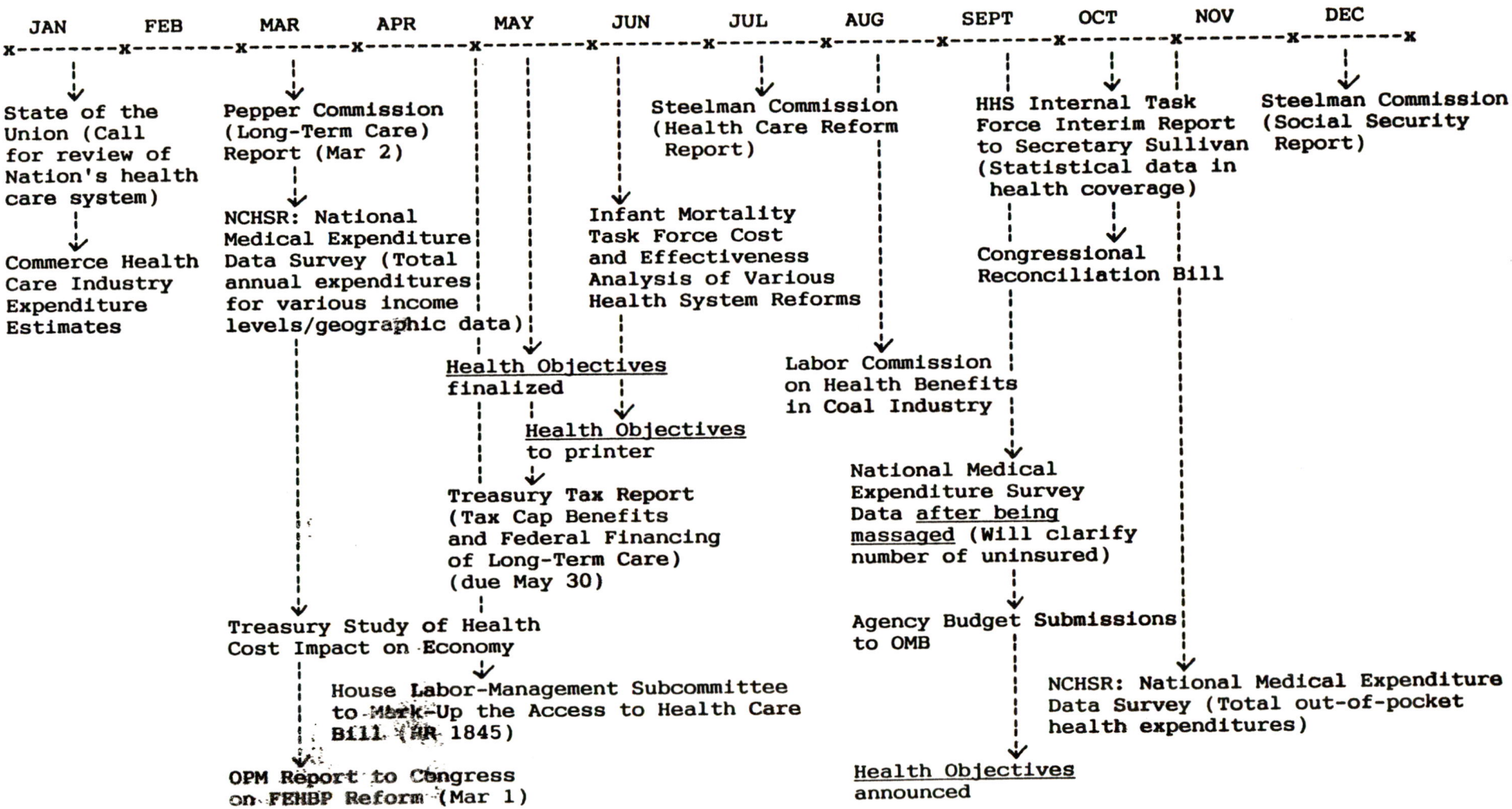
Health Care

Ken Yale

March 15, 1990

KNOWN HEALTH EVENTS ON THE HORIZON

1990



RECOMMENDATIONS TO THE CONGRESS

BY

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

"Access to Health Care and Long-Term Care for All Americans"

March 2, 1990

Summary: Recommendations on Access to Health Care

THE PEPPER COMMISSION PROPOSAL ASSURES UNIVERSAL HEALTH CARE COVERAGE FOR ALL AMERICANS THROUGH A JOB-BASED/PUBLIC SYSTEM.

1. Businesses with 100 or fewer employees are encouraged to provide health insurance for their employees and non-working dependents.

   * To make insurance more available and affordable:

     -- The private insurance market is reformed.
     -- A minimum package is available.
     -- Tax credits/subsidies for certain small employers are available.
     -- Self-employed and unincorporated businesses can deduct 100% of their premiums.

   * If employers purchase coverage and achieve a specified coverage target, there is no requirement to provide private insurance or participate in the federal public health insurance plan ("public plan").

2. All businesses with more than 100 employees must provide private health insurance (for a specified benefit package) or contribute to the public plan for all employees and non-working dependents.

3. The public plan will cover employees and dependents that contribute and non-working individuals who buy in or are subsidized.

   * The plan replaces Medicaid for the specified services and pays providers according to Medicare rules.

   * The fully phased-in plan is financed and administered primarily by the federal government, although states can opt to administer it.

4. The minimum benefit package includes primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

5. System reforms include measures to contain costs, assure quality and initiate innovative delivery systems for the underserved.

6. For both administrative and fiscal reasons, the plan will be phased in, beginning with making coverage available for children through the public plan.

7. At full implementation, all Americans will be required to have health insurance through their employer or the public plan.

Phase-In Schedule and Cost of the Commission Health Care Proposal

(Dollars are in Billions, 1990)

Year 1

- Initiate Insurance Reforms.
- Allow all uninsured pregnant woman and children through age 6, to enroll in the public plan (fully subsidized to 185 percent of poverty).
- Raise Medicaid reimbursement rates for obstetrical and pediatric care.

Total Net New Federal Cost:	$3.4
% of Americans Without Health Insurance:	14%

Year 2

- Firms with fewer than 25 employees and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for the cost of health insurance that is provided. Employees of these firms with family income of less than 200 percent of poverty receive a subsidy.
- Public plan is available to uninsured children up to age 18.
- Improve physician reimbursement.

Total Net New Federal Costs:	$13.5-16.8
Additional Cost from Year 1:	$10.1-13.4
% of Americans Without Health Insurance:	8%-11%*

Year 3

- Firms with 100 or more employees are required to provide health insurance or contribute a portion of payroll to cover employees and dependents in the public plan.

Total Net New Federal Costs:	$17-20.3
Additional Cost from Year 2:	$3.5
% of Americans Without Health Insurance:	6%-8%*

Year 4

- If 80% of uninsured employees of firms with 25-100 employees (as of year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- Raise Medicaid hospital reimbursement rates.

Total Net New Federal Costs:	$19.8 - 23.1
Additional Cost from Year 3:	$2.8
% of Americans Without Health Insurance:	5%-7%*

Year 5

- o If 80% of uninsured employees of firms with fewer than 25 employees (as of year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.
- o Allow all uninsured adults into the public plan.
- o Retain subsidy to small firms with low wage employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 4:	$11.8
% of Americans Without Health Insurance:	0%**

Year 6

- o Retain subsidy to small firms with low wage employees and their employees.

Total Net New Federal Costs:	$31.8
Additional Cost from Year 5:	$0

Year 7

- o Eliminate explicit subsidy to small firms with low wage workers and their employees.

Total Net New Federal Costs:	$23.4
Additional Cost from Year 6:	($8.4)

* Depends on how many smaller firms voluntarily choose to purchase health insurance.

** If 80 percent of uninsured workers and their dependents in firms of fewer than 25 are now insured the Secretary of Health and Human Services must submit to Congress a plan to insure any remaining uninsured. If employers with fewer than 25 do not meet this target, then the imposition of a requirement to cover all workers and their dependents or contribute to a public plan will ensure that all Americans now have health insurance.

Summary: Recommendations on Long-Term Care

THE PEPPER COMMISSION PROPOSAL PROVIDES HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES AND PROTECTION AGAINST IMPOVERISHMENT FOR PEOPLE IN NURSING HOMES.

1. The plan has three components.

   * Severely disabled persons of all ages are eligible for social insurance for home and community-based care.

   * The plan establishes a Nursing Home Program (NHP) for nursing home care to provide an ample floor of financial protection, ensuring that no one faces impoverishment.

   * In addition, all nursing home users are entitled to social insurance for the first three months of nursing home care. This "front-end" insurance allows people who have short stays to return home with resources intact.

2. Financing and administration

   * The federal government finances the home and community-based care program and the three-month "front-end" nursing home care.

   * The federal and state governments share financial responsibility for the NHP.

   * All three components of the plan are administered by the states according to federal guidelines.

   * States are responsible for cost containment, quality assurance and consumer protection within federal standards.

3. Private sector role

   * Private long-term care insurance fills gaps not covered by this plan, subject to government standards and oversight.

   * The federal government encourages the development of private long-term care insurance through clarification of the tax code.

4. The benefits will be phased in over time.

Phase-In Schedule and Cost of Commission Long-Term Care Proposal

(Dollars are in Billions, 1990)

Phase I

- Home Care to 200 hours per year

Home Care	$10.8
Nursing Home Care	$ 0.0
Total Costs Phase I	$10.8

Phase II

- Implement 3 Month Front-end Nursing Home
- Implement Nursing Home Program

Home Care	$10.8
Nursing Home Care	$12.8
Net Increase From Phase I	$12.8
Total Costs Phase II	$23.6

Phase III

- Increase Home Care to 400 hours per year
- Begin to Improve Nursing Home Reimbursement Rates

Home Care	$18.6
Nursing Home Care	$15.6
Net Increase From Phase II	$10.6
Total Costs Phase III	$34.2

Phase IV (Year 4)

- Fully Implement the Home Care Program
- Further Improve Nursing Home Reimbursement Rates

Home Care	$24.0
Nursing Home Care	$18.8
Net Increase from Phase III	$ 8.6
Total Costs Phase IV	$42.8

Net New Federal Costs of the Commission Proposal
(Billions of Dollars, 1990)

SOURCE OF EXPENDITURE	
Access to Health Care	
Public health insurance of non-workers	$12.4
Federal Contribution to the public plan	6.3
Tax Expenditure	6.7
Augmented Medicaid Physician and Hospital Payments	4.0
Less savings from Medicare, CHAMPUS, Medicaid	(6.0)
Sub-Total (Access to Health Care)	**$23.4***
Access to Long-Term Care	
Home Health Care for the Severely Disabled Elderly (includes cost-sharing)	15.0
Home Health Care for the Severely Disabled Non-Elderly (includes cost-sharing)	9.0
Nursing Home Care for the Severely Disabled Elderly	16.8
Nursing Home Care for the Severely Disabled Non-Elderly	2.0
Sub-Total (Access to Long-Term Care)	**$42.8**
Total Net New Federal Expenditures	**$66.2****

*Phase-in plan includes the cost of temporary tax credits/subsidies for certain small businesses. Those costs are not reflected in these totals, which represent the cost at full implementation.

**Program costs are larger than the net new federal expenditures. On health care, states maintain Medicaid spending on services absorbed by the new public plan. On long-term care, states share in the cost of the Nursing Home Program with initial amounts equivalent to state Medicaid spending on long-term care services covered by the overall plan.

Structure of Job-Based/Federal Public Health Insurance Plan

1. Employer Responsibilities (in businesses with more than 100 employees and smaller businesses only if a specified coverage target is not met):

   * All businesses are required to provide private health insurance for at least the specified benefit package to all employees (and non-working dependents) or contribute to the public plan on their behalf.

   * If employers choose to provide private insurance, they must pay at least 80% of the premium for full-time workers and their non-working dependents and a share of the premium for part-time workers and their non-working dependents.

   * Alternatively, employers may contribute to the public plan for coverage for their employees and non-working dependents. The contribution will be equal to a percentage of payroll. The percentage will be set at a level that encourages employers who now purchase private insurance to retain that coverage and establish a fair balance of additional coverage responsibilities between the private and public sectors.

   * Employers may choose to purchase private insurance for their full-time workers and contribute to the public plan for part-time workers.

2. Individual responsibilities

   * All workers receive the specified benefit package through their own employer, although they may receive extra benefits from their spouse's employer. Rules, consistent with tax policy, determine the plan to which children are assigned.

   * Individuals pay up to 20% of the premium for private insurance.

   * To participate in the public plan, individuals who are working pay a percentage of wages as their share of the premium. Self-employed and non-working individuals pay the cost of the plan, subject to their ability to pay. People with incomes below 100% of poverty pay nothing and no one with an income below 200% of poverty would pay more than three per cent of income for the premium for adults or one percent of income for the premium for children and pregnant women.

