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II. NEW SYSTEM COVERAGE

PRELIMINARY WORK PLAN

February 10, 1993

NEW SYSTEM COVERAGE WORKING GROUP

PRELIMINARY WORK PLAN

February 7, 1992

This working group is made up of four subgroups working on developing policies for:

- 1) A core benefit package
- 2) Coverage for working families
- 3) Coverage for low-income and non-working families
- 4) Integration of Medicaid

The work plans for each sub-group include explanation of the work products planned, the major issues that need to be addressed (the list is not intended to be exhaustive), the analysis thought to be required for evaluation of policy options, and the next steps that must be taken to move the work plan forward.

In the course of our initial meeting, the working group determined that a statement of our overall goals was necessary in order to direct the work on the key issues presented in this plan. The goals agreed to were the following.

1. The United States population should have affordable, quality care.
2. Coverage should be seamless, without gaps when moving in and out of work or making other life transitions.
3. The population should have a core package of benefits adequate for maintaining good health.
4. On a broad scale, the system should be equitable and just (fairness to individuals).
5. The system and its administration should be simple and understandable.
6. The system should support long term health in the

population.

7. Costs should be affordable for individuals, businesses and government.
8. The system should encourage individual responsibility.
9. The system should discourage waste, fraud and abuse.
10. The system should be responsive to the needs of vulnerable populations and others with special needs.
11. The reformed system should improve the morale of patients and providers.
12. The system should promote quality care.
13. The reforms should be politically feasible.

Benefit Package

Key issues to be addressed:

1. Should there be a single, standard package of benefits?
 - Is the ability of purchasers and insurers to determine the package offered removed?
2. How comprehensive should package be? How should benefits be designed to reflect needs of different populations?
 - Full coverage of all needed services?
 - Mirror benefits in most group plans?
 - Only basic primary and catastrophic care?
3. What limits should there be on copayments, deductibles, out-of-pocket costs?
 - Will these differ for HMOs and other managed care organizations versus plans providing a free choice of provider?
 - Will cost sharing differ by kind of service?
4. Is balance billing limited? If so, how?
5. How to insure flexibility to:
 - support innovation in benefit design
 - reflect new technology and outcomes research
 - decide coverage, if any, for experimental treatments
 - adjust cost sharing to reflect inflation
 - etc?
6. How specific should the legislation be on benefits?
 - Very specific (legislation provides a detailed list of covered services, to be amended by the National Health Board)?
 - Very general (legislation provides only general principles, NHB defines services)?
 - In between? Legislation defines covered services broadly (e.g., preventive services, inpatient and outpatient, prescription drugs, family planning, basic mental health, etc.), with specifics to be determined by Board.
7. How much state/HIPC flexibility?

- What is the relationship between state insurance mandates and the standard benefit package?
- 8. What are the National Board responsibilities/authority on benefits?
- 9. How should benefits covered or required by other programs be treated?
 - medical tests required by OSHA regs?
 - workers' compensation?
 - auto insurance?
 - other (e.g., no fault insurance, liability insurance -- order of payment)?
- 10. Are parallel benefit expansions required in other federal programs (e.g., Medicare)?
- 11. Supplemental benefits:
 - Can copayments be covered?
 - Is regulation required?
 - Should the core benefit package be supplemented for low-income individuals? If so, how?
- 12. How are the benefit requirements phased in?
- 13. How are non covered services handled?

Analysis required:

1. Benefit analysis in terms of:
 - premium costs for specific benefit
 - marginal cost of adding the benefit
 - changes in patterns of coverage for the benefit
 - contribution to health status
 - out-of-pocket costs and risk selection problems for supplemental plans if not covered
2. Surveys of public expectations/opinion of benefits.
3. Legislative information:
 - current state insurance benefit requirements
 - legislative approaches in congressional and state bills; Hawaii; other countries
 - possible approaches if legislation only lays out principles for the benefit package

4. Analysis of the existing Medigap supplementation market for lessons learned/implications for a core benefit package.
5. Current patterns of retiree health benefits.

Planned work products (for Mid-March):

1. Options paper on benefits:
 - a. Drafting options for coverage of services.
 - Policy arguments
 - Analysis of costs and changes in coverage
 - Survey information, if relevant
 - Political analysis
 - b. Drafting options for cost-sharing limits.
 - Policy arguments
 - Analysis of costs and changes in cost-sharing
 - Survey information, if relevant
 - Political analysis

Next steps:

1. Solidify working sub-group
 - Find additional needed expertise
 - Find someone to staff the group
2. Establish priorities for policy development and analysis
3. Assign tasks with deadlines

Coverage for working families

Key issues to be addressed:

1. Definitions:

- a. Employer
- b. Employee -- full time, part time
- c. Family, dependents
- d. United States (i.e., territory where bill applies)

2. Employer requirements:

- a. Who is responsible for sponsoring insurance coverage (as distinguished from paying for it)?
 - HIPC? employer? individual?
- b. What payments must employers make for employee coverage?
 - What are the options for required employer contributions?
 - Are employers responsible for more than the standard benefit package?
 - Do requirements differ inside and outside the HIPC or with size of firm?
 - How does it work for self-insuring firms? How about for firms that provide some or all health services to their employees?
 - Does it vary with single vs. family plan?
 - What are employer obligations for part timers, short-term employees, contract workers?
 - What about multiple worker families, multiple employment workers?
 - How are financial responsibilities among employers, individuals and governments tracked?
 - How do we treat the self-employed -- incorporated and unincorporated? employees of state, federal governments, military? prisoners and their families?
 - Do employer obligations extend beyond the employment period?

- What is the tax treatment of the employer contribution?
- How do employer requirements interact with current bargaining arrangements and benefit plans?
- b. Do we set an equal contribution rule, i.e., that firms offering health benefits cannot make a different contribution for low- and high-cost plans?
- c. What happens to COBRA, ERISA, other current laws?
- d. How should portability/continuity of coverage across jobs, in and out of employment, through changes in family status be ensured?
 - Does enrollment change with employment or according to some other factor?
- e. Are employers obligated to buy insurance through HIPCs and, if so, what size employers?
- f. Enforcement?
- g. How much discretion is left in legislation to the NHB, Sec'y of HHS, State, HIPC?

2. Employer protections.

- a. Are any employers exempt from the mandate?
- b. Employer subsidies.
 - 1) Who qualifies for subsidy?
 - 2) What costs are subsidized and how are they determined?
 - 3) Are the subsidies time limited or permanent?
 - 4) How is the subsidy distributed?

Analysis needed:

- 1. Current picture for employer-provided health benefits:
 - a. Data on what firms currently provide, broken down by:
 - size of firms, geography, industry
 - cost and extent of coverage for workers and families

- payroll % going to benefits
 - costs of administering benefits
 - distribution of firms using contribution rule
- b. Compensation changes:
- cash vs benefit comparisons
 - effect of costs on consumer prices
 - effect on hiring -- e.g., full vs part time
- c. Trend of employer health benefit costs.
- d. Income distribution of gains from favorable tax treatment of benefits.
2. Impact of employer premium requirements -- including phase in and, if considered, equal contribution rules.
- a. Impact on firms, using same parameters as above.
- Include not only data from modeling, but also historical data from Hawaii.
- b. Impact on workers, in terms of:
- total and cash compensation
 - employment
 - work incentives
- c. Federal and HIPC administration required.
3. Costs and effects of subsidies to employers.
- a. Current employer characteristics in terms of:
- size
 - average wage
 - parameters used in determining who gets subsidies
- b. Costs with different subsidies
- federal
 - administrative
- c. Distribution of subsidies in terms of:
- industry, types of firms
- d. Effect on level of benefits provided
4. Legislation: compile legislative approaches in these areas.
- Congress
 - Hawaii

Planned work products (for mid-March):

1. Options memo on employer premium requirements including:

- Policy arguments
 - Impact on employers, workers, economy, budget
 - Political analysis, incl. congressional views
2. Options paper on equal contribution rule including:
 - Policy arguments
 - Impact on employer and worker spending
 - Relationship to current benefit arrangements
 - Political analysis
 3. Options paper on subsidy design and other employer protections including:
 - Policy arguments
 - Impact on employers, workers, economy, budget
 - Political analysis, incl. congressional views
 4. Options paper on phasing in employer participation including:
 - Policy arguments
 - Impact on employers, workers, economy, budget
 - Political analysis, incl. congressional views
 5. Options paper on other, more detailed issues requiring decision.

Next steps:

1. Solidify working sub-group
 - Find additional needed expertise
 - Find someone to staff the group
2. Establish priorities for policy development and analysis
3. Identify and assign tasks with deadlines

Coverage for low-income and non-working families

Issues to be addressed:

1. How is coverage assured outside the workplace?
 - a. Through subsidy to individuals for purchase of private plans through HIPCs or through a separate program?
2. If through subsidies for low-income and non-workers:
 - a. How is eligibility for subsidy defined?
 - Do subsidies differ for individuals and families?
 - How to treat the self-employed?
 - How to treat prisoners?
 - Are visitors, illegal aliens eligible?
 - b. How much does a full subsidy cover?
 - Is there cross-subsidy from other payers?
 - Are low-income individuals expected to make any contribution?
 - c. How do the subsidy levels vary?
 - d. Administrative and financing issues:
 - What are the sources of subsidies? What are the responsibilities of federal and state governments, employers, and individuals?
 - Who makes income determination?
 - How is subsidy distributed?
 - How are changing financial responsibilities among individuals, employers and government tracked?
3. What is the policy on low-income people covered by Medicaid, other public programs, and private insurance?
 - a. Should Medicaid be integrated?
 - If so, how should integration be phased in?
 - Will cost-shifting continue or will payments be for full premium costs?

- Fold it into the single regional HIPC, a separate HIPC or a reinsurance group?
 - If not, should Medicaid remain as is?
 - Is Medicaid to be expanded, even if temporarily?
 - Should Medicaid be folded into Medicare?
4. Phasing of subsidies:
- a. Who gets phased in when? (E.g., starting with pregnant women and kids?)
 - b. How do we get from the current system of subsidies, especially Medicaid, to the new system?
5. Do we want coverage to be universal? If so:
- a. How is universality assured -- through an individual mandate or other mechanism?
 - b. How is it designed/enforced/administered?
6. How is coverage for under-65 retirees and Medicare ineligible retirees addressed?
7. How do we assure adequate coverage for vulnerable populations?
- a. How is coverage assured for those who haven't enrolled in a plan? What are outreach mechanisms?
 - b. What additional provisions are necessary to assure access for special populations (e.g., non-English speaking, homeless, disabled, migrant workers)?
 - c. In and across HIPCs, how do we guarantee adequate access and service for all populations, especially vulnerable populations?
 - d. If the low-income are "mainstreamed:"
 - Will residual benefit programs (e.g., long term care, supplemental acute care benefits, social services) be needed to address special needs?
 - If so, will they be financed through a residual Medicaid program, by another third-party payer, or through grants-in-aid?

