REFORMS

We have consistently said that the President opposes cuts in Medicare and Medicaid outside the context of health care reform. Reductions in these programs will produce cost-shifting to private payers, particularly smaller businesses that have relatively little power in the health care marketplace. Insurance reforms can improve the efficiency and fairness of the health insurance market and cushion the effects of cost-shifting.

The reforms discussed below can be broken into three categories: (I) portability; (II) availability and affordability of coverage; (III) encouraging competition.

- Changes that assure that people can retain the coverage they have (often referred to as "portability") as well as reforms that make insurance more available and affordable will increase coverage by limiting people being dropped and barriers to access (thereby reducing uncompensated care). Less uncompensated care lowers the burden on providers and makes them better able to absorb cuts in public programs.

- Reforms that improve the availability and affordability of insurance will also improve the overall efficiency of the market by forcing insurers to compete based on price and service, rather than trying to insure only healthier people as they can today. Price and service competition should reduce overall premiums over time which will offset the effects of cost-shifting from cuts in Medicaid and Medicare.

- Promoting purchasing cooperatives also will help to improve market efficiency, both by organizing and expanding the insurance choices available to small business and by giving them a mechanism to pool their bargaining power.

I. PORTABILITY: Measures to improve the ability of the currently insured to maintain coverage.

A. Group Market

1. Prohibit insurers from imposing new pre-existing condition exclusions for new enrollees who were previously insured. This would apply to all plans.

2. Require insurers to renew coverage to small employer groups regardless of health status.

3. Guarantee access to insurance for new employees in businesses that offer coverage at the group's average rate (i.e., the insurer could not consider an individual's health status in determining the rate). Although this would apply to all plans, it would primarily affect small businesses.

4. Treat the self-employed as a "group".

5. Prohibit insurers (and self-insured employer plans) from imposing caps on benefits for specific diseases or overall caps on benefits. This would apply to all plans.

Discussion: Portability (initiatives 1 and 2, and to a lesser extent 3) is the primary focus of Republican proposals in this Congress. Generally, assuring portability for people changing jobs would be relatively noncontroversial (over 40 states have done so for small groups). Initiative 4 is consistent with the NAIC model legislation but many insurers may object on the grounds that verifying "self-employment" is difficult and burdensome.

Initiative 5 would be more controversial because it would prohibit self-funded groups from excluding coverage for specific high-cost diseases, such as AIDS. States commonly prohibit insurers from excluding certain high-cost diseases, but the federal government generally does not regulate the content of self-funded health plans. Senator Jeffords included such restrictions in his bill (S. 1065). Jeffords did not offer this provision as an amendment to the Kennedy/Kassebaum bill mark-up but said he would offer it on the floor.

B. Individual Market

1. Require insurers offering individual coverage to provide coverage (at their average price for an insured with the same characteristics and without pre-existing condition exclusions) to applicants in certain circumstances who had prior insurance coverage for at least 12 months. To protect the market from substantial adverse selection, the provision would be limited to circumstances such as loss of employment, divorce, or changes of residence, and the change would have to have occurred within 60 days. (Representative Johnson's and the Kennedy/Kassebaum proposals are similar to this.)

2. Guarantee renewability at the same rate as people with similar characteristics and without regard to health status.

Discussion: Extension of portability provisions to these situations extends protection to many people who lose coverage because of extenuating circumstances, similar to what currently exists under COBRA. The problem of people simply entering the market when they become sick would be minimized by limiting the circumstances and time period. Insurers will argue that even a limited extension of portability provisions to include individual coverage would increase individual premiums substantially, but with the time and circumstances restrictions, the numbers potentially affected would be too small to significantly effect the insurance market.

Guaranteed renewability would prevent people from being "dumped" by insurers if they began to incur significant medical claims. (The Kennedy/Kassebaum bill would guarantee renewability but does not address the problem of changing premium rates at renewal, which is left to state law.)

II. ACCESS AND AFFORDABILITY: Measures to expand access to coverage and to limit variations in premiums.

Group Market

1. Require insurers to make coverage available to everyone, regardless of health status (generally referred to as "guaranteed issue").

2. Limit premium variations for small businesses by phasing in adjusted community rating over five years.

   Discussion: To improve the insurance market, guaranteed issue and limits on premium rate variations should be done together, and indeed, most states have done both to some degree. Without limits on rate variations, insurers could easily circumvent guaranteed issue by simply charging very high rates to high risk people. The purpose of Federal action would be to insure greater equity by establishing a minimum standard that surpasses what many states have done to date. The recommendation is the same as the NAIC model code[1]. States would, however, be permitted to establish more stringent standards.

   Federal legislation in these areas would be potentially controversial for four reasons, however. First, even though most states have enacted them, there is considerable variation among the states, reflecting local markets and practices. Second, Federal standards, unless set at the most stringent levels, could undermine what the better states have already accomplished, and the insurance industry and some Republicans in Congress may be anxious to reverse what some states have done. Third, Federal legislation raises difficult issues about applicability to self-insured plans and MEWAs that states laws cannot address because of ERISA. And finally, Federal legislation would represent a significant intrusion in an area that has been primarily a state responsibility for nearly 50 years.