   * For low income people, whether covered by the public plan or private insurance, premiums and cost-sharing are subsidized by the federal government. Individuals or families whose income is under 100% of the federal poverty level pay no premiums, deductibles or coinsurance. Individuals or families whose income is up to 200% of poverty at a minimum will pay premiums, deductibles and coinsurance on a sliding scale.

* At full implementation, individuals must obtain health insurance through their employer or the public plan.

3. Public Plan

* At full implementation, the public plan is financed and administered primarily by the federal government. As under Medicare, insurers may administer claims and may, under contract, offer managed care options. States also may administer claims.

* The public plan pays providers for the specified services with rates set according to the rules of the Medicare program.

* The public plan subsumes Medicaid for the specified benefits. Medicaid remains intact for all services not covered by the package.

* Participation in the public plan is financed through:

  -- employer contributions
  -- individual contributions
  -- federal revenues
  -- state contributions equal to Medicaid expenditures for covered services, adjusted for general inflation

4. State Role

* State governments no longer have responsibility for providing the specified benefit package for their low income residents. The new public plan replaces Medicaid for those services. Medicaid is retained for services not included in the package.

* States contribute to the public program as specified above.

* A state, at its option and subject to federal rules, can administer the public plan. All aspects of the administration must be conducted through a new agency which is unconnected to the welfare or Medicaid departments.
* States retain the responsibility for regulating financial stability of insurers.

5. Specified Benefit Package

* Basic services including hospital and surgical services, physician services, diagnostic tests and limited mental health services (45 inpatient days and 25 outpatient visits).

* Preventive services including prenatal care, well-child care, mammograms, pap smears, colorectal and prostate cancer screening procedures and other preventive services that evidence shows are effective relative to cost.

* Early, periodic, screening, diagnosis and treatment services (EPSDT) are included for children in the public program. Privately insured families can buy this coverage for their children from the public plan at cost (or at a subsidized rate for families under 200% of poverty).

* Deductibles are $250 for an individual and $500 for a family. Coinsurance is 20% for all services except prenatal care, well-child care, mammograms and pap smears, which have no coinsurance, and limited mental health services which have 50% coinsurance. The maximum a person or family must spend out of pocket is $3,000 in a year.

* One year after the effective date of this plan, the Office of Technology Assessment shall report to the Secretary on an assessment of the cost-effectiveness of prescription drugs for the purpose of inclusion in the benefit package as a preventive service.

Assistance for Small Business

1. Insurance reforms and a minimum benefit package will make obtaining private insurance for small groups more predictable and affordable. (See below.)

2. To stimulate voluntary coverage, employers with fewer than 25 workers and average payroll below $18,000 will be eligible for tax credits/subsidies for 40% of the cost of health insurance for workers and their dependents. After the tax credit/subsidy for employers of ten employees or less ends, businesses of ten employees or less, previously eligible for the credit, who are at extreme financial risk would be allowed to purchase coverage from the public plan at a percentage of payroll. This specific percentage of payroll would be consistently set at a relatively low rate to ensure affordability.

3. No employer with fewer than 100 workers would be required to purchase coverage or contribute to the cost of coverage if coverage targets were met voluntarily. (See phase-in schedule for details.)

Insurance Market Reform

1. For all employment-based health insurance:

   * No pre-existing conditions exclusions.

   * No denial of coverage for any individual in the group.

2. For those who wish to sell a health insurance product to employers in the small group market new rules would apply:

   * Guaranteed acceptance of all groups wishing to purchase insurance.

   * Insurers would set rates on the same terms to all groups in specified areas.

* Rates may not be increased selectively for any group enrolled in a plan.

* Enrollment would be for a specified minimum period.

* States would be restricted from regulating the content of health insurance benefits, but benefits would be standardized, to the extent possible, across carriers. At least one basic benefit package would have to be offered by each insurer in the small group market.

* Managed care plans would be required to be offered to small groups if such plans are available to larger employers in the area.

* A self-financed voluntary reinsurance mechanism through which insurers could reinsure high-risk persons or groups would be established.

Quality Assurance

1. The federal government should develop and implement a comprehensive national system of quality assurance which includes:

   * The development of national practice guidelines and standards of care, already begun by the newly created Agency for Health Care Policy and Research. Physicians and physician organizations should be widely utilized in establishing and reviewing practice guidelines and standards of care.

   * The development and implementation of a uniform data system that covers all health care encounters, regardless of payment source or setting. These data would provide a common foundation for all payers' quality assessment activities and for examining the effectiveness of medical care and identifying health policy and research concerns.

   * The development and testing of new, more effective methods of quality assurance and assessment.

   * The development and oversight of local review organizations that have skills in data integration and analysis, quality assessment and quality assurance.

2. The appropriate committees of jurisdiction in Congress should hold hearings on the malpractice issue. The Prospective Payment Assessment Commission and the Physician Payment Review Commission will be directed to review costs under the new program. The cost containment commission described below will convene experts, providers, lawyers and consumers to study and conduct demonstration projects related to medical malpractice reform in order to make recommendations to Congress on actions to be taken on the federal level.

Cost Containment Initiatives

1. Insuring all Americans through a job-based/public program and reforming the private insurance market will distribute the costs of insurance more fairly by:

   * Reducing the cost-shift that now occurs from the uninsured to the insured population.

   * Reducing the cost-shift that now occurs from employers who do not provide insurance to employers who cover their workers and dependents.

   * Assuring small business access to a minimum benefit package at predictable rates, regardless of employees' health status.

2. Adoption of a quality assurance strategy (described above) and reform of the medical malpractice system will assure greater value for the dollar in the delivery of medical services.

3. Measures to promote efficiency in provider payment would include:

   * Cost-sharing in the minimum benefit package that makes consumers sensitive to price.

   * Insurance reform that leads insurers to compete around efficient service delivery, rather than competing for "good" risks.

   * Extending "managed care" to small employers and including "managed care" as a means to provide the minimum benefit package in private insurance and the public plan.

   * Extending Medicare payment rules to the public program, which, in turn, serves as a model for private insurance.

   * Recommending that the appropriate committees of jurisdiction in Congress hold hearings on the costs associated with medical malpractice liability, that the Prospective Payment Assessment Commission and the Physician Payment Review Commission review costs under the program proposed by the Commission and that a National Cost Containment Commission, made up of experts, public and private payers, providers and consumers, be created to assess cost experience and initiatives to contain costs in the public and private sectors and to make periodic recommendations to the Congress on federal initiatives.

Delivery Issues

1. Expanding health care insurance coverage should reinforce --not replace -- support for primary care delivery systems targeted at the poor and underserved. Organized primary care providers (e.g., local health departments and community health centers) should be recognized and reimbursed by private and public payors on the same basis as all other providers.

2. The federal government should:

* Promote an adequate supply and appropriate mix of personnel and facilities for underserved areas and populations through mechanisms including:

  -- Provider payment methods in public programs that promote the availability of primary care practitioners and facilities and assure access to other needed services;

  -- Special initiatives (such as the National Health Service Corps and other financial incentives) to attract a range of providers (physicians and other practitioners) to underserved areas, and to assist such providers through mechanisms such as professional backup systems and support networks for rural providers (e.g., telecommunications with other professionals and facilities, mobile medical services).

* Support local efforts to develop outreach and facilitating services, for example, health education, transportation, home visiting, and translation services -- preferably linked to health care delivery programs -- to facilitate access to services and to encourage patients to seek and continue participation in health care.

* Support local efforts to reduce organizational and bureaucratic barriers to access through efforts such as the coordination and/or co-location of medical, welfare and social services (e.g., medical referrals, nutrition counseling and eligibility determinations for welfare and housing programs).

* Undertake and support research and evaluation efforts to determine the effectiveness of primary care models and services aimed at addressing the needs of underserved communities.

* Support programs of health promotion, disease prevention, risk reduction and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles. Federal support for such programs should total at least $1 billion annually beyond current federal efforts.

* Support an effective continuum of care, including short-term hospital-based and/or longer-term community based alcoholism and other drug treatment services.

<u>Phase-In Schedule</u>

<u>Phase I (Year 1)</u>

* Institute insurance reform.

* Allow all uninsured pregnant women, and children ages 0-6, to enroll in public plan, if they are from non-working families or in families of workers whose employers do not provide coverage. Costs would be subsidized, according to ability to pay, at least for those with family incomes below 200% of poverty.

* Begin to improve reimbursement to providers for persons now served by Medicaid.

Phase II (Year 2)

* Firms with 0-25 workers and average payrolls below $18,000 become eligible to receive a 40% tax credit/subsidy for cost of coverage if they provide it. The subsidy would be available for five years.

* The public plan is made available to uninsured children up to age 18 (those from non-working families or families where workers' employers do not offer coverage). Subsidies would be available based on ability to pay, at least for those with family incomes below 200% of poverty.

Phase III (Year 3)

* Firms with 100 or more workers are required to provide private insurance coverage or contribute a portion of payroll toward the cost of covering employees and dependents in the public plan.

Phase IV (Year 4)

* If 80% of uninsured employees of firms with 25-100 workers (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide private insurance coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to cover those still left out.

Phase V (Year 5)

* If 80% of uninsured employees of firms with 0-25 workers (as of Year 1) are not insured through their employers, all employers of this size are required to provide coverage or contribute toward the cost of their coverage in the public plan.

* If coverage target is met, the Secretary of Health and Human Services is required to recommend to Congress ways to increase coverage options for employees (and their non-working dependents) who are not covered by their employers.

* All non-working adults are covered through the public plan.

Phase VI (Year 6)

* Congress considers the Secretary's recommendations.

* All individuals are required to have insurance coverage through their employers or through the public plan.

Revenues for Health Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

Structure of the Plan

1. Social Insurance for Home and Community-based Care

* Severely disabled individuals of all ages are eligible for this program. This includes individuals who need hands-on or supervisory assistance with three out of five ADL's (Activities of Daily Living) (eating, transferring, toileting, dressing, bathing), or who are severely cognitively impaired.

* Eligibility is determined by a state/local government or federally-funded non-profit assessment agency using standardized assessment criteria. This agency conducts annual audits of case managers (described below) and monitors the quality of care.

* Case managers determine the number of hours of care and mix of services the beneficiary receives.

  -- The case manager develops an individual care plan tailored to needs of the beneficiary. The availability of informal supports is included in the decision to allocate resources.

  -- The case manager operates within a budget set by the federal government, and conducts periodic reassessments of the beneficiary with special consideration to be given to cost containment. The case manager budget, in conjunction with other available services, will be sufficient to provide all services, needed by the patient.

* The benefits include:

  -- Home health care
  -- Physical, occupational, speech and other appropriate therapy services.
  -- Personal care services (feeding, transferring, personal hygiene)
  -- Homemaker chore services (meal preparation, laundry, housework)
  -- Grocery shopping and transportation
  -- Medication management
  -- Adult day health and social day care
  -- Respite care for caregivers
  -- Cost-effective training of family members for delivery of home-based family care, and support counseling of family caregivers.

2. Nursing Home Program (NHP)

* Individuals of all ages who are determined eligible for nursing home care by a federally certified assessment agency are covered by this program for the entire length of their stay.

* The plan treats income and assets as follows:

  -- The plan protects $30,000 in non-housing assets for single individuals and $60,000 for couples.
  -- The plan provides a housing allowance equal to 30% of monthly income for the first year of a nursing home stay for single persons and, for married persons, as long as the spouse is alive, but at least a year.
  -- The plan provides a $100/month personal needs allowance.
  -- The plan provides income protection for the spouse living in the community up to 200% of the poverty level for a couple.
  -- Any remaining income goes toward the cost of the nursing home care.

3. Three-Month Front-end Coverage: Protection to Return Home

* All nursing home users are covered for the first three months of care with full protection for their income and assets, except for a modest copayment.

* Benefits include:

  -- Skilled nursing care
  -- Custodial care

Individual Role

1. Home and Community-based Care

* Individuals pay 20% of the costs of care up to a maximum of the national average cost of home and community-based care.

* The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

2. Nursing Home Program

* Individuals contribute their income toward the cost of care minus the housing and personal needs allowances.

* Individuals contribute non-housing assets above $30,000 for single persons and $60,000 for married persons.

3. Three-month "Front-end" Nursing Home Care

   * Individuals pay 20% of the costs of care up to a maximum of the national average cost of nursing home care.

   * The federal government subsidizes the coinsurance at least for persons with incomes below 200% of the federal poverty level.

Financing

1. The federal government is responsible for the home and community-based care program and the three-month "front-end" nursing home care program.

2. The federal and state governments share the financial responsibility for the NHP.

Administration

1. The federal government contracts with states to administer all three components of the plan.

2. The federal government sets standards and guidelines for administration. These include the following:

   * Standardized assessment criteria for determining eligibility for home and community-based care and nursing home care.