- e. Are special provisions for providers necessary regarding low-income populations?
 - Are certain providers to be designated as "essential" to be covered by accountable health plans?
 - Are payment incentives required?
 - Are special classes of low-income providers accounted for (e.g., FQHCs, county health departments, etc.)?

Analysis required:

1. Current distribution of uninsured and characteristics of targeted population in terms of:
 - income, employment, and changes in employment
 - demographics
 - region
2. Subsidy options':
 - costs/savings:
 - federal government
 - state government
 - individuals
 - administrative
 - re/distributive impacts in terms of:
 - income
 - age
 - incentives (work, moral hazard, choice behavior)
3. For under-65 retirees:
 - current distribution of insurance costs and employer liabilities
 - federal, state, firm, individual costs under different options
5. Data on:
 - population profile (SES, demographic, utilization, health status)
 - current program characteristics of relevant

programs, Medicaid in particular, in terms of:

- income and demographics
- benefits and eligibility
- costs
- dynamics of Medicaid population

5. Analysis of Medicaid integration options in terms of:

- Federal, state and private sector costs
- Changes in benefits for beneficiaries

Planned work products:

1. Options paper on subsidies for low-income and non-workers including:
 - Policy arguments
 - Impact on work incentives
 - Costs/savings
 - Political analysis, including Congressional views
2. Options paper on early retiree coverage issues:
 - Policy arguments
 - Costs/savings to gov'ts, firms, retirees
 - Political analysis, including Congressional views
3. Options paper on mechanisms to guarantee universality including:
 - Policy arguments
 - Legal analysis of individual mandate approaches
 - Political analysis, including Congressional views
4. Options paper on addressing the needs of low-income, vulnerable, and other special populations:
 - Policy arguments
 - Impact analysis
 - Political analysis, including Congressional views
5. Options paper on integration of Medicaid including:
 - Policy arguments
 - Cost, distribution and impact analysis
 - Political assessment, including Congressional views

Next steps:

1. Solidify working sub-group

- Find additional needed expertise, esp. from Justice
 - Find someone to staff the group
2. Establish priorities for policy development and analysis
 3. Identify and assign tasks with deadlines

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III. NEW SYSTEM INFRASTRUCTURE
A. QUALITY ASSURANCE

PRELIMINARY WORK PLAN

February 10, 1993

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Workplan for Toll Gate 1 Quality Assurance Subgroup

The document below represents our first cut at a work plan that will outline the questions the subgroup expects to explore, the data and consultations required to answer these questions, and the projected output. The subgroup plans to meet on Tuesday, February 9, 1993 to refine this document further prior to Wednesday's broader meeting.

This work plan is based on the assumption that the legislation to be developed will be consistent with the principles outlined in the Magaziner workplan. We expect the administration proposal to structure a federal system in which there are likely to be at least three levels of regulated quality related activity:

AHPs involved in a wide array of QA/QI activities and especially vigilant about quality problems due to over treatment and inappropriate care;

Regional entities involved in oversight of HIPCs and AHPs; and

A national entity responsible for regional comparisons and other activities that have an impact on multiple regions or nationally.

In answering each of the questions below we expect to pursue a series of action steps that follow this general outline:

A. Assemble data. 1. Review the current state of relevant knowledge as represented by the most current and comprehensive reviews in the literature; 2. Assemble and review any important primary data; 3. Interview national experts and stakeholders.

B. Model development. Subgroups develop models/theories/approaches for answering each question. Review by the entire quality assurance group and infrastructure cluster.

C. Model implications. Test approaches for efficacy (likelihood of achieving goals), efficiency, (cost versus magnitude of effect), and interest group impact. Consider short term and long term feasibility, and transition issues. Review special organizational structures or procedures that may be necessary during a phase in period.

D. Finalize recommendations. Make final team recommendation (include dissenting opinions)

QUESTIONS

I. What are the overall goals of the Quality Assurance effort and implicitly how should we define quality of care? Will notions of quality improvement, value and cost effectiveness be given substantial emphasis?

Methods

Review documents that summarize the state of the art in quality of care assurance (eg IOM report, AHCPR annotated bibliography).

Seek input from provider groups (eg AMA, AHA, Major specialty societies)

Consult with consumer organizations and advocates (eg AARP, Families USA, Sidney Wolfe).

Obtain counsel from stakeholders (eg PMA, HIAA)

Seek input from organizations involved in quality assurance (eg AMPRA, World Health Organization for Quality Assurance in Health Care, JCAHO, Natl Council of Quality Assurance, PROs).

II. What is the role of information and information handling in quality assurance? What information is needed, will it reflect structure, process, and/or outcome, will data on cost and efficiency be included? By whom is the information needed? How does the information content and access vary by recipient? How will the information be generated (produced, gathered)? What are the various means of information dissemination?

Methods:

Review current experience with government quality assurance at the regional and national levels. Pay particular attention to differences in relation to type of care setting (eg nursing home versus hospital) and location (urban versus rural). Review HCFA's experience with the PROs.

Review private sector efforts.

Seek input from providers and provider groups on(eg GHAA, Kaiser, HCHP, Blue Cross, AHA, AMA, IHS, DVA, ANA, ACHE) the use and barriers to implementation.

Seek input from existing monitoring agencies (PROs, JCAH, ASQA).

Ascertain the governmental, regulatory view (eg Department of Commerce, Justice).

Consult with manufacturers of health care and health-related products, such as medical devices, lab equipment, pharmaceuticals, x-ray equipment, etc.

Obtain input from patients and patient groups and business groups (eg AARP, Families USA, Military Coalition, labor).

III. How should Clinical Practice Guidelines (CPGs) and Technology Assessments (TA) fit within the quality assurance program. At what level should CPG's and TA's be developed and implemented-national v. regional? Who will be responsible for developing the CPG's and TA's - private sector or government? How will their accuracy and overall quality be assured? How will CPG's and TA's be translated into standards and review criteria. Will they be tied to reimbursement? Can CPGs be used across practice settings?

Methods

Review current experience with using CPG at regional and provider levels for quality assurance.

Review HCFA experience with TA's.

Review experience with CPG development- AHCPR, AMA, American Pediatric Association, CDC, NIH Consensus Panels other professional organizations.

Review Institute of Medicine Reports on Technology Assessment and Guidelines.

Seek input from providers (eg. GHAA, Kaiser, AHA) on the use and barriers to implementation.

Seek input from insurers HIAA, Prudential, Aetna, Blue Cross/Blue Shield.

Seek input from consumer groups.

IV. What is the role of the consumer in the ongoing quality assurance activities?

Methods

Review the experience in existing quality assurance organizations and activities(eg PROs, large prepaid groups).

Identify forms of consumer participation in other management structures. eg Co-Operatives, Consumer Ownership, Stockholders.

Consult with consumer groups and consumer advocates (eg Mark Green, Citizens Transition Project).

V. How, if at all, should providers be held accountable for unintended/bad outcomes? Who is held responsible -- the "plan" or individuals as well? Is accountability based on public quality measurements sufficient? Is accountability for individual errors or for rates and system-level performance? Who holds the plan/provider responsible -- government entity, malpractice system, market forces, individual consumers? Are quality failures without adverse outcomes included in such accountability? Can we exclude a "plan" or provider from participation by simply not contracting or do we pursue punitive action with due process protection? Does the punitive part of accountability interfere with quality improvement?

Methods

Obtain information on the actual experience of plans and of those who contract with plans, on accountability at the plan and, individual level (NCQA, GHAA, AMA, AHA, HMOs with active programs such as US Healthcare, United Healthcare, licensing boards (OH, CA), a few PROs).

Seek legal advice regarding actions. Information on experience in licensing individuals and plans. There is a major overlap with malpractice reform and close consultation is needed.

VI. What incentives are needed for quality improvement in a managed competition system? Will reasonably valid information on "plan" performance and quality be made publicly available in a timely manner? Will standards be nationally/locally consistent? If so, will market mechanisms provide sufficient incentives? If employers use quality data, what happens to individuals who cannot interpret or understand the information, especially the elderly? What public entities are needed to interpret quality information? Could incentives be made sufficiently strong to eliminate the need for licensing?

Methods

Very close overlap with numbers II and V above. Seek input especially from: AMA, AHA, AARP, New York State people re CABG data, JCAHO, some people who consult to hospitals in managed care, licensing board types.

VII. Are there institutional structures or capabilities that need to be developed to implement the Administration's health care reform proposal?

If we accept the recommendations for 3 levels of activities and responsibilities specified in the transition team's options paper, the following issues arise: Will existing structures suffice or must new structures be developed to carry out the specified functions? AHPs will presumably emerge but may need assistance in developing QA systems. Regional activities to certify and oversee AHPs, monitor for under-treatment and substandard clinical practice, and conduct other audit functions could be performed by or in conjunction with HIPC's, state governments, DHHS regional offices, or new entities created solely for this purpose. National responsibilities to help structure and monitor the entire quality assurance system, develop tools and techniques (through guideline development, technology assessment, and medical effectiveness and health systems research), develop and oversee data systems, etc., could belong to a new free-standing entity, be split among the proposed National Health Board and existing federal agencies, reside in a new amalgam of existing programs.

Methods

These issues go far beyond the purview of quality assurance; we will first and foremost need broader consultation from other task forces.

Determine the extent to which existing transition team papers address these issues (get copy of L. Etheredge paper).

Review literature on models for structuring public-private and regulatory activities.

Obtain expert opinion on adequacy of current structures, especially at the regional level.

VIII. Assuming an adequate array of QA approaches and methods, is there an adequate cadre of appropriately trained people to implement the required QA activities and/or provide necessary technical assistance?

Methods

Review the capabilities of professional and trade associations (ANPRA, etc.) to train and certify needed personnel.

Review capabilities of Federal programs to do same (e.g., AHCPR User Liaison Program, DHHS training center).

Review similar capabilities of academic institutions and foundations.

Obtain expert input.

IX. What role will Total Quality Management play in the overall quality assurance program? Will there be incentives for AHPs and other organizations to take part in TQM? Will the government facilitate or require information systems and data collection that is designed for TQM?

Methods.

