TO: BBK
FROM:DAVE, PAT
RE: Health Care Task Force
DATE:June 8, 1993

As you know, we attended an Ira Magaziner briefing on the current status of the health reform task force on June 7. Although there was a lot of information that was not exactly new, there are a couple of major things we'd like to make you aware of.

In addition, I (DAVE) attended a briefing the next day by Magaziner for the leadership and relevant committee and subcommittee staffs. The sections to follow which are denoted with an asterisk are facts garnered from a hand out at that briefing. Unfortunately they would not let us take this paper out of the room. At the end of this briefing, they mentioned that there will be a document for "internal use" which will be made available for members of the leadership early next week. This will either be distributed, or provided in a briefing.

Timing: While he would not commit to a date of introduction or announcement, he indicated that there is only a very slim chance that the plan would be unveiled before the President goes to Tokyo for the G-7 meeting July 7, 8, and 9. The timing is going to be based on how far along reconciliation is in the Senate. The President will continue to consult with Congress before the plan is released, and after some type of formal announcement by the President, legislation will be presented to Congress. Using an optimistic timetable, and good movement on reconciliation, the plan could be introduced in mid-July. However, he did not rule out the possibility that the plan wouldn't be unveiled until September--this would be reconciliation driven.

The most significant thing we learned in the meeting is that **4 major decisions have yet to be made.**

1. Whether or not to have short term cost controls: Although he did not elaborate much here, it seems that the types of controls they may be considering are: completely voluntary controls, a voluntary control with a trigger that will establish controls if a specific target is not met, or some kind of rate controls. He stressed that this is very much up in the air.

2. Whether or not anyone will be allowed to opt out of the health alliance: The task force is deliberating between two models

A. Companies above a certain size, he mentioned 5,000 employees (presumably very large employers like General Electric and IBM as well as Taft-Hartley Plans--big union plans) will be allowed to form their own health alliance and must play by the same rules as everyone else. If this option is chosen, these private alliances will be expected to make a financial contribution to the health alliances to help cover the cost of subsidies for low income and the unemployed. Large businesses that the task force has talked to about this do not seem to have a problem with that requirement.

B. Everyone is required to purchase through the health alliance regardless of company size

They have looked at two other options but right now they are off the table. They are:

a. have the alliances be completely voluntary

b. require only companies that have fewer than 100 people to purchase through the cooperative. The problem with this is that it takes the most fragmented, difficult part of the system and includes it in the new system without any mechanism to help absorb the risk. I.e--smaller employers are traditionally higher risks.

3. How employer contribution will be determined: They still have to decide whether the contribution will be a fixed percentage of payroll, or if businesses will contribute a certain amount per employee.

4. Final Financing methods: They are still not sure exactly how much the new system will cost. One concern which came up today was Sen. Moynihan's comments about saving more money for reconciliation from Medicare. If this is done, money from Medicare the task force expected to use to offset the health care reform bill will not be available and other financing mechanisms will need to be tapped. He did state that there will be some kind of tobacco tax. In addition, because hospitals will do less uncompensated care as universal coverage is phased in, the administration is looking at ways to recapture some of this savings the hospitals will experience. BBK, here is where the notion of a windfall profits tax on providers is taxed about in the press. However, what I think is more likely to happen is on the spending side where we spent about half of the Financing Work group's time identifying areas where existing federal and state spending could be cut in the event of universal coverage. This is literally tens of billions and includes thing like eliminating the Medicare disproportionate share adjustment ($10 B) on the theory that these institutions no longer need because there will be no uncompensated care.

There is also likely to be a tax cap but not in the sense we have been thinking about it thus far. The notion is that the

employer provided plan remains deductible/excludible. But certain things would be specifically non-deductible/excludible--cosmetic surgery and the like as well as copayment and deductibles. It will not be enforced through the Treasury but rather through the employer/employee contributions. For instance, if I wanted cosmetic surgery, my employer health insurance would not pay and I could not deduct the cost.

Consumer Choice of Plans:

Consumers who purchase their coverage through the health alliance would have at least "three flavors" to choose from when selecting a health plan:

1. fee for service
2. health maintenance organization (H.M.O.)
3. preferred provider organization (P.P.O.)

The intent is to make it more costly for people to join the fee for service plan: specifically they envision a $200 deductible for individuals, $400 for families; a 25% co payment, and a stop loss of $3,000 per year. Copayments and deductibles for HMOs and PPOs will be lower.

Mental Health Benefits:

Will be included in the basic benefits package, but not sure to what degree because they are still working out costs. It is the intent of the task force to try as much as they can to establish parity with how physical care is covered. The task force expects that the benefit package will include better mental health coverage than most plans do currently.