   * Certification of assessment agencies.

   * Guidelines for certifying case managers.

   * Determination of case manager budgets.

   * Determination of provider payment rates for home and community-based care and nursing home care.

3. State administrative functions include the following:

   * Building on the current infrastructure for management and delivery of services, where long-term care programs already exist.

   * Designing and implementing the system for managing and delivering services, in states without existing programs.

   * Certifying providers.

   * Establishing the review and appeals process.

Private Sector Role

1. Private long-term care insurance fills gaps not covered by this plan.

2. The federal government encourages the development of private long-term care insurance through clarification of the tax code. This includes:

   * Treating, for tax purposes, the premiums paid and the benefits received as health insurance.

   * Enabling qualified long-term care policies to be sold in employers' cafeteria plans.

3. The federal and state governments share responsibility for standards and oversight of the private long-term care market.

   * The federal government establishes minimum standards which private long-term care policies must meet to be eligible for the tax clarification. It establishes methods of disseminating to consumers non-biased, professional information regarding private long-term care policies.

   * States regulate private long-term care insurance, using federal or stricter standards. The federal government will encourage states to strengthen civil penalties for misrepresenting policy standards, knowingly selling duplicative insurance or marketing unapproved policies by direct mail. In addition, states should train benefits specialists regarding private long-term care insurance and the availability of state information on that insurance.

Phase-In Schedule

Phase I

   * A maximum of 200 hours of home care per year is made available to all severely disabled persons.

Phase II

   * The three-month "front-end" nursing home care benefit is made available to all eligible nursing home users.

   * The nursing home program is implemented providing income and asset protection for all eligible nursing home users.

Phase III

   * The maximum hours of home care available per year is increased to 400.

   * Begin to improve nursing home reimbursement rates.

Phase IV

   * The home care program is fully implemented.

   * Further improve nursing home reimbursement rates.

Research Agenda for Long-Term Care

1. The federal government should move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying and dealing with long-term illnesses and disabilities. This effort should include research on outcome measures and national practice guidelines in long-term care. That effort should move toward a funding level of $1 billion annually and should do the following:

   * Explore how to reduce the risk for certain physical and mental disorders (e.g, Alzheimer's disease, osteoporosis, breast cancer, urinary incontinence) that are associated with increased need for long-term care

   * Examine how to enhance the quality of long-term care including the integration of services and case management.

   * Improve functional assessment tools to best target services to populations in need of care

   * Examine the special long-term care problems of subpopulations such as disadvantaged racial and ethnic minorities and the rural elderly and nonelderly disabled.

   * Evaluate the implementation of the home and community-based care program.

Revenues for Long-Term Care

A. Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B. In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

   1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

   2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

   3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C. Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 13 199

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Pepper Commission Recommendations of March 3 on Health Care Financing Reform

As you know, on Friday, March 3, the Pepper Commission voted on its recommendations to provide expanded access to coverage for health care and long term care. The plans are described below. The Access plan carried on an 8-7 vote and the Long Term Care Plan carried on an 11-4 vote.

It may be helpful to you to know how the Commission broke down the health care reform issue, and the basic choices they made, albeit on a widely split vote:

MANDATED EMPLOYER BASED INSURANCE -- By a one-vote margin, the Commission recommended requiring larger employers to provide insurance to all employees or pay a payroll tax to fund a public insurance plan ("pay or play"). This is similar to the Massachusetts plan that is experiencing significant difficulties. Senator Kennedy and others have made similar proposals in the past.

-- As part of the access package, the Commission also called for insurance reform, including guaranteed acceptance of all groups wishing to purchase coverage.

-- Also as part of the access package, the Commission would replace the federal-state Medicaid program for the poor with a federal plan like Medicare for non-working persons.

The Pepper Commission estimated a net Federal cost of $26.6 billion; OMB's preliminary estimate of the "pay or play" approach is $30-$45 billion.

LONG TERM CARE -- The Commission gained more support for its proposals on long term care. The Commission recommended a new federal program providing benefits to all persons, with eligibility based largely on the degree of disability.

The Pepper Commission estimated a net Federal cost of $42.8 billion, in current dollars; OMB's preliminary estimate for long term care is between $55 and $70 billion.

While the report is seen as a starting point, its proposals are seen as lacking adequate support to make them a serious contender in or for the comprehensive health care reform debate.

Additional details are provided on the attached, should you wish to review them.

Louis W. Sullivan, M.D.
Secretary

The Pepper Commission voted on its recommendations to provide expanded access to coverage for health care and long term care. The plans are described below. The Access plan carried on an 8-7 vote and the Long Term Care Plan carried on an 11-4 vote. The Commissioners voted as follows:

UNIVERSAL ACCESS

YES: Waxman, Pryor, Oakar, Kennedy, Davis, Balog, Rockefeller, Stokes

NO: Tauke, Stark, Heinz, Gradison, Durenberger, Cogan, Baucus

LONG TERM CARE

YES: Waxman, Pryor, Oakar, Kennedy, Heinz, Durenberger, Davis, Baucus, Balog, Rockefeller, Stokes

NO: Tauke, Stark, Gradison, Cogan

Despite the defection of Democrats Stark and Baucus, the Universal Access plan passed with the help of two Presidential Commissioners, Davis and Balog. However, the 8-7 vote was short of the clear majority for which Rockefeller hoped.

The major Pepper Commission recommendations are:

UNIVERSAL ACCESS

Employers would be required to provide health insurance for all employees and their dependents through one of two ways: employers would pay for the employees' health insurance, covering 80% of the premiums, with the employees paying the remaining 20%; or, employers could pay a payroll tax into a public fund for a Federally defined minimum health benefits package (a public insurance plan). Under the second option, employees and their dependents would have their basic health insurance needs covered by the public insurance plan. This employer mandate approach is commonly called "pay or play."

A public-insurance plan would be created to cover uninsured individuals who did not have access to insurance through their employer. This plan would be financed through Federal taxes, employer contributions (from non-playing employers subject to the "pay or play" mandate), beneficiary premiums, coinsurance and deductibles from enrollees whose income exceeded the poverty level, and transfers from current State Medicaid funding.

There are exemptions for small businesses. Firms with fewer than 100 employees would be exempt from the "pay or play" mandate with

one exception. If 80 percent of the workers in such firms did not have health insurance in the fourth year of the plan, the employer would then have to either provide health insurance, or pay into the public insurance fund. Firms with fewer than 25 employees would be exempt from the mandate unless 80 percent of workers in such firms did not have health insurance in the fifth year of the plan. If the 80 percent tests are met, as Secretary of Health and Human Services, I would be required under the Pepper Commission proposal, to make recommendations to Congress on how to provide insurance to any remaining uninsured workers in those firms.

To encourage small employers to provide health insurance, the private insurance market would be reformed (pre-existing condition clauses would be outlawed, a community rating would be required, and premium increases would be regulated) and a 40 percent tax credit would be offered to firms with fewer than 25 workers and an average payroll of under $18,000. The tax credit would end in the seventh year of the plan.

The Pepper Commission estimated a net Federal cost of $26.6 billion; OMB's preliminary estimate of the "pay or play" approach is $30-$45 billion.

LONG TERM CARE

Coverage under the long term care plan is based on the individual's need for personal assistance and ability to pay. Need for personal assistance is determined by assessing the person's ability to perform a standardized set of "activities of daily living" -- dressing, eating, bathing, and so on. Any individual, regardless of age, who has severe cognitive impairments or who needs assistance with 3 of 5 Activities of Daily Living would receive a broad range of home and community based services (home health care, personal care, homemaker services, respite care). Persons covered by this plan would be required to pay 20 percent of the premium. Individuals earning below 100 percent of poverty would be fully subsidized and individuals earning between 100 and 200 percent of poverty would be subsidized on a sliding scale.

All individuals at any age would be entitled to the first three months of a nursing home stay with a requirement that the recipient pay 20 percent coinsurance for covered nursing home care. The coinsurance would be subsidized for individuals with incomes below 200 percent of poverty.

If a nursing home stay lasted longer than three months, nursing home care would be subsidized. The plan would protect non-housing assets up to $30,000 for an individual and $60,000 for a couple. To enable individuals to keep their homes, thirty

percent of the individual's monthly income would be protected the first year of a stay to retain funds to maintain the home. For each individual residing in a nursing home, an additional $100 a month would be protected as a personal needs allowance. For married persons, who represent about 23 percent of nursing home patients, thirty percent of monthly income would be protected as long as the spouse is alive. And the income of a spouse living in the community would be protected up to 200% of the poverty line.

The Pepper Commission estimated a net Federal cost of $42.8 billion, in current dollars; OMB's preliminary estimate for long term care is between $55 and $70 billion.

IMPLICATIONS

The Commission plan is already being criticized as inadequate because it does not specify revenue sources to finance it. At the Press conference following the Commission vote, Rockefeller referred the financing issues to the relevant Congressional committees, Senate Finance and House Ways and Means. However, both Ways and Means representatives, Gradison and Stark, voted against both parts of the plan.

The Universal Access plan is also controversial because of its mandates on small businesses to provide health insurance to workers or pay a tax to a back-up public plan if minimum levels of health insurance coverage are not achieved. Representatives of small business groups are already questioning these provisions and Senator Baucus voted against the Universal Access plan because of small business concerns.

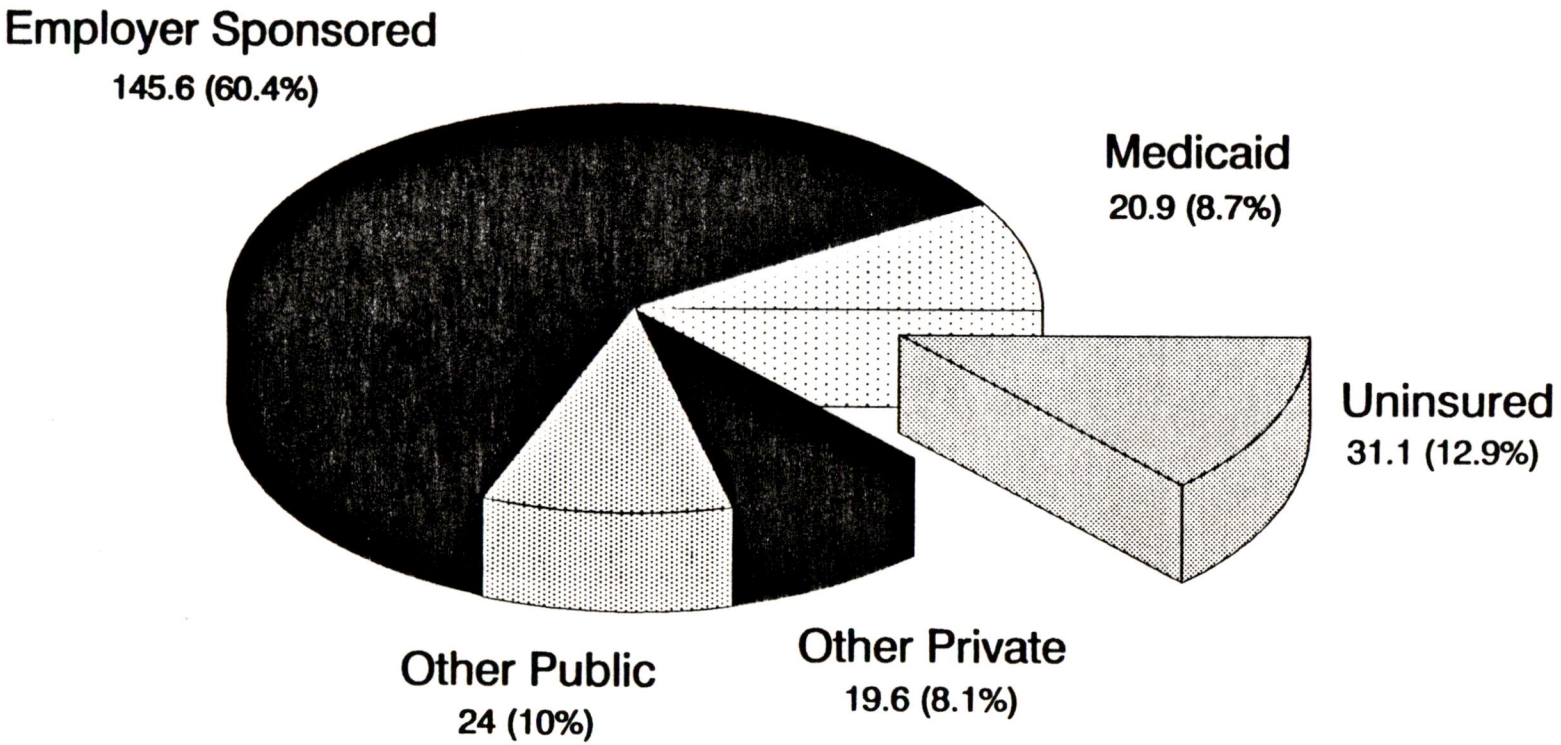
Although less controversial among the Commissioners, the Long Term Care plan is more costly. At the Commission press conference, Representative Gradison criticized the fact that the Long Term Care plan would provide three months of nursing home care to Donald Trump as a misapplication of priorities. The Long Term Care plan is one and a half times as costly as the Universal Access plan.