   During the last Congress, a number of Republicans (including Senator Dole) supported comprehensive access and rating reforms. The current Republican proposals (e.g., bills by Representatives Thomas and Johnson), however, are limited to portability. The Kennedy/Kassebaum bill, which was recently marked-up, included portability provisions similar to those above, but it did not include any restrictions on premium variations.

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[1]/In the NAIC model adjusted community rating would permit rates to vary only for age in 5 year increments, family composition, and geography. Overall rates for an insurer could only vary by 200 percent between the highest and lowest group with similar characteristics.

III. ENCOURAGE COMPETITION: Measures to restructure the market to promote competition among insurers based on efficiency and service, and to reduce opportunities for risk selection by insurers.

Promote the establishment of purchasing cooperatives for small businesses, including:

a. Providing administrative funding and technical assistance

b. Establishing standards for cooperatives (e.g., cannot bear any insurance risk, must be geographically based, non-profits, rating rules applicable within coops, etc).

c. Making FEHBP -- the federal employee health program -- available to small businesses in states that do not establish purchasing cooperatives (i.e., carriers selling insurance outside the FEHBP program would have to offer appropriate insurance plans to small businesses through the FEHBP, but such plans would be rated separately from those offered to Federal employees).

Discussion: State governments and private organizations are already working to form voluntary small business purchasing cooperatives. Facilitating these initiatives would likely attract broad support (but requiring their establishment or enacting uniform standards might be perceived as overly regulatory). Providing technical assistance and funding could greatly spur the development of cooperatives. Cooperatives are administratively complex organizations, so finding start-up funds and expertise has been a significant barrier for some groups that want to begin one. Establishing appropriate standards for cooperatives would be extremely important, however; without such standards the cooperatives could become a variation of a MEWA, which could exacerbate problems in the market rather than improve them. Finally, Treasury has been examining whether legislative language clarifying the eligibility of certain purchasing cooperatives to be non-profits is necessary and has tentatively concluded that a clarification would be desirable. This could be included in an Administration legislative package.

The idea of using FEHBP as a purchasing mechanism for small businesses had broad, bipartisan support in the last Congress. However, opening up FEHBP without insurance reforms in the rest of the market providing for guaranteed access to coverage and limitations could result in mainly sicker people joining the FEHBP, which in turn could lead to significant premium increases.

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SPECIFICATIONS FOR A PROGRAM OF HEALTH INSURANCE FOR THE TEMPORARILY UNEMPLOYED

I. Grants to States

The Federal Government would provide annual grants to states which choose to participate to operate a health insurance program for unemployed individuals who meet the criteria set out below. The grants would be administered by HHS. If a State chooses not to participate, the Secretary of HHS will determine how a system would operate in that State. HHS would have the authority to contract out.

Health Insurance for the Unemployed will be a capped entitlement to the state. Funds will be "appropriated until expended", a budget classification which permits excess funds to be carried over at the end of the year to the next year. This will permit funds to be appropriated at a relatively level cost over the course of a business cycle.

States would be provided with funds adequate to pay for the actuarial value of the basic benefit package (modelled on the FEHP BC/BS Standard option) based on estimates of unemployed persons and their dependents that would meet the eligibility criteria. The total amount of the grant would be based on the number of eligible individuals (see below) who collected unemployment insurance (UI) benefits in the state in the prior year. Allocations would be adjusted to reflect variation in health costs among states. State administrative costs for the program would be paid out of a state's allocation and may not exceed limits set by the Secretary of HHS.

As a condition of the grant, States would have to demonstrate that recipients have access to an insurance product equivalent to the BC/BS standard option plan. Coverage could be through 1) COBRA coverage from their prior employer; 2) an insurance product in the private market; or 3) an alternative means of coverage (e.g., state high risk pools, medicaid buy-in, a special plan for the temporarily unemployed, etc.). The Secretary would have the discretion to vary the content of the benefit package within certain parameters to adjust for varying availability of insurance products at the average cost level assigned to the State. A state could make adjustments in its benefits package, with the approval of the Secretary of HHS, if allocated funds are inadequate to meet actual costs. States would also have the option of extending eligibility periods or providing a more generous package using state funds.

HHS would have the authority to require the states to provide the information necessary to support a grant, such as information on UI eligible populations, benefit take-up experience and actual enrollment.