Review the existing literature on TQM with special emphasis on its diffusion, expense and efficacy.

Seek inputs from experts, both advocates and detractors.

Substantial overlap with other questions above, use similar methodological approach.

X. How far should the government oversight role extend. Financial incentives to reduce care and the unfamiliarity of managed care organizations with special needs populations both pose substantial threats to quality of care. How active should the government be as a watchdog for substandard care?

Methods

See number II above.

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III. NEW SYSTEM INFRASTRUCTURE
B. ADMINISTRATION, REIMBURSEMENT, AND PATIENT INFO SYSTEMS

PRELIMINARY WORK PLAN

February 10, 1993

I. Work Plan for Cluster 3 - B

II. Vision:

The managed competition model assumes that comparative value information will be available for practioners, consumers, buyers, managers and policy-makers. There is lack of objective data to support this model. We envision a national health information infrastructure which will provide efficient access to information for effective competition.

III. Key Assertions & Assumptions:

- A. There is a need for a Health Care Information Infrastructure as a component of the National Information Infrastructure.
- B. The Health Care Information Infrastructure must enable informed decision-making for ALL users.
- C. Health Care data must be captured effortlessly and one time at the point of care or decision making. Redundant entry of data must be mercilessly eliminated throughout the system.
- D. This subcluster is focusing on information systems and infrastructure. We are not addressing business practice improvements.

IV. Questions

- A. What is the current information infrastructure?
- B. What are limitations of existing infrastructure?
- C. How will information infrastructure address the problems of escalating costs, lack of access and quality of care?
- D. The following questions will be applied to the current and future intrastructures and will be applied to the following process categories: Claims/reimbursement, clinical/patient, general health information uses.
 - 1. Who are the key decision-makers?
 - 2. What decisions do they have to make?

3. What information do they need and how should it presented to be maximally useful?
 - a. What is NOT needed?
 - b. How do we provide this information to consumers in a fashion they will understand?
4. What are the sources for the information and how is info processed

E. Health Information Infrastructure

1. How is information managed - stored, accessed, secured, owned, archived
2. What is the relationship to the National Information Infrastructure?
3. What are key elements?
 - a. Commonality
 - b. Diversity
 - c. Utility
 - d. Leverage Points
 - e. Key Cost Drivers
 - f. What are the potential benefit to the Health Care industry?
4. What are the key technology issues?
5. What Information Services Are Needed?
 - a. Multimedia and objectbase managers
 - b. electronic commerce
 - c. Mediators
 - d. Trusted transactions and archives
 - e. EDI Servers
 - f. Knowledge repositories
6. Other Issues
 - a. Standards (Data, transmission, etc.)
 - b. Universal Identifiers
 - c. Privacy

- d. Legacy Systems
- e. Priorities/Preemption

F. Administrative Costs and Savings

- 1. What are the inefficient or non-value added practices?
- 2. Are there new business practices or economies of scale?
- 3. Federal Health Care Data needs?
 - a. What are they?
 - b. Are they consistent and integrated?
- 4. What processes and information will be needed by the new structures?

V. General Approach

- A. Formulate questions - outline of scope of problems
 - 1. What is the issue
 - 2. How does it relate to the "target" - how does it fit in the big picture
 - 3. How critical is this - essential --> nice to have
 - 4. What are the current costs
 - 5. What are known technical and cultural impediments
- B. Identify what information needed to address question (source matrix)
- C. Request information
 - 1. Request Technology/Functionality Forecast
 - a. High Performance Computing and Communications
 - b. NIST
 - c. OTA
 - d. IOM
 - e. DARPA
- D. Synthesize information on problems
- E. Identify alternative solutions
- F. Criteria for evaluation of alternative solutions

1. What are the business practice improvements
2. Benefits
3. Costs
4. Time to solution
5. Evaluate commonality, diversity
6. Legacy systems
7. Pilots, demonstrations which are working on solution
8. Technical, social, political implementation issues associated with solution

G. Recommendations

H. Ranked Options

I. Implementation Strategies

1. Short term versus long term
2. Implementation requirements
3. Roles of decision-makers and stakeholders
4. Opportunities for early win (cost savings, acceleration)
5. Incentives for early adoption
6. How does solution work within the National Information Infrastructure
7. Synergy with other clusters options
8. Existing federal, state or commercial programs

VI. Report Outline

A. Recommendations

1. Technical
2. Legislative
3. Public

B. Technical Report

1. Executive Summary
2. Current Health Care Environment
3. Vision of the future business practice for health care

4. Benefits
5. Technical Issues
6. Impediments to Change
7. Alternative Solutions
 - a. Benefits
 - b. Costs
 - c. Roadmap
8. Strategies
 - a. Short-term
 - b. Long range
 - c. Specific Implementations
9. Conclusions
10. Appendices
 - a. Methods
 - b. References
 - c. Participants
 - d. Documents, reports and other source materials

VII. Definitions

VIII. "Parking Lot" for Issues

- A. Reference Library space for incoming data
- B. Numbering scheme for documents

- C. Version control
- D. Where to park
- E. Automation support

IX. Appendices

A. Roles

1. Federal
2. State
3. Local
4. Private Sector
5. Consortia
6. Citizens!

B. Sources of Information

1. Examination of Existing Literature
 - a. Published
 - (1) IOM and other studies
 - (2) CPRI Compendium
 - (3) ADL Report
 - (4) WEDI Report
 - (5) Work Group on Administrative Costs and Benefits
 - (6) Task Force Report on Computerizing Patient Record
 - (7) Task Force on External Performance Monitoring
 - (8) NLM
 - b. Departmental documents
 - c. Review criteria for examining evidences
2. Hearings
 - a. National organizations
 - b. Subject Matter Experts
 - c. Citizens
3. White papers to address specific topics
4. Briefings on specific topics

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III. NEW SYSTEM INFRASTRUCTURE
C. MALPRACTICE AND TORT REFORM

PRELIMINARY WORK PLAN

February 10, 1993

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Malpractice and Tort Reform Toll Gate 1

The task group has started work, basing its initial discussions on the transition consensus paper on malpractice that I was involved with. At this time, we do not have participation from Justice and DHHS General Counsel. While those absences should not affect our early attempts to broaden the questions, narrowing will require their participation. In addition, relationships between medical tort reform and overall tort reform and medical malpractice liability and product liability cannot be fully explored without representation from Justice.

I. General Considerations

A. The Choice Between Short Term Relief vs. Long Term Reform

1. Will moving on short term improvements, such as modified traditional tort reform, hamper or improve the prospects for more fundamental reforms?

- a. Is tort reform compatible with possible long-term initiatives, such as increased reliance on private contracting mechanisms (involving use of alternative dispute resolution (ADR) and moves to AHPs assuming enterprise liability?
- b. Will adoption of short term relief take the political pressure off for more fundamental reform?
- c. Alternatively, if we demonstrate we are supportive of short term relief, might we be able to engage the various interested parties, especially organized medicine, in discussions leading to more meaningful long term change?
- d. Do we know enough about the proposed long-term reforms to do more than study these approaches at this time?
- e. Will attention to long-term approaches divert attention from contentious issues around short term improvements?

B. Medical Malpractice Reform Relationship to General Tort Reform and Issues Around Product Liability

(needs to be developed)

C. The Mechanism for Reform

1. Since malpractice law has traditionally been a responsibility of the states, what mechanism would be adopted to move malpractice reform?

- o Federal preemption?
- o Withholding Federal funds if the States do not comply, e.g., Medicaid funds?
- o Model legislation, with gentle incentives for States to adopt the model?
- o Other?

D. Budgetary Considerations

1. Which kind of reforms are likely to be scored as savings by CBO and others?

- a. What data are available to permit estimates of savings (or increased expenditures) from the various proposals?

2. Are reforms that potentially cost more but have other merits and probable economic offsets reasonable to consider?

- a. no-fault type approaches
- b. other theoretical approaches that have not been tested, e.g., "early offer" of settlement?

3. How financially significant is "defensive medicine?"

- a. Should greater weight be given to proposals that are more likely to have an impact on reducing defensive medicine?

II. Specific Issues

A. Modified Traditional Tort Reform

1. Because traditional tort reform proposals can contain a large range of items, what are the merits of the following:

- a. capping liability for "non-pecuniary losses" like pain and suffering?

- by a simple cap, such as \$250,000?
- by a payment schedule?
- b. discouraging double recovery through "collateral source offsets?"
- c. shortening the "statute of limitations?"
- d. modifying the contingency fee system for attorneys?
 - by a sliding-scale based on the size of award?
 - by paying costs and reasonable attorney fees?
- e. requiring periodic payments for large awards?
- f. other, mostly procedural reforms, particularly designed to reduce the number of nonmeritorious claims that are presented to the system?
- 2. How much state by state variation should be permitted?
- 3. How much system savings can be generated from tort reforms?
 - a. directly in altered premiums?
 - b. by altering provider behavior?

B. Inducement of Voluntary "Early Offers" of Settlement

1. While theoretically appealing, but untested, do we have enough confidence in this approach to recommend it as an alternative or complement to tort reform?
2. Can we estimate the economic impact of this approach?
 - a. More injured patients should receive compensation for damages, but what is the order of magnitude?
 - b. The current very large transaction costs in the tort system should be reduced significantly. Any estimate?
3. Will consumer advocates view this approach as a major take-away because it reduces the possibility of awards for noneconomic damages?
 - a. However, would the perception be different if the only alternative was caps on such damages?

4. Can we combine the best features of early offers with some elements of traditional tort reform?

5. Isn't this approach a logical one that AHPs would use in private contracting?

a. Should early offer be promoted as a broad based alternative for the country or states to adopt or tested further and made available as a private contracting option?

6. Would there be a need for regulatory oversight to assure that early offers were in fact being made when appropriate?

a. But, arguably, the potential plaintiff is no worse off if the offer is not made?

C. Alternative Dispute Resolution

1. Because there are so many variations of ADRs, do we know which approaches have been successful? Are there any lessons to be learned from the States?

a. mandatory vs. voluntary?

b. formal arbitration vs. settlement conference vs. screening panels, etc?

c. results of ADR admissible in trial?

d. etc.

2. Why hasn't there been more reliance on ADRs, which seem so appealing?

3. Again, is the potential of ADRs best developed in relation to private contracting mechanisms?

D. Private Contracting Mechanisms

1. What has been the experience with this approach, from Kaiser, elsewhere?

2. How confident are we that Courts will uphold private contracts that define how providers (or AHPs) and patients would settle disputes over injuries?

a. Are the relations symmetrical? Do patients actually have the ability to evaluate the mechanism identified in the

contract?