Despite the larger vote in favor of the Long Term Care recommendations, it is unlikely any Long Term Care plan could pass the Congress if the Universal Access needs of the Uninsured were not simultaneously addressed. By linking these concerns, the Pepper Commission itself has made it more difficult to address the needs of one group without addressing the needs of the other.

CONGRESSIONAL ACTION

Universal access has generated tremendous Congressional interest, with varying approaches proposed (e.g., tax incentives, state risk pools, employer mandates, or a combination). It is likely that Senator Rockefeller will introduce legislation based upon the Commission's recommendations. Senator Kennedy may reintroduce legislation using an employer mandate approach as he has in the past. While we do not expect Congressional action to take place this year, there will almost certainly be much activity in the form of hearings, public debates and so on.

Insurance Status of U.S. Population
(Millions)

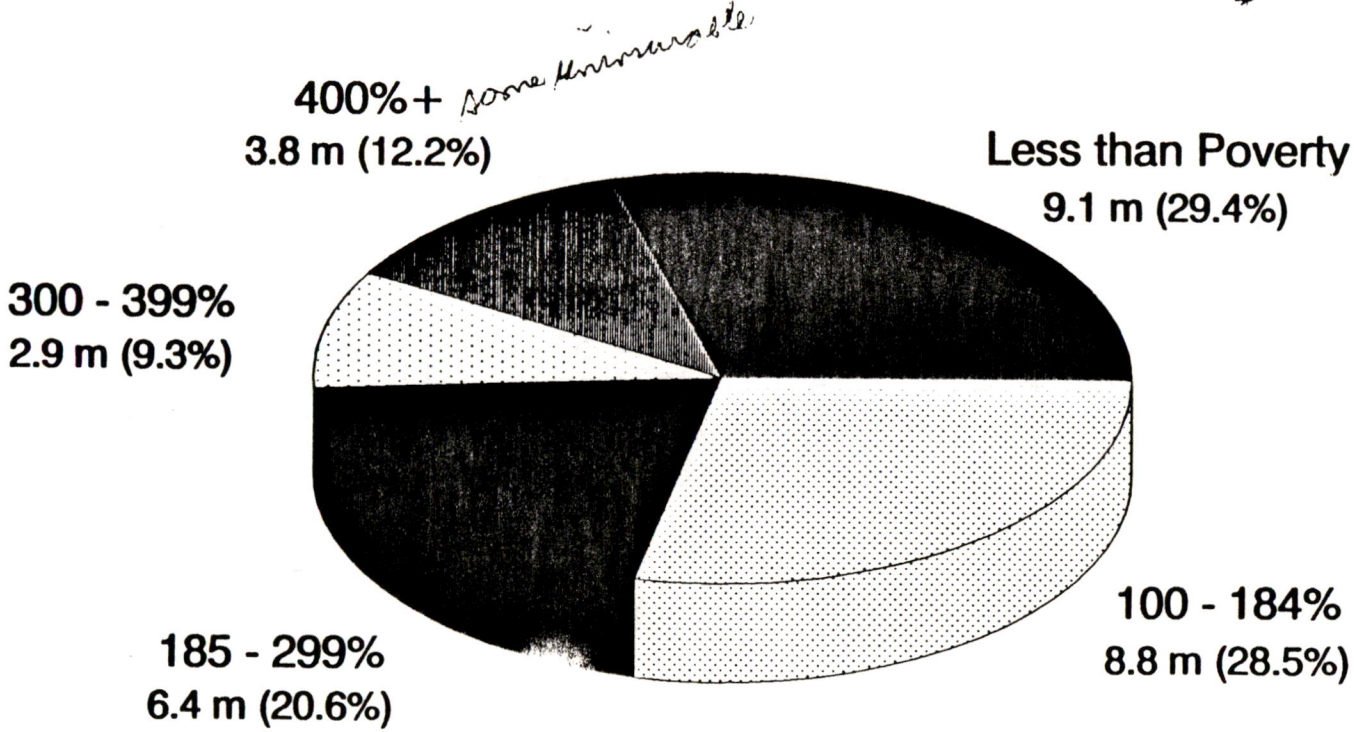


Total - 241.2 M

1987

aspe117a

The Uninsured: Poverty Status
(Poverty = $11,611 for a family of 4)



Total - 31.1 M

1987

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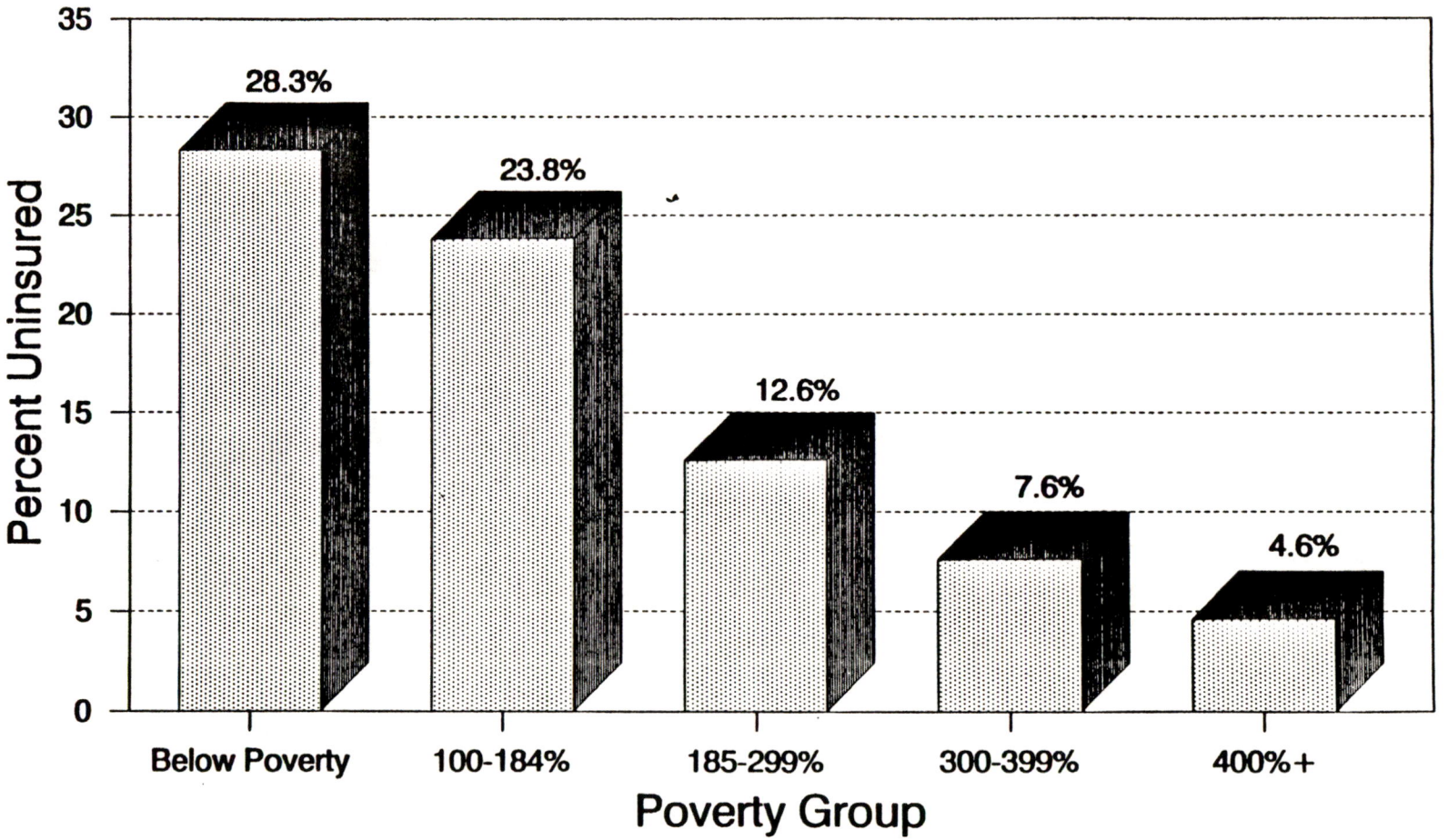
Percent Uninsured Within Poverty Group



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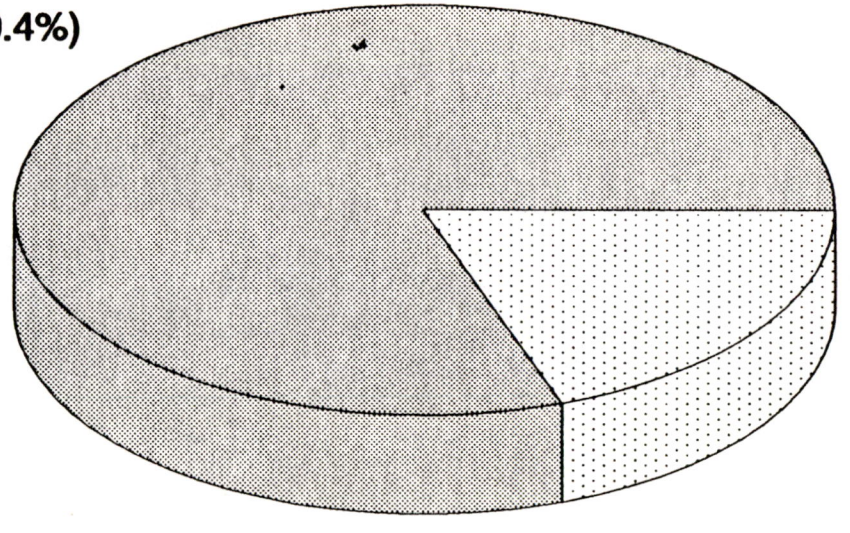
The Uninsured: Employment Status



Total - 31.1 M

1987

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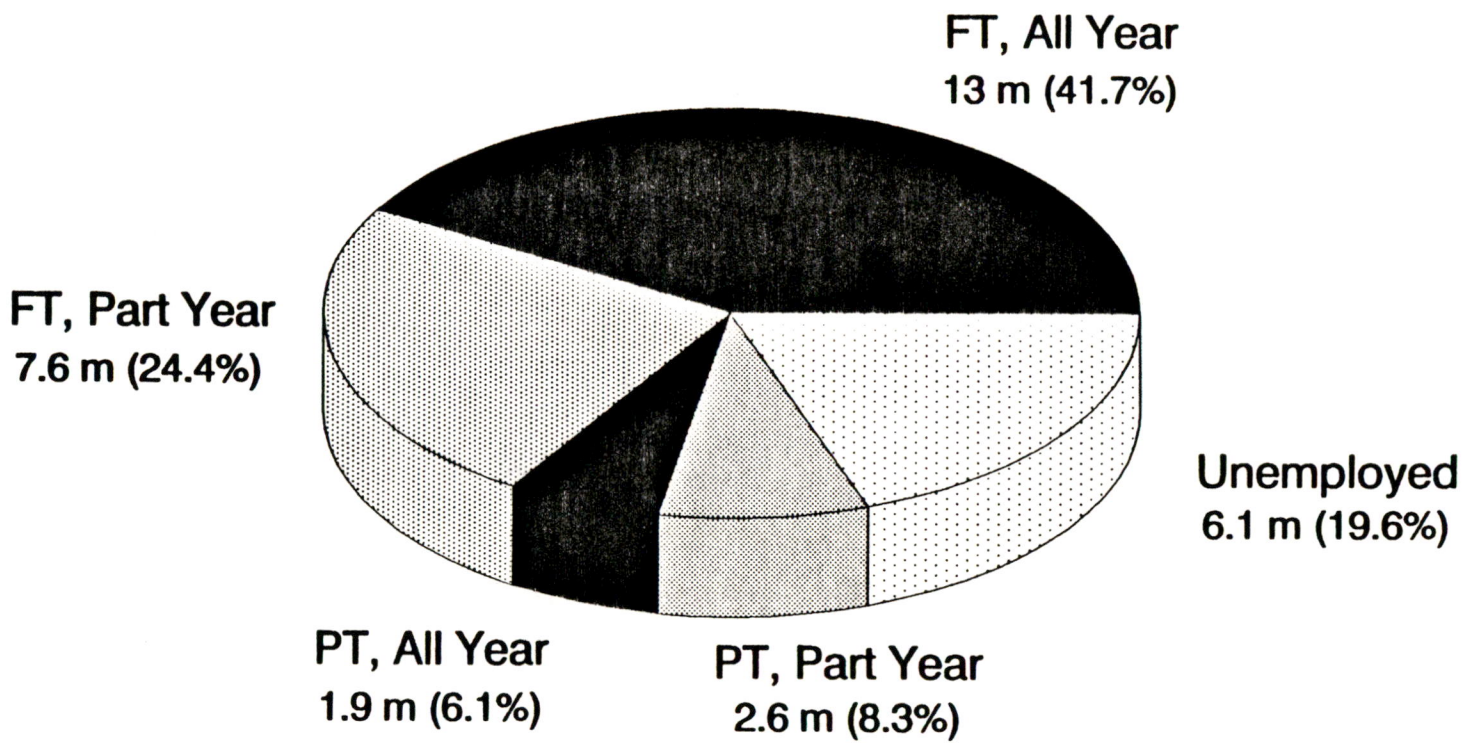
The Uninsured: Employment Status