They want to stress case management to encourage a more preventive approach, however, the actuaries are concerned about how much that will cost. Another approach would be to get away from a time limit (ie 30 days) that currently exist for mental health, however, this would have to be offset financially to include copays and deductibles in a fee for service type arrangement.

Fraud and Abuse: They are still finalizing here but the intent is to have tougher penalties and enforcement to crack down on abusers. It is not their intent to address fraud and abuse through regulatory micromanagement.

Coverage: There will be an employer and employee mandate (every employer must provide health insurance, every American must have it). These mandates will be phased in to lessen the burden on small businesses who do not currently offer coverage. This will be helpful for those companies, however, we may want to keep in mind that there could be concerns with this from small businesses

who have struggled for years to provide coverage for their employees. It is somewhat unfair to give a subsidy to those businesses that did not make an effort to provide coverage for their employees, while making no accounts for those who have.

Also, for low income individuals, some kind of subsidy will be available to help them purchase coverage. In addition, there will probably be some type of copay for these individuals (perhaps as low as $1) to reinforce that receiving health care does have costs associated with it.

Cost Containment: A more competitive marketplace will control costs through competition amongst competing health plans, and health alliances (through the issuance of quality data on plans) will make individuals better health care consumers. Also, individuals will have to pay out of pocket for plans which exceed the basic benefits package.

Other aspects intended for cost control are:

1. Federal law will establish a per capita spending limit nationally for the basic benefit package

2. The National Board determines state premium targets by adjusting the national average premium to reflect each states population characteristics (age, gender, health status) and historic costs relative to the national average.

3. State premium targets will increase annually by the rate of increase of the consumer price index plus a fixed percent.

4. State health plan premiums, on average, cannot exceed state premium target.

Malpractice: There will be serious malpractice reform, but the details are being worked out. You will recall that enterprise liability is the concept that individual doctors will not be held liable for malpractice, but instead the health plan would be. As you can imagine the insurance companies have expressed concern with this. The thought of the task force is that enterprise liability will be an option for the states, but this will not be mandated.

Federal Employees: All federal employees will be folded into the new system. Politically, this is intended to show that government employees will be in the system the same as everyone else.

Supplemental Coverage: This will be available to individuals who wish to purchase additional benefits, however, it is not the intention of the task force for supplemental coverage to cover copays and deductibles. Although this supplemental coverage could be purchased through the alliance, it was not ruled out that supplemental coverage could be purchased directly from an

insurer. Although it would not be a huge market, this could potentially be a market that independent agents or smaller companies could get into. Unclear what happens to CAFE plans and flexible spending accounts.

Workers Comp/Auto: folded in for the medical portion. Workers comp indemnity and auto liability stay in the private sector. Works comp could still be experience rated in the private sector.

Medicare/Medicaid:

Medicaid: the accute care portion gets folded in immediately. The disability portion and the long-term care portoins do not get folded in in the forseeable future.

Medicare: does not get folded in in the short term. In the long-term it will be a state optoin whether or not to fold it in.

Abortion: This issue has been under a great deal of discussion. Pregnancy related services are to be included in the basic benefits package, and this is intended to include abortion. There has been sensitivity expressed for certain state laws which restrict abortion, and it is not the intent of the bill to over-ride these state laws. The thought is that abortion coverage will be modeled off existing insurance plans, and that it will be up to the health plan whether or not they will cover this service.

National Health Board: This board will be made up of seven individuals with expertise in the medical arena who will be appointed by the President with the advice and consent of the Senate. The board's primary role will be to review and update the benefits package, implement and enforce the national budget, and oversee quality improvement.

Long Term Care: Focus will be on home and community based care. the new Federally financed home and community based program includes:

* an array of services defined by the states,

* state established mechanisms to determine eligibility, develop care plans, coordinate services, and assure quality,

* federal funding capped for each state based on estimated number of eligible patients and per capita spending. This funding would increase annually by the consumer price index plus a fixed amount.

* eligible individuals are entitles to $500 per month in services

* individuals with incomes above 150% of poverty will be required to pay 20% of service costs.

Medicaid Nursing Home Benefits:

* all states required to establish medically needy programs allowing individuals with incomes exceeding eligibility levels to spend down to become eligible for medicaid.

* nursing home resident will be allowed to retain $12,000 (currently $2,000) in assets and $100 per month (up from $30) in income.

Private Long Term Care Insurance

* preferred tax treatment now accorded health insurance medical spending is extended to cover long term care insurance premiums and expenses

* states required to establish a plan for regulating the content and sale of long term care insurance policies.

While this appears to be good for the long term care partnership in Connecticut, we must keep in mind that Mr. Waxman hates this and will probably try to do something about it.