- b. Do patients really have a meaningful choice or would these be contracts of adhesion?

- o in the current system, where employees often receive care from the plan of the employer's selection?

- o In managed competition, where consumers should have individual choice of competing AHP?

3. Fundamentally, should the mechanism for handling negligent acts vary by plan or do we want to recommend something more precise? Is this an area in which we want to preserve flexibility and promote innovation by AHPs?

- a. Should laws that define the nature of private contracting approaches to malpractice be prescriptive or permissive, within certain bounds?

- o What bounds?

- o Permitting variations primarily on procedural issues, or also on substantive items?

- b. Is the mechanism for how injuries are handled part of the spectrum of factors that we want consumers to weigh or not?

E. Practice Guidelines

1. What is the state of the art of practice guidelines?

- a. When will there likely be a significant body of guidelines that can be relied on?

- b. Are they based more on consensus or scientifically-based data or combinations?

2. Are Courts likely to give weight to adherence with guidelines as meeting appropriate standards of care?

- a. Will this vary based on who's guidelines are adhered to?

- b. How will Courts deal with variations in guidelines for the same clinical problem?

3. Since most malpractice claims involve allegations of performance error, turn primarily on factual questions, or raise only causation or damages questions, how much forensic impact are guidelines likely to have?

4. Do providers need immunity from liability for adherence to guidelines, as in the Maine statute?

F. No-fault and Quasi No-fault approaches

1. Are no-fault approaches beyond consideration because of their anticipated inflationary impact on expenditures.

2. Do related, but less expansive approaches, such accelerated-compensation events, deserve testing?

3. Are their particular untoward clinical outcomes that are so pervasive and, arguably, poorly handled through tort experience that particular classes of no-fault payments should be recognized, e.g., birth injuries.

G. Enterprise Liability

1. Aside from its appeal-- that responsibility for injury resolution should be integrated with responsibility for quality assurance under the umbrella of the AHP-- do we know enough about how enterprise liability would work to endorse it at this time?

a. Is there a need to endorse it at this time?

2. Would the concept of enterprise liability work where providers maintain non-exclusive arrangements with AHPs or is it really applicable only where providers are agents of a particular AHP?

a. Are there certain providers, e.g., hospitals, tertiary specialists who are unlikely ever to be in exclusive arrangements with AHPs?

b. Is there, then, the potential for enterprise liability to involve major institutions, including AHPs and hospitals, but not physicians, who would be the agent of one of the other institutions?

3. Does the theory of AHP enterprise liability actually make sense?

a. Should exposure to liability be properly assigned to the party in the best position to avoid negligent outcomes?

o. Since the hospital controls nursing and pharmacy policies and procedures, for example, isn't the hospital better able to minimize nursing and pharmacy errors than the contracting AHPs?

4. What is the functional difference between corporate liability and enterprise liability?

H. Insurance Availability

1. Since the two malpractice crises of the mid-'70s and mid-80's, are there still issues related to the availability of insurance?
2. Are there issues related to the structure of the malpractice insurance industry that need to be factored into the debate on reform?

I. Data Bank and Related Issues

1. Are there issues related to current operations of the data bank that we need to have a position on?
2. As we move to approaches that do not involve formal judgements that can be reported to the Data Bank, how do we assure that physicians requiring ongoing scrutiny are identified?
3. How should the system deal with "egregious" bad acting?

III. Methodology

Most of the data sources required to proceed on cost estimates are available within DHHS. In recent years there have been an a series of governmental and private task forces which have offered malpractice reform recommendations. These will be reviewed in detail.

There will be a need to consult with certain outside parties who are most knowledgeable about certain aspects of reform proposals. In particular, Clark Havighurst at Duke has thought most about private contracting options. Other experts who should be consulted include Randy Bovbjerg at the Urban Institute and Patricia Danzon at the University of Pennsylvania.

Finally, all of the proposals, other than traditional tort reform, need to be vetted to interested parties to determine their likely acceptability.

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III. NEW SYSTEM INFRASTRUCTURE
D. PREPARATION OF HEALTH CARE WORKERS

PRELIMINARY WORK PLAN

February 10, 1993

Health Workforce Reform Subgroup**I. Purpose of Subgroup:**

Develop a strategy for assuring an adequate, supply, mix, demographic composition, geographic distribution of well-prepared providers to meet the nation's health care needs in the context of a health care reform strategy that features universal coverage and cost containment. The salient elements of the plan would then be developed as proposals designed to dovetail with the omnibus health care reform legislative package.

II. Operating Assumptions:

This proposal is built on the assumption that health care reform, within a managed competition framework, will feature the following elements:

- o universal coverage
- o primary care and prevention
- o managed care
- o cost containment
- o community-based services

III. Health workforce reform will feature:

- a. a rational and planned approach to the health workforce that links supply and competencies with need
- b. the expansion of training and practice in primary care
- c. the expansion of training and practice in public health
- d. concern with the cost-effectiveness of health care providers and the cost impact on the system of various disciplines and specialties

IV. Scope/Domain:

The initial scope of consideration for this task group will be the entire health workforce, although time and practicality will require an early decision as to the key disciplines relevant the health care reform omnibus proposal. The task group deliberations will include two general domains:

- a. the education of the health care providers (entry into the workforce)

- b. the practicing workforce, including analysis of numbers, types, trends, costs, imbalances and innovations.

V. Issues/Questions:

- a. What are the numbers and types of health workers needed in practice under the presumptions of the health care reform omnibus proposal?
 - Discipline (beginning with physicians, nurses, nurse practitioners/midwives (NP/CNMs), physician assistants (PAs), and then addressing those providing care to long term and chronic care populations, and others.)
 - Specialty mix within discipline
 - Racial/ethnic/sex mix
 - Practice Location (especially urban, inner city and isolated rural areas)
 - Practice model (e.g., solo practice, team models, groups, etc.)
 - Cost to system of provider mix
 - Other
- b. What are implications of future need for the training of current and future health providers under health care reforms?
 - Targets for production by (see a. above)
 - Other
- c. How should the financing of health worker education be changed?
 - Who pays - Federal/State/private
 - How much financing and when (e.g., residency level, undergraduate, etc.)
 - What mechanisms
 - Venue (e.g., where)
 - other

- d. What are the structures necessary to plan and manage the process of health workforce development and deployment?
- What is current structure
 - What should there be (National/State/Local/other)
 - Ad hoc and/or ongoing
 - Phasing?
 - What data and analytic capabilities are necessary
 - Other
- e. How can services at point of care be reorganized to increase effectiveness and customer satisfaction and lower costs.
- How do we arrange practice structurally to assure that work is performed at the lowest appropriate level?
 - What are competencies and resources needed?
 - Are there aspects of the current systems of accreditation, certification, licensure, institutional privileging and practice regulation vis- a-vis education and practice which need to be modified?
 - Other
- f. How can we develop the informal care network (e.g., volunteers, family members, and other unpaid helpers) in concert with formal health workforce development?
- What type of care is currently being provided by the informal system (particularly long term care)?
 - What care can best be provided by the informal system?
 - How can the formal system and providers work more effectively to encourage, develop, and support informal care helpers and their networks?

VI. Data Sources and Contacts:

Question A -- Current Workforce and Training: Data available is variable, with the most comprehensive data available on physicians and nurses, and progressively more

sketchy for other providers. The list which follows lists in order of how adequate the data is likely to be:

Physicians: AMA Masterfile/AOA File
Bureau of Health Professions (BHP), HRSA
DoD/VA/IHS on federal and non-federal

Nursing: BHP
National Nursing Sample Survey
ICONS (Interagency Council on Nursing Statistics)

Advanced Nursing BHP

- Nurse Anesthetists
- Clinical Nurse Specialists
- Nurse Practitioners
- Nurse Midwives

Physician Assistants BHP
American Academy of PAs

Long-Term Care Providers National Institute on Aging (NIA),
DVA, HRSA Study on Future Requirements

Dentistry BHP, ADA, PHS Dental Coordinating Committee

Mental Health SAMHSA Report

Public Health BHP Report to Congress, Schools of Public Health,

Other BHP Report to Congress

Question B -- Workforce in Training

Physicians: BHP, AANC, AMA, AOA
DoD/VA/IHS on federal and non-federal

Nursing: BHP, National League of Nursing
American Association of Colleges of Nursing (AACN), American Nurses Association (ANA)

Advanced Nursing

BHPr, Specialty Associations for

- Nurse Anesthetists
- Clinical Nurse Specialists
- Nurse Practitioners
- Nurse Midwives

Physician Assistants

BHPr
American Academy of PAs and
American Assoc. of PA Programs

Long-Term Care Providers

National Institute on Aging (NIA),
DVA, HRSA Study on Future
Requirements

Dentistry

BHPr, American Association of
Dental Schools, PHS Dental
Coordinating Committee

Mental Health

SAMHSA Report

Public Health

BHPr Report to Congress, Schools of
Public Health,

Other

BHPr Report to Congress

Projection Capabilities

- o BHPx
 - Physician Supply Model (MD)
 - Physician Utilization Model (MD)
 - Nursing (basic, RN) Supply Model
 - Nursing (basic, RN) Demand Model
- o Empiric Data Bases
 - International
 - HMOs, GHAA, etc.

Question C -- Financing of Education The data on physician education is available, with very limited data on other professions.

- HCFA
- IHS/HRSA/DoD/DVA
- States
- Professional Associations such as American Association of Medical Colleges (AAMC), other.
- Employers
- Private Health Insurers

Question D -- Workforce Planning Development

- o International Comparisons
- o State Models (New York Council)
- o Federal - Civilian, DoD, DVA, IHS
- o Other

Questions E -- Workforce Competencies

- o Pew Commissions
- o Certification Bodies
- o State Licensing Bodies
- o Accrediation Bodies
- o International Comparisons

Question F -- Informal Care

- o Consumer Groups
- o HIV Organizations

- o Senior Organizations
- o Other?

VII. Output/Product

- o Organized similar to health workforce transition format, e.g.,

General Outline for Each Issue

- Background
 - Policy Options and Analysis
Pros/Cons
 - Recommendations with Legislative or Program Specifications
- o Would like to build upon the issues addressed in the workforce transition document:
 - What's wrong with it?
 - What's right with it?
 - What should be added?