Total - 31.1 M

1987

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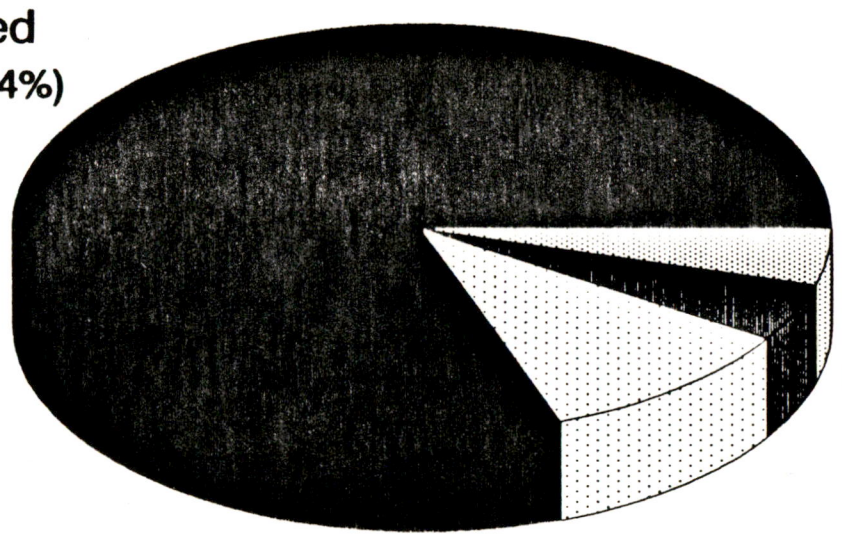
The Uninsured: Employment & Poverty



Total - 31.1 M

1987

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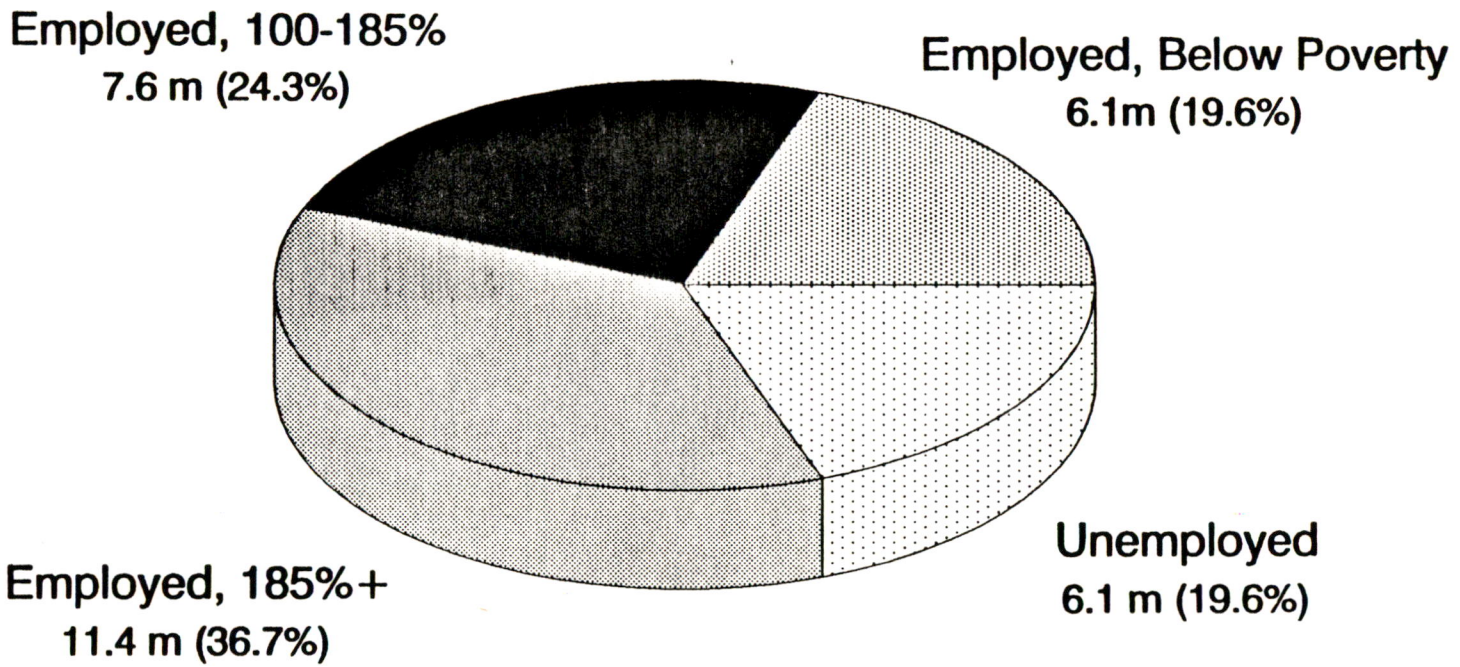
The Uninsured: Employment & Poverty



Total - 31.1 M

1987

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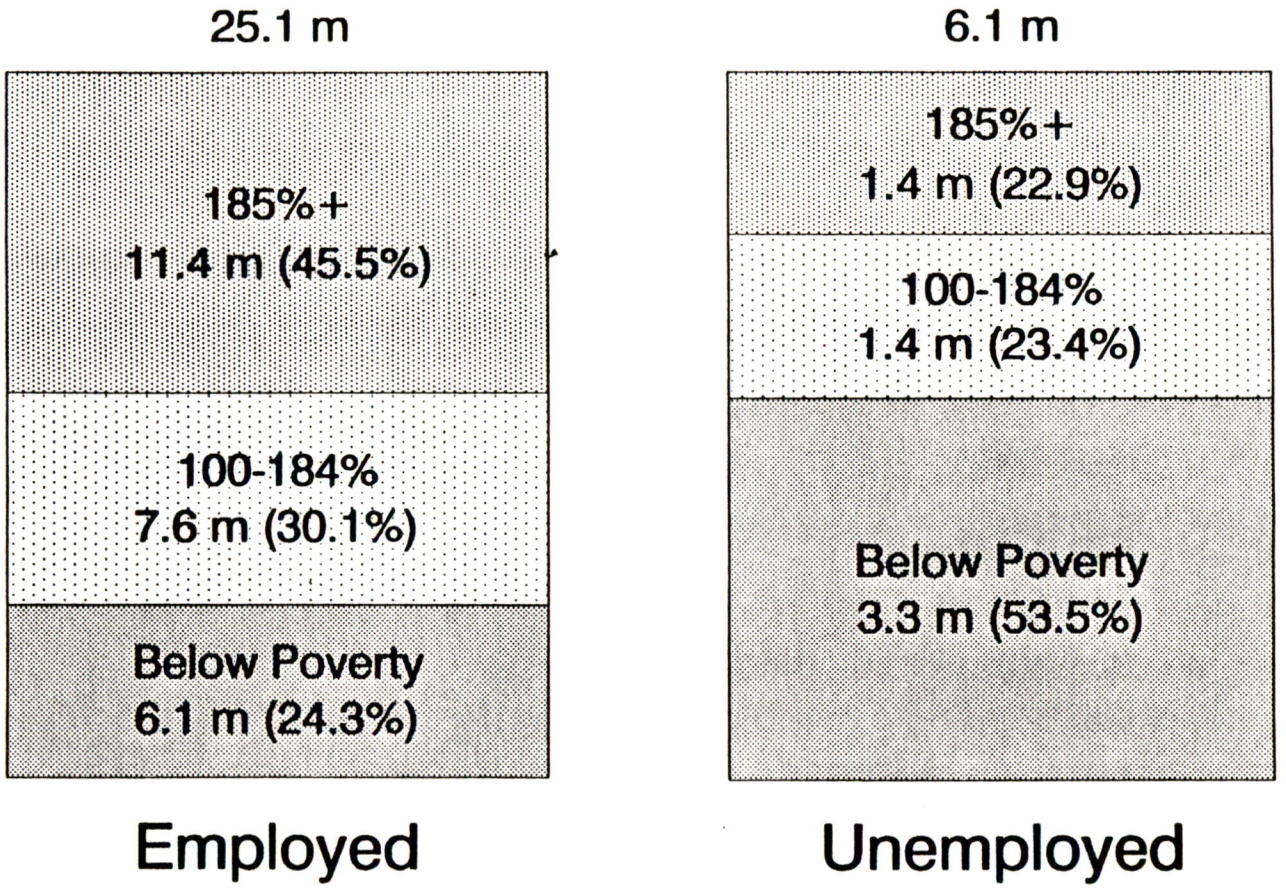
The Uninsured: Employment & Poverty



Total - 31.1 M

1987

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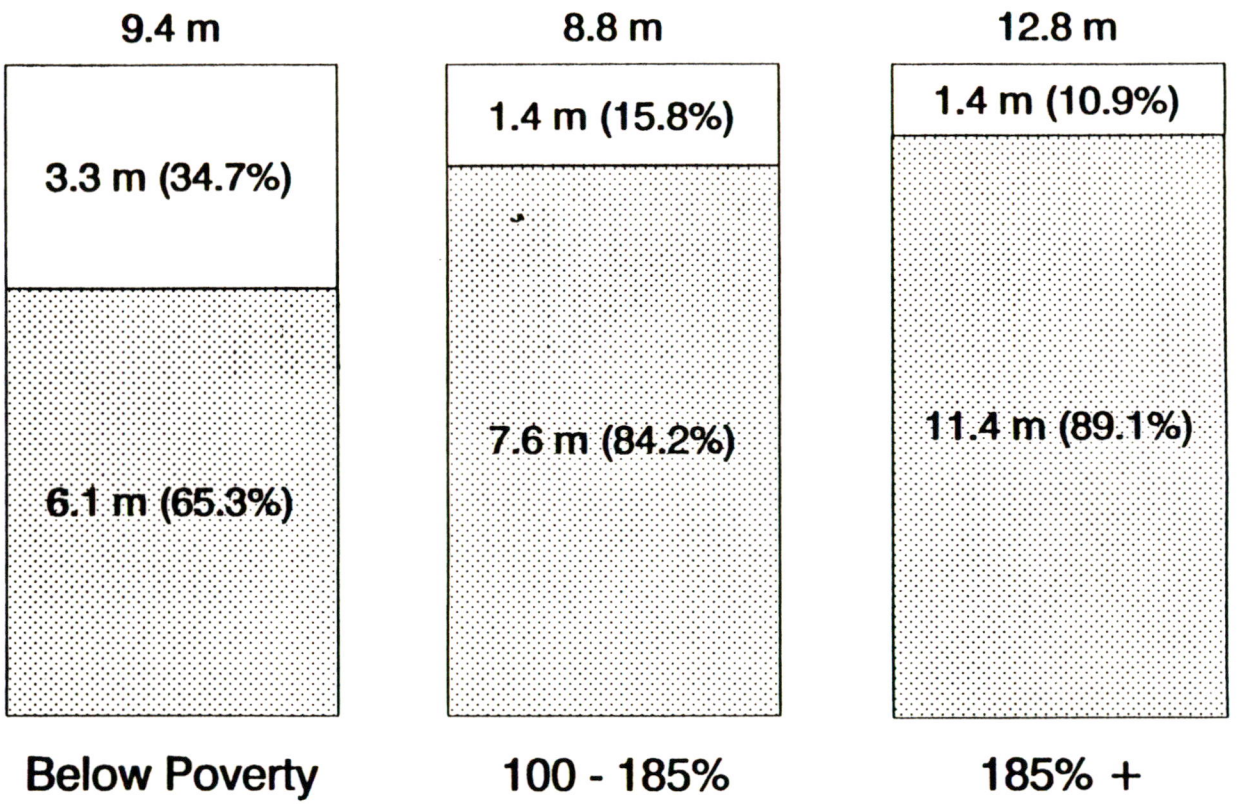
The Uninsured: Employment & Poverty