II. Eligibility for Coverage

As a condition for receiving the grant, the Governor must certify that funds will only be spent for health coverage under the following conditions:

- Recipients must be in active unemployment insurance claims status.
- Coverage would not exceed 6 months. (The cost of any extension would be borne fully by the state.)
- Individuals must have had health insurance coverage through their last employer for at least the six previous months (including plans where the employee paid the full cost). The definition of what constitutes "coverage" (e.g., potential exclusion of certain catastrophic plans) would be determined by the Secretary of HHS.
- A full subsidy is provided up to 100% of the poverty level for family income and phased out at 240% of the poverty level (determined on a monthly basis).
- An employed spouse has no health insurance coverage or, if covered, the employer contributes less than 50% of the premium.
- The individual/family is not eligible for Medicaid or Medicare.
- Individuals will be eligible based on their place of work, rather than their place of residence.
- No reduction can be made in the duration or amount of unemployment benefits as the result of an individual participating in the health care coverage program.

III. Administration

Administration of the program would be the responsibility of the Governor, but must meet the following basic criteria:

- The state must conduct all eligibility determinations subject to the oversight of HHS. The state has the option of contracting out eligibility and enrollment. However, the state may not contract with an entity that is engaged in underwriting insurance contracts for any part of the enrolled population or has any financial interest in any entity that does so.
- Eligibility determinations and appeals would be handled in a manner consistent with procedures established by HHS.
- Any reduction in either the duration or extent of health coverage benefits would have to be approved by the Secretary.

- o Unemployment claimants are informed of possible coverage eligibility at the time that an eligibility determination for UI benefits is made.

- o Recipients must be informed that program funds are capped, which could result in reduction or elimination of benefits if funds become exhausted.

- o Funds from the grant will take the form of letters of credit to the states.

- o Governor will ensure that program information and applications are available in every local unemployment office/one-stop office.

- o Appropriate arrangements, taking into account confidentiality and other requirements, will be made to permit the state employment security agency to share current benefit recipient tapes with the state health insurance agency/service provider on a monthly basis in order to make eligibility determinations.

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FEDERAL MEDICAID PER CAPITA GROWTH LIMIT: ISSUES

FRAMEWORK

In an effort to 1) provide incentives to states to control the growth of Medicaid per capita spending and 2) achieve federal Medicaid savings without endangering coverage, the President's budget includes a proposal to limit the rate of growth in federal Medicaid spending per capita.

The application of federal growth limits on per capita spending is distinct from the aggregate Federal cap in block grants in that it takes enrollment out of the cost containment equation, promoting efficiency rather than coverage reduction as the means of reducing costs. The policy preserves critical aspects of the current Medicaid program, including: existing Medicaid eligibility rules; mandatory services as well as state flexibility to cover optional benefits; and the current matching approach to spending. None of these would be guaranteed under a block grant.

MAJOR ISSUES

Expenditures Under the Per Capita Growth Limit

Multiple expenditure groups would be established, corresponding to broad Medicaid eligibility categories -- specifically, the aged, disabled, adults and children. These expenditure groups will be the basis of the growth limits (e.g., a limit of $1,250 per adult recipient; $2,500 per aged recipient; etc.).

Staff discussed and will work to resolve, an issue concerning whether high-cost users within these broad expenditure categories should be treated separately.

Expenditures for disproportionate share hospital payments, the Vaccines for Children program, Indian Health Service providers, and Medicare cost-sharing paid on behalf of certain Medicaid-eligible individuals would be excluded when calculating per capita limits. (Please note that a separate DSH policy is being developed.) However, per capita limits would include expenditures for administration and undocumented immigrants.

Base Year and the Frequency of Rebasing

One year, specifically FY 1995, would be used to calculate limits for the first year under the per capita cap. These limits would not be rebased subsequently every year but would grow at some growth rate.

The per capita limits would be based on each state's total computable expenditures (federal and state spending for Medicaid) by expenditure category in the chosen base year.

Growth Rates

The growth rate would be a nationally uniform rate applied to each expenditure category. However, if desired, this national rate could be adjusted to allow a different growth rate for each expenditure group.

Staff reviewed the relative strengths and weaknesses of different indices (CPI, GDP, etc.) and will prepare a working paper on the subject.

Transition and Implementation

Per capita limits would become effective October 1, 1995, with the cap effective in FY 1996 but not enforced until FY 1997 to accommodate differences in states' abilities to change their Medicaid laws and regulations.

The existing Medicaid payment mechanism by which states receive Federal matching payments would be retained.

Section 1115 Demonstrations

Staff must review and resolve a number of issues before a recommendation can be offered. Policy officials agree that individuals made eligible under expansions in coverage would remain covered under the cap. However, officials could not agree on whether the waiver states should comply with the per capita growth limits set under this policy or let the states keep the growth rates approved in their waivers.

Other Issues:

One issue not thoroughly addressed in this paper is the idea of reallocation of federal Medicaid expenditures. Federal funds could be redistributed among states. For example, the federal government can determine a national per capita amount and adjust the national per capita for each state based on differences in health care costs and other factors, e.g., a state's total taxable resources or poverty rate. The federal government could then pay a certain percent of the state's per capita. While interstate variation based on utilization levels and other factors would be minimized, such an approach would open up a "formula fight" as states scramble to protect their share of federal Medicaid expenditures.