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IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEM

PRELIMINARY WORK PLAN

February 10, 1993

Suggested Outline for Final Reports for Task Group 4 Teams

Program Name

- I. Program Background:
 - A. Summary of key features of current program, eligibility, benefits, cost growth, etc.
- II. Comparison with Model Reform System:
 - A. Comparison of how current program differs from proposed program for general under 65 population.
- III. Problems and Issues with Current Program (assuming no comprehensive reform)
- IV. Potential Integration Problems and Issues Resulting From Comprehensive Reform
 - A. Problems and issues for the program (assuming no major change in the program)
 - B. Problems and issues for the reformed health care system for the general under 65 population (assuming no major change in the program).
- V. Options (to follow at later date)
 - A. Summary of problem being addressed
 - B. Current law
 - C. Proposed Change
 - D. Likely Impacts:
 - 1. Beneficiaries
 - 2. Budget
 - 3. Other
 - E. Pros:
 - F. Cons:

Characteristic	Yes/No	Comparable Program Feature	Comment
Individual Choice of Multiple, Competing Plans			
Level Contribution for All Plans Set at Lowest Cost Plan in Geographic Area			
Standardized Benefit Package			
Detailed Comparative Information at Point of Purchase			
Coordinated Open Enrollment			
Risk Adjusted Premiums			
Income-Related Financing/Subsidies for Low-Income Groups			
Global Budgets			

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IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEM
A. MEDICARE

PRELIMINARY WORK PLAN

February 10, 1993

I. Program Background

- A. Program Origination
- B. Eligibility Rules
- C. Benefit Structure
 - 1. Benefits at program origination
 - 2. New benefits (1972 S.S. Act)
- D. Costs of Program
 - 1. 1965-1992
 - a. Areas of greatest growth
 - b. Reasons for growth in costs
 - 2. 1993-1997
 - a. Areas of greatest growth
 - b. Reasons for growth in costs

II. Comparison of Managed Competition Approach to Current Medicare Program

- A. The current managed competition approach has several elements that are different than the current Medicare program. These include the following:
 - 1. The level of contribution from the employer would be set at the cost of the lowest cost plan in a local market. The beneficiary contribution would then be based on the plan chosen, i.e., a more expensive plan would result in higher beneficiary premiums.
 - 2. The benefit package might contain drug coverage provisions and is likely to contain catastrophic stop loss.
 - 3. There is a coordinated open enrollment period for all beneficiaries.
 - 4. There will be income-related financing with subsidies for low income groups.

III. Problems and Issues with Current Program

- A. Medicare's cost-containment efforts have focused primarily on controlling price. Volume and intensity have increased dramatically.
- B. Failure of Medicare HMO program to attract beneficiaries, attract HMOs, and pay appropriately
- C. In contrast to almost all other health insurance, Medicare does not have a catastrophic stop loss. As a result, most Medicare beneficiaries purchase medigap coverage, which encourages increased utilization.

IV. Potential Issues Resulting from Comprehensive Reform

- A. Assuming Medicare is Folded Into Managed Competition Initiative

1. Financing Issues

- a. Some believe that it is less expensive to provide the Medicare benefit package to beneficiaries through Medicare than if it were provided by private payors due to lower Medicare administrative costs and lower Medicare prices. On the other hand, others believe it is possible that managed care plans could lower utilization to the point where Medicare costs could be reduced below current Medicare costs.

Will Federal outlays or beneficiary premiums be increased if managed competition does not succeed?

- b. The elderly generally have higher utilization than the non-elderly. If a standard benefit package is provided to all persons under managed competition and a single premium is charged, the non-elderly would subsidize Medicare beneficiaries. Should there be a separate premium for Medicare beneficiaries under managed competition?
- c. What is the Federal budget target for Medicare within the context of national budget cap for all health expenditures? Would there be a separate global budget for Medicare or would it be part of the overall global budget?
- d. Under one managed competition approach, the employer contribution is set equal to the bid

of the lowest cost plan. How would the Medicare contribution fit into this structure?

2. Benefit Structure

- a. Currently, the Medicare benefit package is different than private sector packages (e.g., Medicare does not cover drugs or has catastrophic provisions, but covers some additional long-term care services such as home health). Should there be a separate package for the elderly? What would be the budgetary and political impact of conforming benefit packages?

3. Medicare as An Option

- a. Should the Medicare program be maintained as a option for all Medicare beneficiaries?
- b. Should a residual Medicare be maintained as a fall-back plan in areas where managed competition is not still viable (e.g., rural areas)?

4. Phase-In

- a. How is Medicare phased-in to managed competition in terms of timing, population groups?

5. Other Issues

- a. Currently, Medicare fills in gaps for beneficiaries who are still working rather than paying the full cost of care (Medicare Secondary Payer Provision). This results in lowered Medicare outlays. How will this be handled?
- b. Currently Medicaid pays the cost-sharing for low-income Medicare beneficiaries. If Medicaid is folded into the new system, how will this subsidy be handled?
- c. How will Medicare premiums to the AHP be financed (i.e., FICA, general revenues, beneficiary premiums, etc.)?
- d. Currently, Medicare does not allow a physician to bill a beneficiary more than a pre-determined amount above the fee for each

service. Would this type of beneficiary financial protection be continued?

- e. Would new data and information need to be collected for the elderly, and do they need to be presented and disseminated differently?

B. Assuming Medicare is Not Folded Into Managed Competition Initiative

1. Impact of Managed Competition on Medicare

- a. What will the impact of reduced utilization in the managed competition world have on Medicare, e.g., will providers induce additional demand for Medicare beneficiaries or will they become more efficient for all beneficiaries?

2. Impact of Medicare on Managed Competition

- a. What will the impact that further price controls on Medicare will have on managed competition plans? Will it drive the price of managed care up?
- b. Will the managed care system be able to develop the new practice norms necessary to bring costs under control with Medicare still under a fee-for-service system?

3. Relationships with Other Programs

- a. If Medicaid is incorporated into HIPCs, how is cost-sharing for the poor elderly handled?
- b. How will Medicare secondary payer provisions be affected?

4. Relationships to Global Budget

- a. Will a separate global budget for Medicare be established?

5. Entry into Medicare

- a. What are implications for beneficiaries when they become 65 and move from managed competition into Medicare?
- b. Should new or current Medicare enrollees be allowed to enroll into managed competition?

6. Program Eligibility

- a. What provisions should be made for the ESRD and disabled populations?

7. Restructuring

- a. Should the Medicare program be restructured to be more efficient if it is maintained separately?

V. Methodology

Most of these issues require consultation with HHS staff, further discussion within the cluster, and cost-estimates for alternative scenarios. In addition, significant coordination and information sharing with other clusters will be necessary since there are significant policy and cost interactions.

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IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEM
B. DOD

PRELIMINARY WORK PLAN

February 10, 1993

DRAFT

BACKGROUND ON THE MILITARY HEALTH CARE PROGRAM

The Department of Defense (DoD) spends more than \$16 billion a year running a dual system of health care. As a provider of health care services, DoD runs a worldwide network of 137 hospitals and medical centers, and several hundred outpatient clinics, staffed by more 100,000 active-duty and 50,000 civilian personnel (the direct care system). As a purchaser of services, DoD operates the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a Blue-Cross/Blue-Shield type of plan that covers 75 percent to 100 percent of the costs of care provided by civilians.

ELIGIBILITY

About 8.5 million people are eligible for some form of military health care. The 2 million active-duty personnel have top priority for using the direct care system. Their 2.5 million dependents may use the direct care system if space is available; if space is not available, or if travel to a military facility is unduly inconvenient, dependents may use CHAMPUS. The 3 million retired military personnel and dependents of retired personnel who are under age 65 face the same rules as active-duty dependents, though military treatment facilities give them lower priority for space-available care. Finally, the 1 million retired military personnel and their dependents who are eligible for Medicare may use the direct care system, but cannot use CHAMPUS.

USERS

Although DoD knows the number of beneficiaries eligible for military health care, it does not know precisely the size of the population served by the military health care system. Beneficiaries do not pay premiums to enroll in DoD's system except for active-duty personnel (who must use the direct care system), beneficiaries may flow into and out of the system as they wish. As best we can tell from survey data and patterns of utilization, at least 90 percent of active-duty dependents rely on the military health care system; only about 50 percent of retired military personnel and their dependents who are under age 65 rely on the military. Beneficiaries who are eligible for Medicare rely least on the military because of constrained access to direct care. If DoD made more space available to these beneficiaries, or extended them CHAMPUS-type coverage, proportionally more of them would rely on the military.

PROBLEMS AND ISSUES WITH THE CURRENT SYSTEM

Just as health care has been consuming an ever greater percentage of GDP, so too has health care been claiming an ever greater share of the DoD budget. As a share of the defense budget, spending on health care has climbed from less than 3 percent in 1984 to more than 5 percent today. Unless DoD reverses the last decade's trend, spending on health care will absorb an ever-increasing proportion of the shrinking defense budget.

DoD faces three major challenges in managing the military health care system's costs:

- 1 **System-wide obstacles:** a nebulous benefits package, limited financial constraints on demand, limited incentives and tools for managing volume;
- 2 **Demographic obstacles:** ever-increasing numbers of elderly military retirees and dependents eligible to use the direct care system; and
- 3 **Mission obstacles:** the vastly diminished military threat reduces the "core" military requirement for staff and capacity by some as yet undetermined amount..

SYSTEM-WIDE OBSTACLES

The system-wide obstacles to managing health care involve (1) the nebulous scope of benefits; (2) the minimal role of cost-sharing; and (3) the lack of providers' accountability.

The military health care system does not offer a well-defined benefits package. One's scope of benefits depend on where one lives, one's proximity to a military treatment facility (e.g., a retiree living in Washington, DC can receive a rich range of services from the area's 2 medical centers and 4 community hospitals, while a retiree living in Minneapolis can only receive the benefits allowed under CHAMPUS), and one's military status (i.e., active-duty personnel, active-duty dependents, retired military personnel, and dependents of retired military personnel).

Cost-sharing is minimal in the direct care system, and therefore exercises little restraint on demand (though beneficiaries may face heavy time costs). Cost-sharing is significant under CHAMPUS, particularly for retired military personnel and their dependents, but many beneficiaries undercut CHAMPUS's cost-sharing features by purchasing supplemental policies;

Military providers are neither accountable for nor--given the paucity of management tools--necessarily capable of managing the volume of services. As a result,

the system lacks control over the volume of services, and probably supplies a good deal of unnecessary or inappropriate care. The problem is exacerbated by the absence of regional planning among nearby facilities that belong to different military services (e.g., in Washington, DC, the Walter Reed Army Medical Center, the National Naval Medical Center at Bethesda, and the Malcolm Grow Air Force hospital operate pretty much as stand-alone systems.) Thus, eligible beneficiaries who actually use the military health care system receive relatively high amounts of health care.