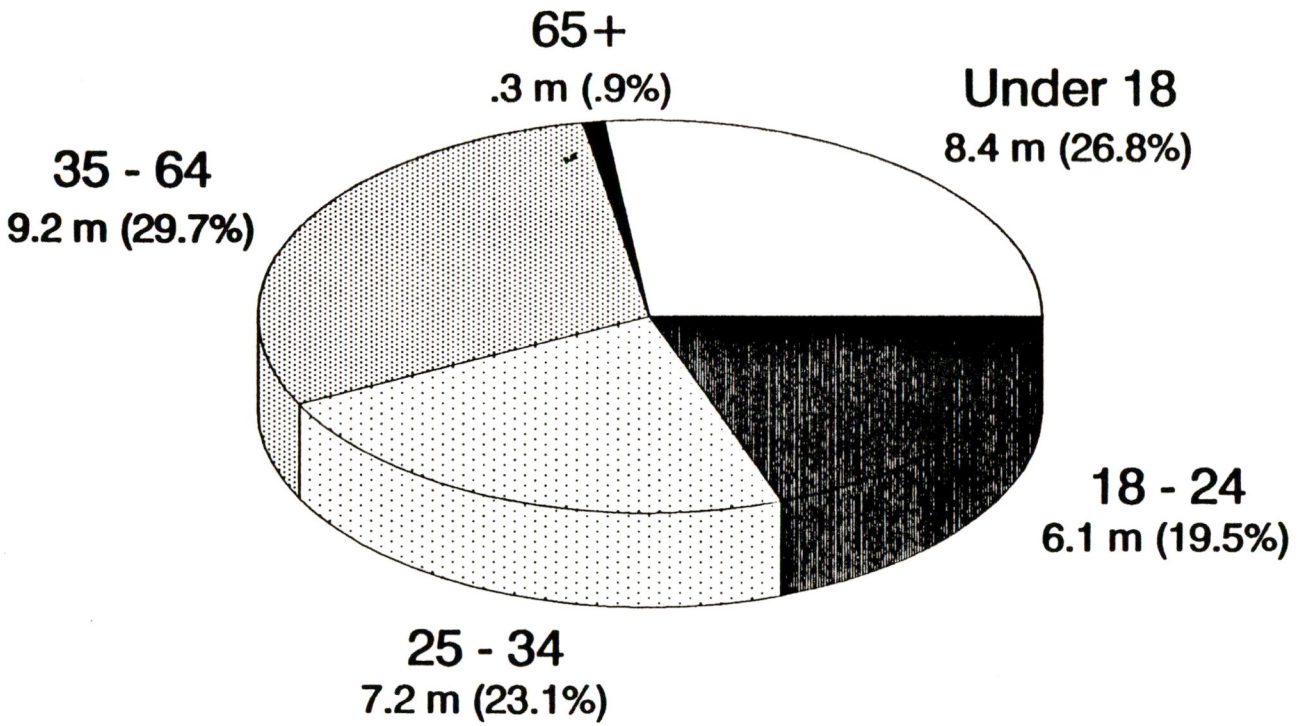


Total - 31.1 M

Employed Unemployed

aspe117g

The Uninsured: Age



Total - 31.1 m

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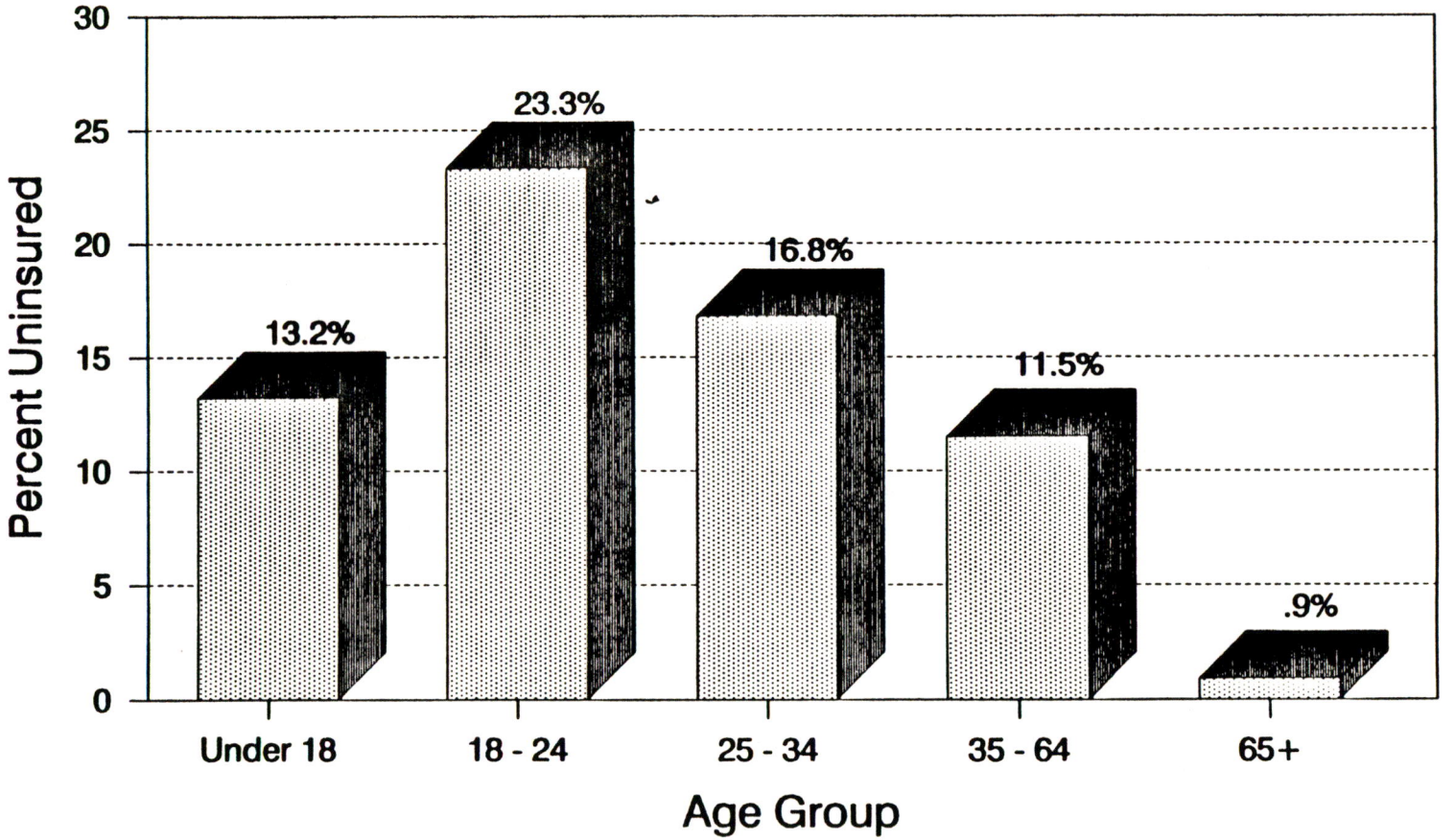
Percent Uninsured Within Age Groups



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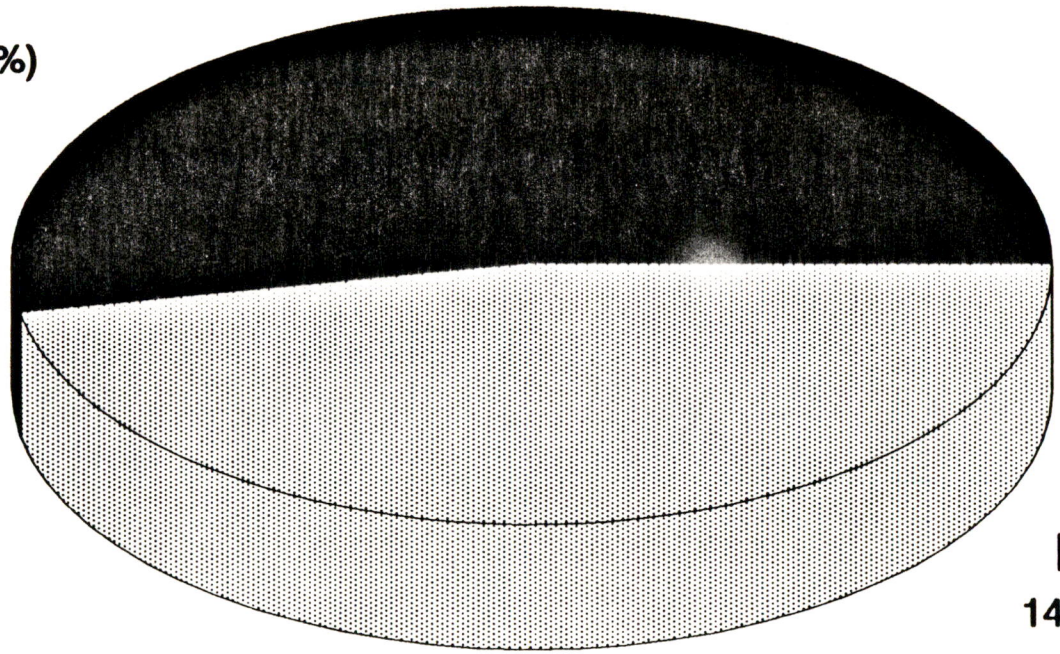
The Uninsured: Sex

Male
16.5 m (53%)



Female
14.6 m (47%)

Total - 31.1 m

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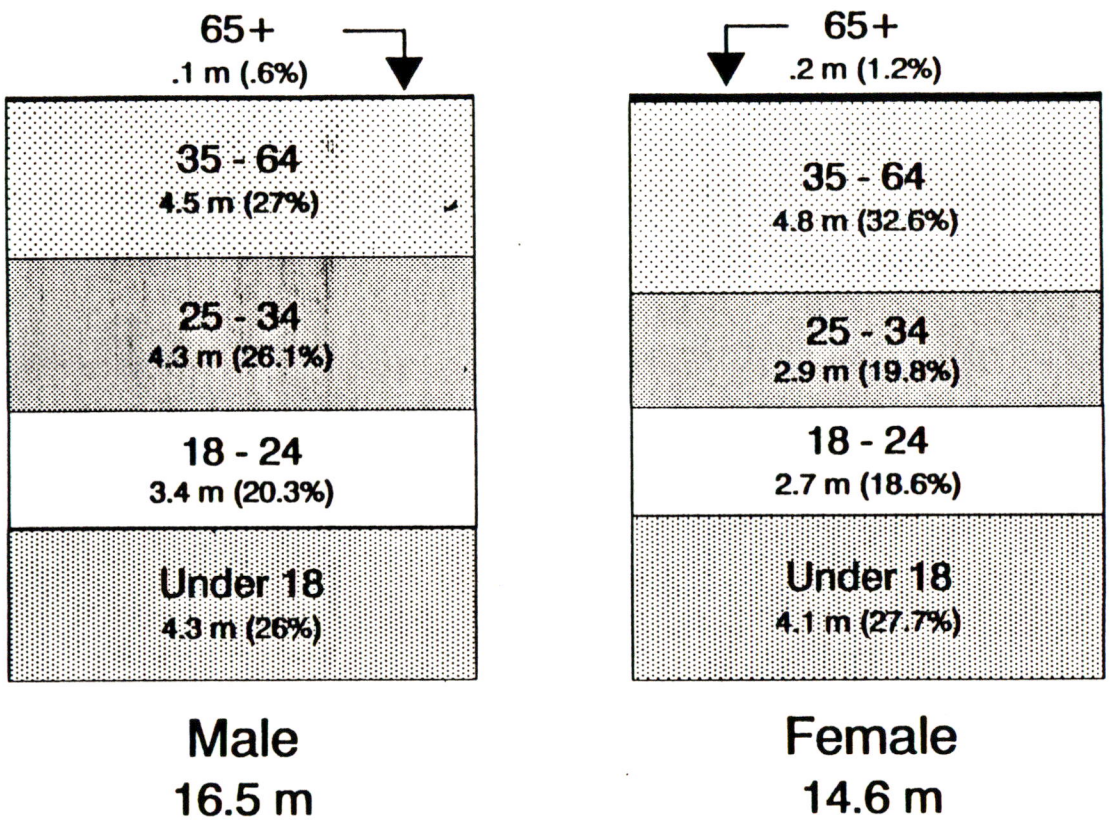
The Uninsured: Age & Sex