DEMOGRAPHIC OBSTACLES

The changing demographic composition of the beneficiary population may add to costs. Over the next 5 years, the number of eligible beneficiaries will shrink by about 10 percent, entirely because of the planned reductions in active-duty personnel. However, the total number of retired military personnel and their dependents over the age of 65 will increase by 25 percent. To the extent that DoD chooses (or is forced) to care for these elderly beneficiaries, costs will rise.

MISSION OBSTACLES

Under guidance adopted in 1974, DoD bases the size and staffing of the direct care system on two criteria. First, the direct care system should be large enough to support the military's wartime requirements: military medical personnel must be trained and ready to serve with combat forces, and troops must be healthy enough to be deployed at a moment's notice. Second, DoD can add staff and capacity to the core requirement if doing so would be the most cost-effective way of providing care in peacetime.

When the threat to national security was large (Soviets overrunning Western Europe), a substantial proportion of the military health care system's staff and capacity could arguably be credited to the readiness mission. One of the challenges in peacetime was to use that capacity effectively, at relatively low marginal cost.

Today, however, with threats to national security greatly reduced, DoD will be hard-pressed to justify its extensive health care system on the grounds of readiness. While no one yet knows what the new "core" requirements will be, the core will, in the future, undoubtedly comprise a far smaller proportion of the military health care system than it has in the past. That will leave a large amount of "extra" staff and capacity. Capacity that was cost-effective to operate in peacetime when that capacity was needed for readiness may, under the new mission requirements, no longer be cost-effective.

INTEGRATING DoD AND THE MANAGED COMPETITION INITIATIVE

The advent of national health care reform will intensify the focus on three dimensions of military health care delivery:

- The Scope of Benefits;
- The Structure and Management of the Delivery System; and
- The Degree of Beneficiary Choice.

This section outlines the broad options facing DoD on each of these three dimensions – the DoD Team expects to explore these options and their associated questions.

SCOPE OF BENEFITS

We envision two broad options for the DoD health care benefit:

1. Nonactive-duty beneficiaries are entitled to the standard, comprehensive benefits package established by the National health board. Nonactive-duty beneficiaries would have to pay for the added costs of a richer benefit, or be taxed on those added costs.
2. Nonactive-duty are entitled to a relatively enhanced benefits package and cost-sharing provisions that will make them no worse off on average than today.

Questions for the DoD Team:

Will the benefits package differentiate between different classes of beneficiaries (i.e., will dependents of active-duty personnel receive a better deal than retired military personnel)?

Will CHAMPUS disappear?

What are the possible range of differences between the standard package and an enhanced package?

In funding the new benefit, will DoD continue or end the distinction between different appropriations categories: MILPERS money, O&M money, and CHAMPUS money?

Questions for other Teams:

Will Medicare integrate into the managed competition initiative; if so, to what degree? The answer will influence whether DoD beneficiaries who are over age 65 will be entitled to the DoD benefits package.

How will the initiative deal with dual-eligibles? Will people be allowed to have multiple coverage?

STRUCTURE OF DELIVERY SYSTEM

DoD faces three broad options along this dimension:

1. DoD reduces its direct care capacity to a newly defined (and diminished) readiness-related core. We define the core as the minimum set of resources needed to support the armed services' military missions. DoD's challenge is to use the core effectively in peacetime.
 - a. DoD could augment its limited direct care capacity by contracting for care with a single provider (as in the CHAMPUS Reform Initiative); or
 - b. DoD could subsidize the premiums of beneficiaries who join private plans through a regional HIPC (or through a Federal HIPC, depending on the evolution of the FEHBP).
2. DoD keeps enough capacity above and beyond the core to compete with private sector insurers and providers for military beneficiaries within the regions defined by the HIPCS (i.e., DoD runs regionalized HMOs that are centered around military hospitals). If demand exceeds current staff or capacity, DoD expand capacity by purchasing services (comprehensive or product-line specific) from private providers or other Federal health providers.
3. DoD health care loses its distinct military identity by merging with other federal health care providers (although still keeping its core capacity and staff). As part of a joint-federal health plan, DoD competes for the enrollment of military beneficiaries.

Questions for the DoD Team:

What will happen during wartime? Will the new structure make it easier or more difficult than at present to deploy medical personnel overseas?

Who is financially at risk – would a military health plan keep some or all of any savings, would it be forced to close if it lost money?

Given a particular structure, how can DoD improve control over the volume of services? Should DoD adopt the same reimbursement mechanisms as the HIPCs? (DoD currently plans to change the basis of budgeting from workload to population.)

What initiatives should DoD take in measuring outcomes? Should DoD wait for and adopt new, national systems for measuring outcomes? To what extent can DoD--because of its unique position as a federal purchaser and provider of services to a distinct

population--inform the debate, and offer lessons to the nation by initiating a rigorous program of outcomes measurement?

To what extent could DoD use its direct care staff or capacity to serve civil needs? How would DoD be reimbursed for providing that care? Could DoD directly provide care to underserved populations in rural areas or inner cities? Or might DoD transfer any "excess" capacity to other Federal providers (e.g., PHS), or to private, commercial or non-profit organizations. (For lessons on what not to do, consider the experience of the former Merchant Marine hospitals that became Uniformed Services Treatment Facilities.)

CHOICE AVAILABLE TO MILITARY BENEFICIARIES

We see two approaches on choice:

1. Beneficiaries are restricted to the choices sponsored by DoD (unless a family member has access to other coverage, or beneficiaries wish to pay the full cost of other coverage)
2. DoD will subsidize beneficiaries who wish to receive coverage through a private or Federal HIPC.

ISSUES UNIQUE TO A GLOBAL BUDGET

If DoD integrates into the managed competition initiative, how will it relate to a global budget? Suppose that the states set budgets and premium caps. Will spending on military health care in general come under the limit? What about spending that is related to the readiness mission? Separating readiness expenses from peacetime expenses could raise some thorny issues, and invite creative accounting. Suppose further that some states decide competition is not possible and instead regulate provider fees to meet the budgets. How far could the states intrude into DoD territory? And how difficult would it be for DoD to budget and manage military health plans operating under a variety of state systems?

MATRIX OF OPTIONS

Benefit Package	Delivery Structure		
	Minimal Direct Capacity	DoD-Run HMOs	Federal HMOs
No Beneficiary Choice			
Standard	I	II	III
Enriched	IV	V	VI
Choice Allowed			
Standard	VII	VIII	IX
Enriched	XI	XII	XIII

Combining the various approaches on benefits, structure, and choice yields a matrix of options. On further analysis, some may fall out as technically or politically infeasible. We plan to evaluate the remaining options on the basis of the following criteria:

1. Per capita health care costs of military beneficiaries, to DoD and to the Federal Government.
2. Effects on specific regional health care markets.
3. Distributional effects on military beneficiaries' out-of-pocket costs – who are the winners and the losers?
4. Effects on access to care for non-DoD populations.
5. Effects on non-medical military missions (i.e., will the option disrupt the military's culture and harm morale, will it hurt or help recruiting and retention).
6. Effects on quality of care – is there a great risk of catastrophic failure?
7. Effects on administrative complexity

METHODOLOGY AND DATA

Per Capita Costs

Estimate effects on beneficiaries' demand for care, including patterns of utilization. Data sources include DoD survey data from 1984 (nationwide), 1988/1989 (CRI study); evidence on consumer choices from private sector plans and Medicaid and Medicare HMOs. We expect to bring on Susan Hosek of the Rand Corporation as a technical consultant.

DoD cost accounting systems make it difficult to estimate direct per capita costs, because costs do not track individual patients, or even classes of patients. Nonetheless, we can use existing cost tools to take a swag at estimating current costs.

Estimate the savings possible from structural changes that modify the volume of services. Draw on DoD analyses of specific "product lines" to estimate potential overall for change, and experience of various managed care demonstrations (e.g., CRI).

Effects on Regional Markets

Identify areas of the country which have extensive military health presence and excess civilian capacity (e.g., Denver). Discuss qualitatively the likelihood that a military health plan would raise or lower costs for the region as a whole.

Out-of-Pocket Costs

Review studies that place a relative value on military and civilian health care benefits. (See Attachment 1 for a summary description of military benefits.)

Access for Non-DoD Beneficiaries

Analyze distribution of DoD health care capacity – how well does it match up with underserved areas?

Non-Medical Military Missions

Draw on an extensive body of military manpower research to estimate likely effects on recruiting and retention of modifying the health benefits package. Compare effects with the President's latest end strength goals to estimate likelihood of problems.

Quality of Care

Rely on expertise of the Team's two physicians to flag options that might seriously compromise the quality of care. Beyond that, assume that quality holds constant.

EXAMPLE: OPTION I

Option: Military beneficiaries are entitled to the standard benefit through DoD. DoD limits direct care staff and capacity to meet core requirements, and augments that care by contracting with a single provider. Beneficiaries have no other choice but to receive care from that provider.

Sample Analytic Issues:

Effects on demand for care: Relatively modest among those under 65. Some beneficiaries with other insurance will stop using the military health system. If Medicare is not integrated, some 65+ beneficiaries will presumably want to join the DoD plan. Will DoD be able to pay for their care from a civilian provider?

Effects on civil needs: Existing direct care staff and capacity probably not sufficient to provide much care to non-DoD population. However, any "excess" capacity might be used to improve access in underserved areas. Where is that excess capacity likely to be in relation to areas of greatest civilian need, and what is its size?

Sample Pros and Cons:

- Pro:
- Standard benefit would end managerial and equity problems associated with today's ill-defined benefit.
 - If DoD structures contract properly, single provider will be able to manage the volume of services – study experience of the CHAMPUS Reform Initiative (CRI) for lessons. Beneficiaries' care would be tightly managed.
 - DoD can respond quickly to changes in the demand for care by changing scope of contracted services.
- Con:
- For some substantial number of beneficiaries, the standard benefit may be worse than the current, ill-defined benefits. Politically charged.
 - Significant managerial challenge if DoD has to issue bids in each HIPC region. If DoD relies on a single provider for the nation, that provider becomes too big to fail.

PROBLEMS AND ISSUES IF DOD DOES NOT INTEGRATE INTO THE MANAGED COMPETITION INITIATIVE?

Can DoD deal with its three-pronged problems without integrating into the managed care initiative? An overarching question is whether DoD's growth in health care costs will be allowed to exceed growth in national health expenditures? The rest of this plan discusses the other problems and issues that the DoD Team will explore, along the dimensions of benefits, structure, and choice.

SCOPE OF BENEFITS

Although the military benefit is ill-defined, the typical military beneficiary might well receive a benefit more generous than that set by the national health board.

Policy Questions

Will benefits in excess of the national standard plan be treated as taxable income or in some other way be treated differently than at present?

How much (if any) access will Medicare-eligible beneficiaries have to military health care benefits? The answer will depend on the degree to which Medicare integrates into the managed competition initiative.

With the national board setting a standard benefits package, DoD will come under added pressure to define its benefits package precisely, and to apply those benefits more uniformly across various categories of beneficiaries and types of users.

STRUCTURE OF DELIVERY SYSTEM

DoD would presumably continue to base direct care system capacity on readiness considerations, with additional capacity based on the cost-effectiveness of providing care directly. DoD would close or downsize facilities in accordance with the Base Realignment and Closure process. Civilian care would be purchased as at present.

Policy Questions

Should facility sizing rules be changed, in light of the considerably reduced core requirement?

How can incentives and tools for managing the volume of services be introduced to the military if it operates independently of the national program? Can the limited beneficiary incentives for appropriate utilization be expanded?

Should CHAMPUS continue to exist? Will there be a health care market in which to purchase civilian services for military beneficiaries? Should DoD purchase care on a per service basis as at present, or could it enter into arrangements with AHPs or other entities?

BENEFICIARY CHOICE

Beneficiaries initially would retain freedom of choice under the constraints of the current military rules. Additional programs to facilitate management of the health benefit would be introduced as appropriate.

Policy Questions

How will military beneficiaries eligible for other coverage be treated? Who will be financially responsible, and where will they obtain care?

Should the military pursue further managed care programs featuring enrollment and restricted freedom of choice, in effect operating in parallel with the national health care reform program? Should military managed care programs require multiple options from which beneficiaries would choose?

Assuming cost sharing equity between the direct care system and CHAMPUS care, should some beneficiaries be impaneled in the direct care system, with others impaneled in the civilian sector?

IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEM
C. VETERANS

PRELIMINARY WORK PLAN

February 10, 1993

TOLL GATE 1

TABLE OF CONTENTS

- I. BACKGROUND
- II. DIFFERENCES BETWEEN VA AND THE NEW SYSTEM
- III. CURRENT ISSUES IN THE VA SYSTEM
- IV. IMPACT OF THE NEW SYSTEM
- V. POTENTIAL QUESTIONS TO BE CONSIDERED

I. BACKGROUND

OUR NATION'S VETERANS

- o Currently, there are 26.7 million veterans.**
- o Over the next twenty years:**
 - the veteran population will decline by 27 percent,**
 - the proportion of elderly veterans will increase 12 percent, and**
 - the number of veterans age 85 and over will increase six-fold (the same age group in the national population will only double).**

USERS AND ELIGIBILITY

- o VA provides direct health care to 2.5 million veterans each year (9.4% of total veteran population).**
- o All veterans are eligible for some type of VA health care. Priority for care is primarily based on veterans' disabilities related to military service and the veterans' annual income.**
 - 40 percent of inpatients have a military-related disability.**
 - 54 percent of inpatients have income below the means-tested threshold.**
 - Veterans with service-connected disabilities or annual incomes below \$19,408 receive VA health care at no cost. Other veterans must pay deductibles and copayments.**

VA HEALTH CARE PROGRAMS

- o Most care is provided through VA's 171 hospitals, 358 outpatient clinics, 132 nursing homes, and 35 domiciliaries. Bed capacity includes 66,600 hospital beds, 13,500 nursing home beds, and 8,000 domiciliary beds. In some cases, non-VA contract care may be provided.**
- o Average occupancy rate in VA hospitals in FY 1992 was 65 percent.**
- o 133 VA facilities are affiliated with 104 medical schools 59 dental schools, and more than 850 other health professional schools. Approximately**

100,000 health professionals (including 58,000 medical residents and students and 22,000 nursing students rotate annually through VA as part of their medical education.

- o VA conducts medical rehabilitative and health services research to improve health and medical care for veterans.**
- o VA medical system provides backup to DOD health care system in time of war or national emergency.**

RESOURCES

- o Direct medical care in FY 1993 totals \$14.6 billion.**
- o Research in FY 1993 totals \$922 million, with funding from a variety of sources (e.g., appropriations, DOD, and National Institutes of Health).**
- o Medical system is the largest non-DOD, non-Postal employer in the Federal Government (estimated 18% of total non-DOD, non-Postal FTE in FY 92 -- over 200,000 FTE).**

II. DIFFERENCES BETWEEN VA AND NEW SYSTEM

KNOWN DIFFERENCES AT THIS TIME

- o VA benefits package is broader (e.g., covers rehabilitative, long-term care, medication, supplies and prosthetics).**
- o Most VA care is provided at no cost to the patient.**
- o VA's patient case-mix is different:**
 - predominantly male**
 - no children**
 - older than general population**
 - more chronic illness.**
- o VA lacks patient based integrated management information and cost accounting systems (e.g., quality/outcomes data).**
- o VA does not offer choice among competing plans.**
- o VA has continued to focus on inpatient care as private providers have moved more to outpatient care.**
- o Specialty care programs have no counterpart in private sector (blind rehab, PTSD, prosthetics).**
- o VA is backup to DoD in time of war or national emergency.**

III. CURRENT ISSUES

ACCESS

- o Eligibility criteria simplification.
- o Changing demographics (declining population, age, migration).

BENEFITS

- o Definition of VA benefits package.
- o Implementation of managed care.
- o Shift from inpatient to outpatient orientation.

QUALITY

- o Availability of practitioners for appropriate levels of care.
- o Ensuring high quality care throughout the system.

RESOURCES

- o Aging infrastructure (facilities/equipment).
- o Allocating resources efficiently (including staffing).

MANAGEMENT

- o Redefining VA facility missions.
- o Lack of patient-based cost accounting information.
- o Implementation of management network.

EXTERNAL RELATIONS

- o Management constraints from external bodies (Congress, VSOs).
- o Poor public image.

IV. IMPACT OF THE NEW SYSTEM

IF VA DOES NOT CHANGE...

- o Demand for VA acute hospital care could decline significantly if non-insured veterans now using the VA system are given an alternative.**
- o Decline in acute care could leave the VA system as a chronic, long-term care "safety net" for conditions not covered by the national plan (e.g., nursing home care, alcohol/drug abuse, and psych care).**
- o Separation of acute services from chronic services could lead to fragmented care delivery and decreased quality in chronic care.**
- o Quality of acute care remaining in the VA system could also decrease (e.g., medical universities may discontinue affiliations with VA hospitals).**
- o More veterans would have duplication of health care coverage (i.e., VA and the national plan) potentially creating another layer of secondary payor and coordination of benefits issues/problems.**

IF VA DOES CHANGE...

- o Demand for VA care could increase if VA:**
 - increases its market share of veterans.**
 - increases its sharing agreements with DOD hospitals.**
 - becomes a provider in the community for non-veterans.**
 - offers a richer benefits package.**
- o VA's support for medical activities that have an impact beyond VA could decrease (training of residents, clinical research, DOD contingency, and special programs such as spinal cord injury units).**

V. POTENTIAL QUESTIONS TO BE CONSIDERED

- o How would VA function within the new health care network?**
- o How would demand for VA care be affected?**
- o Will a VA and non-VA benefits packages be the same?**
- o How will VA's areas of special expertise be affected (e.g., blind rehab)?**
- o How will quality of care be ensured?**
- o What will be impact on VA research programs?**
- o Will financing mechanisms differ?**
- o Could VA offer a "buy-in" option for veterans other than core-entitled veterans or to non-veterans.**
- o Will investment in new technology be needed (e.g., information systems for costs and quality)?**
- o How will VA's external relationships be affected (i.e, DOD and medical schools)?**
- o What will be impact on VA role as DOD contingency backup?**
- o Will VA have a role as a community provider in medically underserved areas?**
- o How will coordination of benefits, multiple eligibility be addressed?**

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IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEM
D. FEHB

PRELIMINARY WORK PLAN

February 10, 1993

INTEGRATION OF GOVERNMENT PROGRAMS: FEHB SUBGROUP**I. Program Background**

The Federal Employees Health Benefits Program (FEHBP) covers over four million employees and annuitants plus their dependents. The cost to the Government is \$9.8 billion a year. Total cost, including enrollee contributions, is \$13.6 billion.

There are about 300 health benefits plans participating in the current program. Fifteen of those are fee-for-service (indemnity) type plans; the rest are prepaid plans (HMO's). Overall enrollment is distributed 75 percent fee-for-service, 25 percent HMO. However, since annuitants are concentrated primarily in six fee-for-service plans and two HMO's, employee enrollment in HMO's is actually about 35 percent of the total.

Out of approximately 2.9 million Federal employees, we estimate that about 15 percent or around 435,000 are not enrolled under the FEHBP. Recent survey results indicate that 60 percent of the non-participants are covered elsewhere. The balance, or 6 percent of employees (between 175,000 and 185,000 people), have no health insurance coverage.

II. Comparison with Model Reform System

Assuming that the Model Reform System will resemble Jackson Hole proposals with a global budget, FEHB is probably as close to that system as anything that exists in today's Federal world. There are, of course, some key differences as well.

Like the model, FEHB is comprised of multiple plans, each competing for the consumer's business during an annual open season when Federal employees and retirees can choose any plan. There are no exclusions for preexisting conditions, nor any waiting periods.

Unlike the model, FEHB has no standard benefit plan; it includes fee-for-service plans as well as HMOs; the employer contribution is based on the average premium of the big plans; and there is no adjustment for risk. Although much work has been done in attempts to control costs, to date there has been no budget for FEHB: the HMOs receive "community rate" premiums for each enrollee and are at risk for the costs of those enrollees; the fee-for-service plans reimburse based on either negotiated or reasonable and customary prices after rudimentary screens to avoid unnecessary care (hospital precertification, for example.)

III. Problems and Issues with Current Program

Serious concerns about the Program emerged beginning in 1987. Published reports highlighted the problem of risk segmentation that results from multiple plans competing for enrollees. They also pointed out the structural basis for the economic

inefficiencies and premium inequities that have developed over the years because of adverse selection and duplication of administrative costs.

The incentives, both for carriers and for enrollees, to maximize efficiency and control costs are insufficient. Contracting mechanisms, partially structural and partially politically protected, make it difficult to achieve effective Program administration. In addition, the Government contribution formula is out dated, does not reflect current enrollment patterns, and does not necessarily reinforce enrollee selection of the most efficient plans.