Total - 31.1 m

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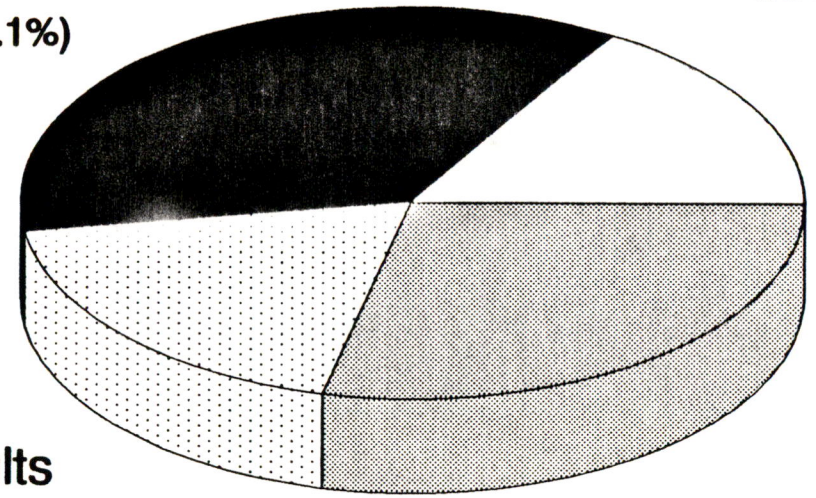
The Uninsured: Family Type



Total - 31.1 m

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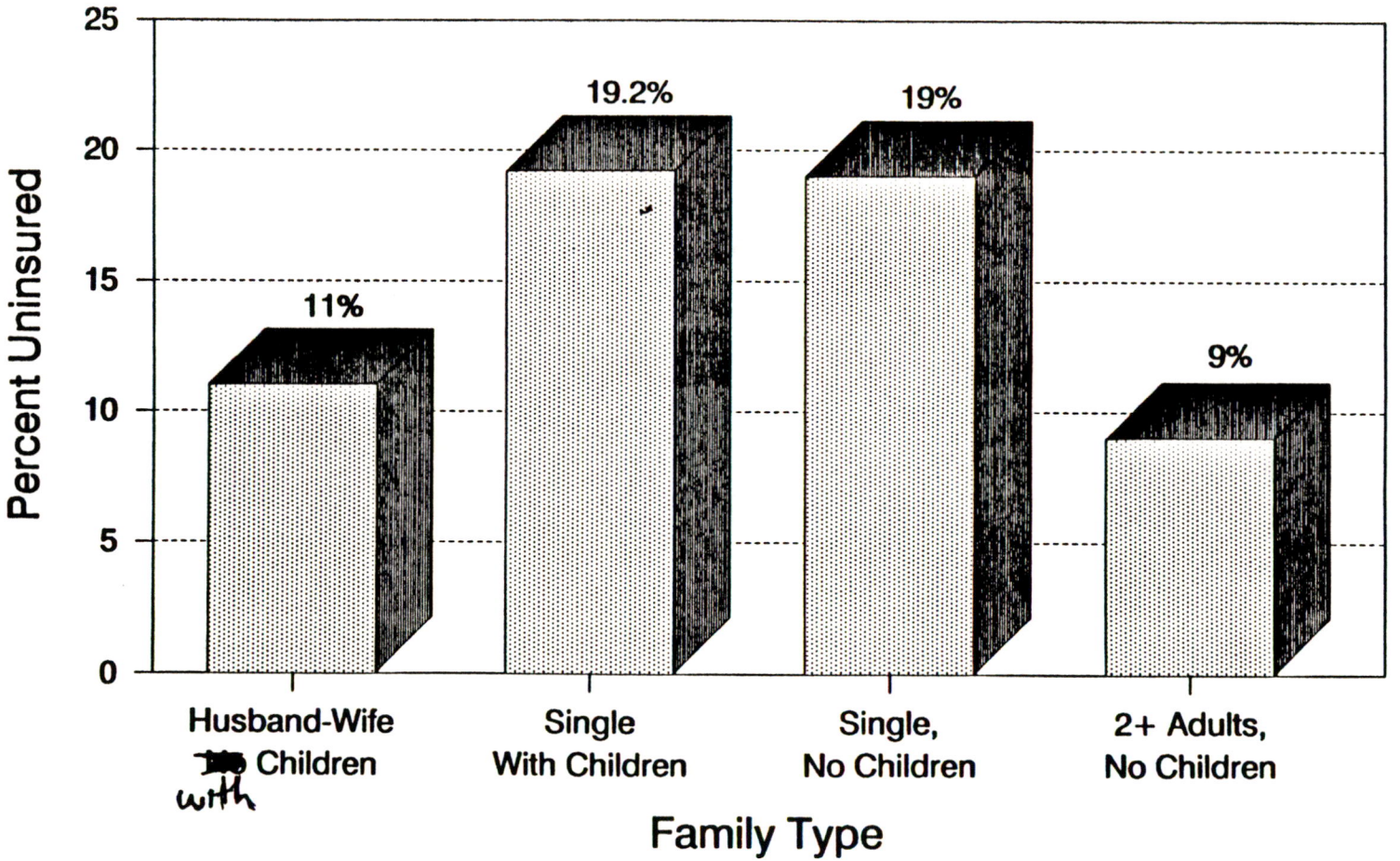
Percent Uninsured Within Family Types



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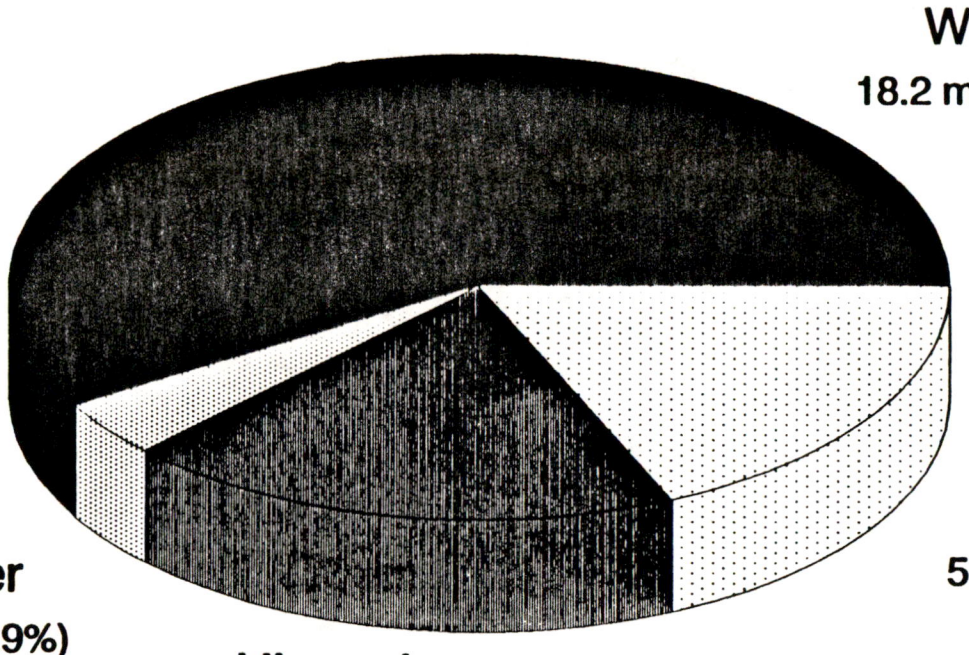
The Uninsured: Race



Total - 31.1 m

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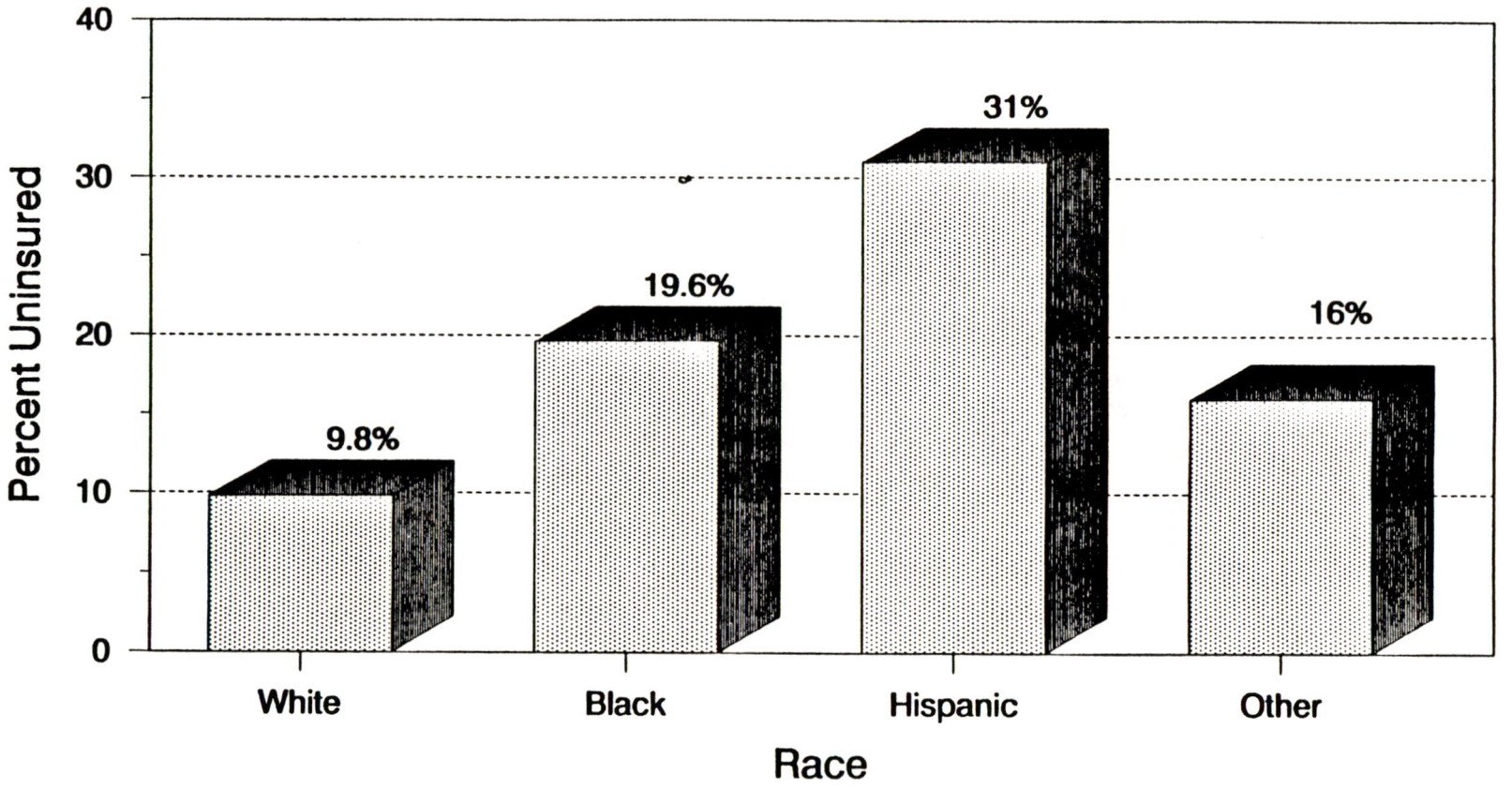
Percent Uninsured Within Racial Groups



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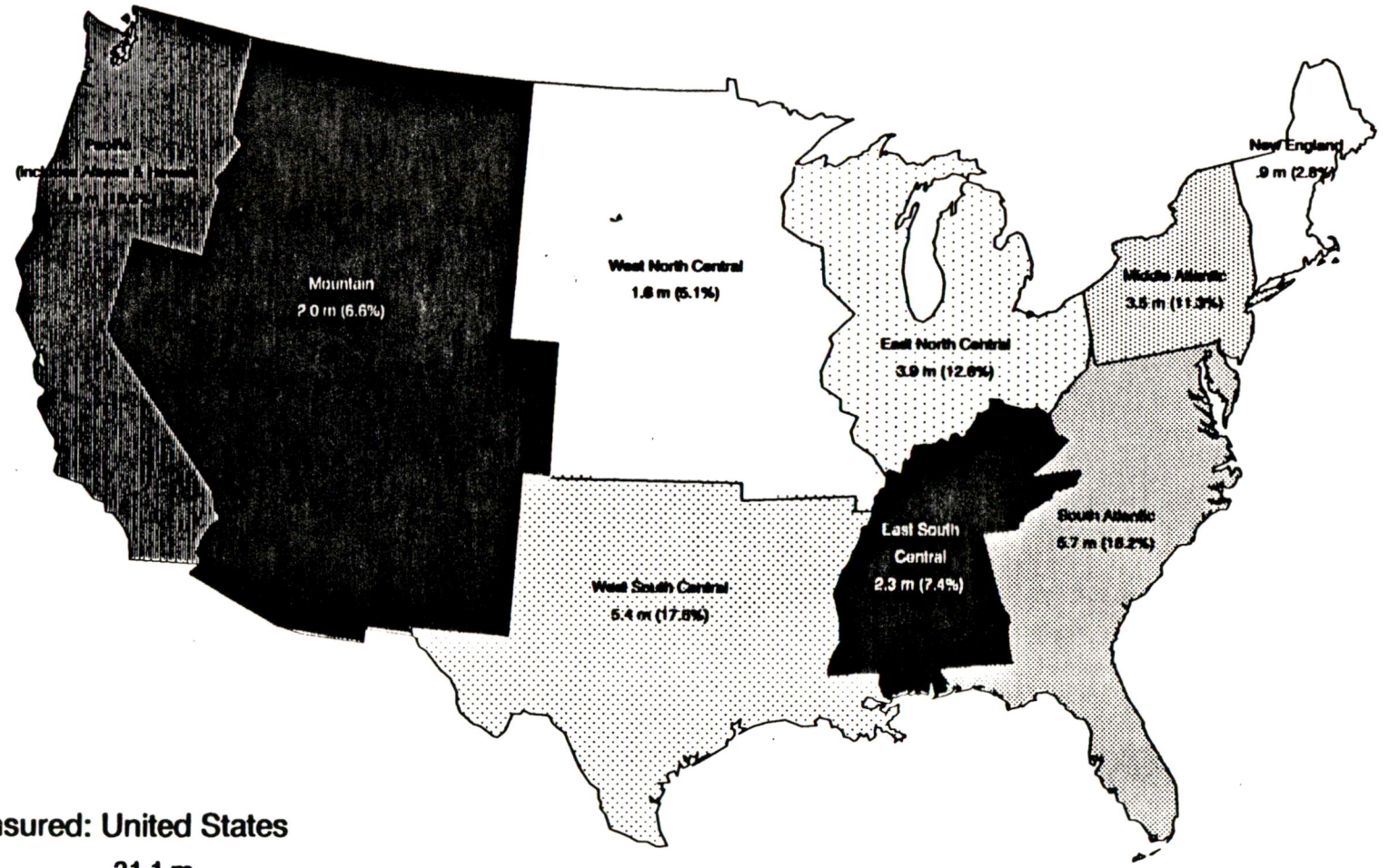
Uninsured by Region

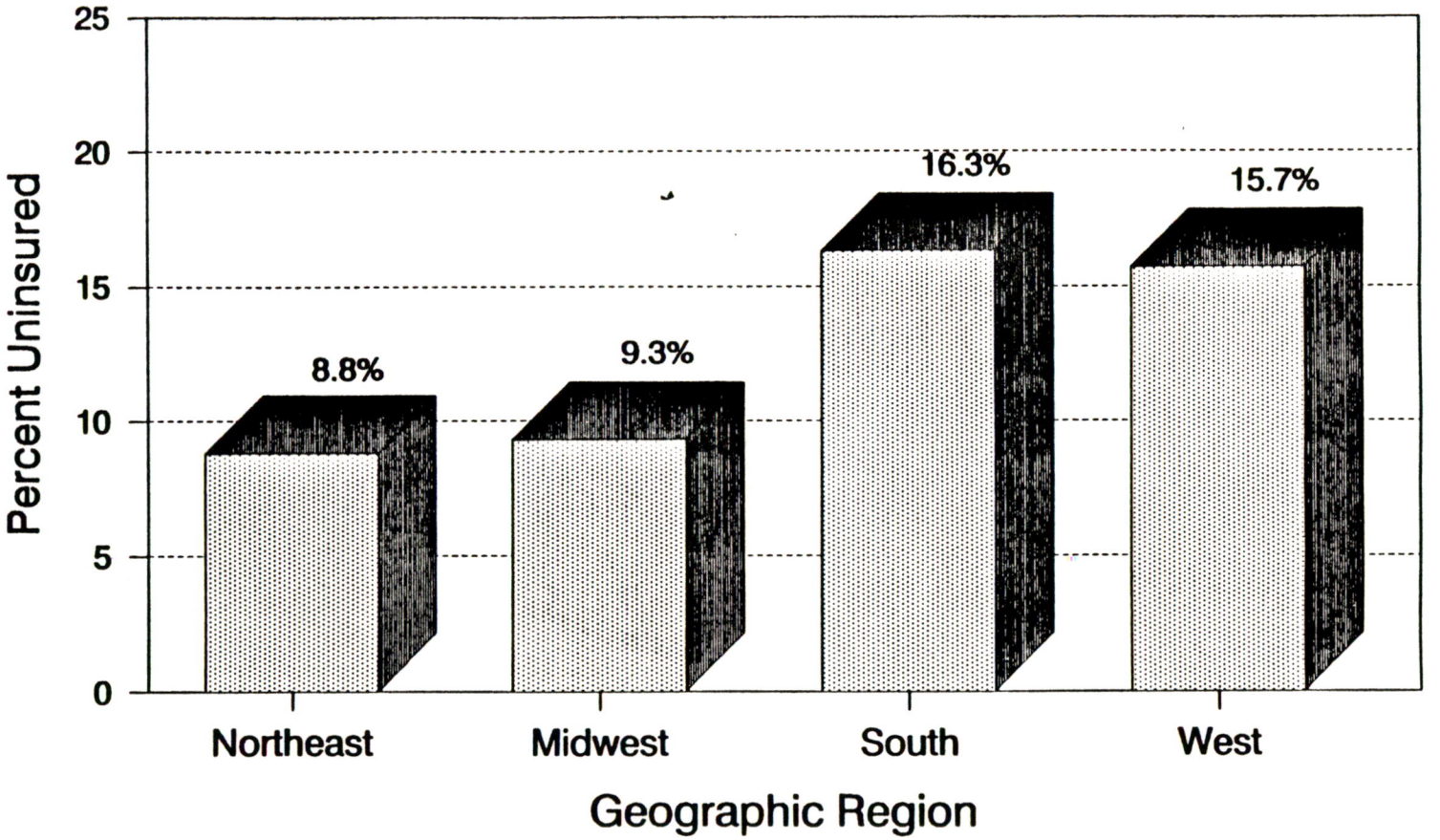


Uninsured: United States

31.1 m

aspe117w

Percent Uninsured Within Geographic Region



1987

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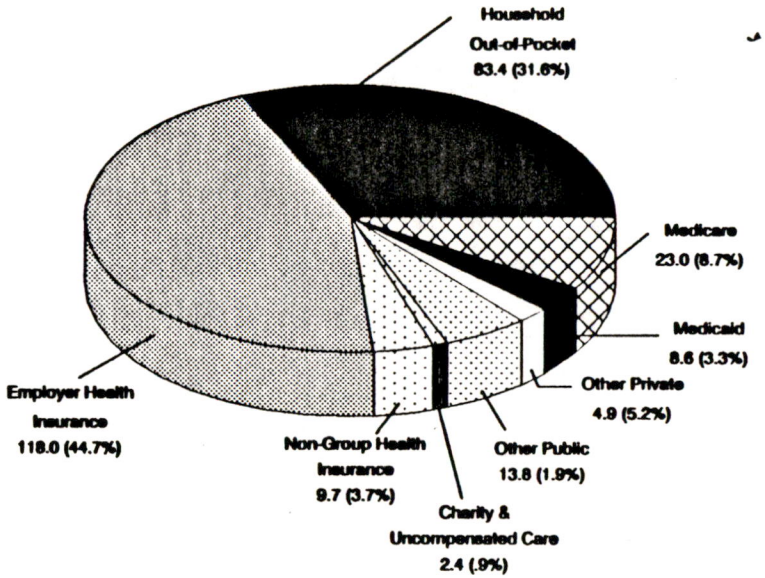
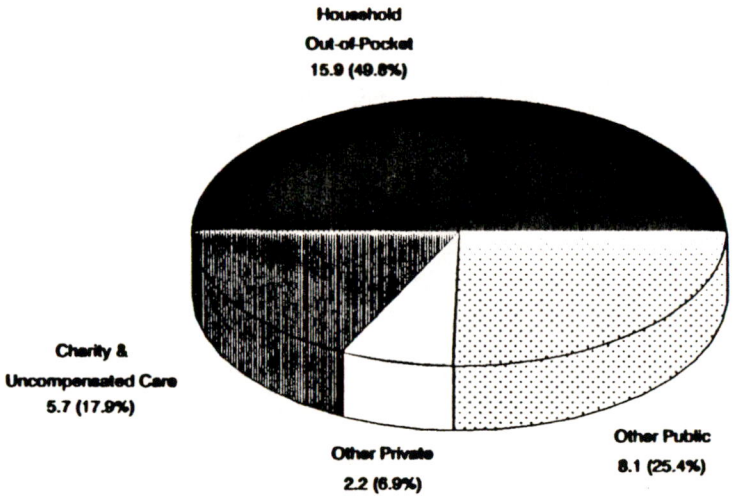
Estimated Personal Health Care Expenditures For Non-institutionalized Non-elderly Persons By Source Of Payment

(In Billions of Dollars)



Insured Persons



Uninsured Persons

aspe117p

Per Capita Personal Health Care Expenditures for Non-institutionalized, Non-elderly Persons By Type Of Service (1988)

	Insured Persons		*Uninsured Persons*	
	Per Capita Expenditures	Percentage of Total Expenditures	Per Capita Expenditures	Percentage of Total Expenditures
Hospital Inpatient	$396	27.2%	$313	36.0%
Hospital Emergency Room & Outpatient	143	9.8	90	10.3
Physicians Office Visits	459	31.6	239	27.6
Prescription Drugs & Medical Sundries	92	6.3	67	7.8
Other Health Care	367	25.1	157	18.3
Total	*$1,457*	*100.0%*	*$866*	*100.0%*

aspe117u

Distribution of Families by Estimated Out-of-Pocket Expenditures as a Percentage of Family Income for Non-elderly Families by Insured Status of Family Members

	Families Where All Members Are Insured	*Families Where Some or All Members are Uninsured*
Out-of-Pocket Expenditures for Health Care as a Percentage of Family Income		
<5%	75.5%	62.6%
10-20%	6.3	12.3
30% or more	2.0	8.9

aspe117v

DRAFT

March 6, 1990

PRINCIPLES FOR RESPONSIBLE HEALTH CARE REFORM

1. Coherence: Rational coherence should be an over-arching priority of any systemic reform of the nation's health care system.

2. Individual Choice: Americans should retain their freedom to choose the method and level of care that is best for them according to their means and individual needs. Mandating care, benefits, or coverage by the Federal government seriously undermines the natural market advantages of individual choice.

3. Volunteerism: The care and resources of family, neighbors and community volunteers are often the best and most appropriate type of care available. It builds upon the strength of the American family and the valuable involvement of private sector intermediate institutions, such as churches, volunteer groups, neighborhood associations, and the volunteer efforts of health care practitioners. Care provided by family, neighbors, and community volunteers constitutes a significant portion of long term care currently being provided and must not be displaced. The support and care provided by family caregivers and the volunteer sector must not be undermined. Reforms should also promote the integrity of intact families.

4. Quality Assurance: The Federal government should promote the availability to all Americans of needed services of adequate quality. This principle of quality assurance must be balanced with the need for cost containment.

5. Cost Containment: In an era of rapidly rising health care costs, measures to ensure cost containment must be at the foundation of any reform of our nation's health care system. Health insurers should be encouraged to offer coverage at the lowest possible rate, and safeguards against over utilization need to be in place.

6. Balance and Participation: General health care reform must include participation and responsibility of: individual beneficiaries; families; service providers; private sector insurers; public sector payers; employers; and local, State, and Federal levels of government. The Federal, State, and private sectors must achieve the appropriate balance between them in sharing the burden of providing services and paying for those services.

7. Payer of Last Resort: The Federal government should be the payer of last resort. The Federal role, as provider of direct health insurance, should only address unmet essential needs. No genuine reform can merely shift health care costs to the Federal government and displace existing funding sources. Acceptable reform proposals must avoid the "Federalization" of health care.

8. Targeting: Any acceptable reform proposal must identify and target those subpopulations least able to obtain and pay for adequate health care. Any tax system treatment of health care should be graduated, emphasizing the needs of low-income families.

9. Individual Responsibility: Personal responsibility to save, seek cost-effective services, and plan for the future most not be undermined. Individuals should be encouraged to minimize discretionary behaviors associated with foreseeable risks to their own health. Systemic reforms should not insulate individuals from bearing consequences of their own risks.

10. Federalism: States and community groups have a vital role in improving health care and must be given flexibility in using their resources to meet their own specific problems. The Federal government should continue to provide support through State-administered programs, such as Medicaid, and should reduce the red tape in the Medicare and Medicaid programs.

11. Budget Neutrality: Any health care reform package must maintain budget neutrality (i.e., any expansions of health care coverage or services must be offset with other savings) and should allow legislative oversight and control through the annual Congressional appropriations process int he same way most discretionary spending is reviewed.