IV. Potential Integration Problems and Issues Resulting from Comprehensive Reform

A threshold set of questions need to be considered to determine the advantages and disadvantages of integrating the FEHBP into the new system:

- Given the range of possibilities, what should be the relationship between the FEHBP and the new system?
 - What is best for the Government as an employer as it competes for talent against other large employers?
 - What is best for Federal employees and retirees in terms of benefits for the dollar?
 - What is best for the national health care system?
- If other large employers are included in the HIPC's, should the FEHBP be included as well; can it be integrated in exactly the same way as private sector employer programs given the budgetary considerations specific to the Government as an employer?
- If other large employers are not included, should the Federal Government as an employer be included nevertheless?
 - Would it be to the Government's advantage as an employer to be included?
 - Would it be to Federal employees and retirees advantage?
 - Would it be to the HIPC's advantage?
- If FEHBP is included in the HIPC
 - In which regions (geographic areas) would Federal enrollees have a major impact?

-- What would the impact be?

-- Should the FEHBP be used (at least in regions where there is a large Federal population) as the core around which the regional HIPC would be structured?

A. Problems and issues for the Program (assuming no major change in the Program)

- If FEHBP is not included in comprehensive reform it would affect the local health care markets in areas where there is a concentration of enrollees. There would be considerable potential for cost shifting to the FEHBP by providers affected by cost containment efforts elsewhere in the system.
- The Program would continue to be at a disadvantage in contracting with insurance carriers because of its non-competitive contracting structure.
- Since the Federal Government would be using a different contribution formula than private employers, it would be contributing disparately toward the purchase of benefits packages. If the Government contribution was greater in the same geographic area, and/or if Federal enrollees received a contribution based on more generous benefits packages than the standard package, there would likely be accusations of preferential treatment.

Because of these and other potential problems and issues, we would need to consider some alternative strategies. To examine those strategies, we would ask the following questions:

-- To what degree should the FEHBP conform to the new health care system?

-- How long would it take to make the desired conforming changes?

-- Should the conforming changes be made as quickly as possible, or should there be a phase in to evaluate the success of various aspects of the HIPC approach elsewhere before implementing them?

-- As an interim strategy, should Federal Programs that serve Federal employees (broadly defined) and use comparable financing systems, e.g., CHAMPUS, OWCP, CHAMPVA, be integrated?

-- Would such an integration increase efficiencies and help control costs?

-- Would it adequately serve the respective populations of these disparate programs?

-- If implementation takes several years to accomplish, what needs to be done in the meantime?

B. Problems and issues for the reformed health care system (assuming no major change in the program).

- The FEHBP would not be included in global budgeting.
- It would be more difficult to manage competition in areas with large FEHBP enrollments.
- Some individuals would remain uninsured.

V. Options (to follow at a later date)

VI. In order to reach Toll Gate 2 we will begin contacting the available sources within the potentially affected agencies, e.g. OPM, DOD, DOL.

Further down the road, we also will need input from some of the other cluster groups, e.g. Quantitative Analytic Support and HIPC Organizations. In addition, at some point in the process employee representatives, executive branch leaders, and retiree representatives should be contacted.

Our initial data sources will be OPM's Central Personnel Data File (CPDF) and the annuity roll. We also will seek cost data from DOL, VA, and DoD, and Medicare rating data from HCFA.

Our output will be a paper that provides (1) background information on the FEHBP including an analysis of its strengths and weaknesses; (2) identification of problems, including possible short term solutions; and (3) options for coordinating with the new system, including pros and cons.

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VI. SHORT-TERM COST CONTROLS AND TRANSITION TO NEW SYSTEM

PRELIMINARY WORK PLAN

February 10, 1993

DRAFT

Preliminary Work Plan: Short-term cost controls and transition to the new system

OUTLINE

- I. Key questions/options for exploration.
- II. Methods and information needs.
- III. People to contact and cross-linkages with other clusters.
- IV. Output.

This cluster needs some preliminary division into task groups. The following seem appropriate:

- A. Accelerating new system development.
- B. Short-term steps toward administrative simplification.
- C. Interim cost controls.
- D. Program roll-out.

The interim cost controls group may in turn be divided into further subgroups.

I. KEY QUESTIONS AND OPTIONS

NOTE: Options listed in this draft are meant to be illustrative rather than exhaustive.

A. Accelerating new system development.

The basic objective of this group is to identify potential implementation barriers and ways to remove them, to suggest strategies for inducing cooperation from the states, localities, and private organizations, and to produce options for rapid implementation. The problems can be divided into two areas:

- (i) How do we get the health insurance purchasing cooperatives (HIPCs) and other new institutional arrangements running in the minimum feasible time?
- (ii) How should the federal government enable and encourage the states to move toward a new system?

(i) Questions about accelerating development of HIPCs, health plans, and other components of the new system:

1. Organizing purchasing cooperatives:

What existing organizational resources and systems in both the public and private sectors are available to serve as resources and platforms for HIPC development?

Options to explore: (a) designation of "purchasing cooperative prototypes" (e.g., California public employee system) as technical assistance centers for new purchasing cooperatives; (b) use of prototype organizations to manage new purchasing cooperatives; (c) opening up of the federal employees health benefits and state benefit program to other groups; (d) conversion of existing state programs for special populations of the uninsured.

2. Structuring the phase-in of HIPC participation:

How should we get the purchasing cooperatives up to large enrollee populations in the least time?

Options to explore for initial HIPC enrollment base: (a) "Cooper" mandate (to get tax subsidy, any employer under given size must go through regional purchasing cooperative for health insurance, if they choose to insure); (b) employer HIPC mandate (employers of given size must participate in purchasing cooperative); (c) individual mandate (individuals without insurance must insure through purchasing cooperative); (d) fold-in of public employee programs; (e) fold-in of Medicaid; (e) voluntary employer and individual enrollment.

3. "Advance" organizational development:

What authority currently exists for federal efforts to support a national technical center for HIPC development? What resources such as curriculum and training programs and manuals for organizational start-up are currently available? How can the federal government work with the private sector to remedy key deficiencies?

Options to explore: (a) redeployment of existing research and training budgets; (b) public-private coordinating councils or programs; (c) informal consultation with groups like Jackson Hole.

4. Health plan development:

How should the federal government remedy limits in the availability and capacity of health plans?

Options to explore: (a) capital and technical assistance for health plan start-up; (b) use of private technical assistance to provide managerial and specialized managed care services; (c) adequate transitional coverage during phase-in; (d) give HIPC powers to contract with providers directly where acceptable health plans are unavailable; (e) expedited regulatory procedures.

5. Transitional adjustments in fee-for-service sector

6. Avoiding and overcoming legal impediments to rapid implementation:

What is a minimum feasible schedule for federal regulations and organization of the National Health Board? What special provisions for a transitional period might be made to minimize potential delays?

Options to explore: (a) make an existing agency responsible for developing a provisional benefit package to prevent delays in organizing the NHB from holding up HIPC contracts; (b) leave initial decisions about qualified health plans to states and HIPCs, postponing federal qualification of "accountable health plans"; (c) limit federal regulatory requirements for accountable health plans.

What existing federal laws and regulations may be barriers to implementation and should be revised?

Options to explore: (a) repeal or revise federal HMO qualification once new regulations take effect; (b) put Medicare's treatment of HMOs on parallel foundation to HIPC; (c) identify and resolve potential antitrust barriers.

What restrictive state laws should be overridden by federal statute to accelerate new system development?

Options to explore: (a) override of anti-managed care laws; (b) override of state laws regarding "scope of practice."

7. Minimum information needs for system start-up:

What are the minimum federal information needs for a national budgeting process and what is a realistic schedule for satisfying them?

(ii) Questions about federal-state partnerships:

1. "Readiness for reform"

How do states vary in their readiness to reform?

Options to explore: (a) categorize states according to their readiness for change and concentrate selectively on big states in "high readiness" like California or Florida to get the most effect on costs the earliest; (b) give states Medicaid waivers to enable them to experiment in integrating Medicaid into new structures; (c) revise ERISA to permit state all-payer rate regulation and uncompensated care pools.

2. Timetables for state legislation:

How should the federal government get the most rapid state action on purchasing cooperatives?

Options: (a) federal law would set a target date for the states to establish purchasing cooperatives, failing which the federal government would do so; (b) the federal government would designate HIPCs, but allow the states to assume control over them once they passed satisfactory legislation; (c) the federal government would establish and regulate the HIPCs directly.

3. Incentives for state action:

Should the federal program reward states for early action and, if so, how? What existing federal programs create potentially conflicting incentives?

Options to explore: (a) subsidies become effective as soon as states reach given objectives; (b) states get more flexibility if they agree to stay within budget targets.

4. Model state legislation:

How can we promote the quickest development of model state legislation for HIPCs?

Options to explore: (a) follow precedent of Medigap

standardization--NAIC model with state deadline; (b) give states deadlines but no designated model.

(B) Short-term steps toward administrative simplification.

1. Accelerated standard-setting:

What are the possibilities for more rapid development of uniform standards for claims forms and electronic data interchange (EDI)?

Options to explore: (a) maintaining voluntary process but on accelerated schedule; (b) legislate deadlines for nongovernmental development and adoption of electronic transmission standards for insurance and other related transactions and for standard claims forms; (c) development by HCFA of standard information formats and require their use by all payers; (d) require HHS to develop and all payers to use standard identification numbers for patients, providers, and payers.

2. Impact of purchasing cooperatives on administrative costs:

How can purchasing cooperatives help to reduce administrative costs of insurers and providers?

Options: (a) requiring plans under HIPC contract to use uniform data formats and electronic transmission standards; (b) benchmarking--identifying best-practice organizations as information system standard for others to meet or beat.

3. Purchasing cooperative information systems:

How do we ensure fastest, least-cost startup of HIPC information systems?

Options to explore: (a) federal RFP for software companies to develop state-of-the-art, turnkey packages to do HIPC transactions, membership accounting functions, etc., to be provided free to HIPCs; (b) in year 2, HIPCs issue RFPs for private contractors to run information service operations and networks linking HIPCs to plans, employers, and government agencies.

4. Privacy issues:

What needs to be done to resolve privacy objections to a national data system?

Options to explore: (a) preemptive federal legislation regarding privacy of medical and insurance data; (b) national commission on confidentiality of medical information; (c) investment in technologies (e.g., smart cards) that assure greater security.

5. Public versus private networks:

What institutional basis for network development will get us the needed system soonest but with what drawbacks?

Options to explore: (a) federal ownership and operation; (b) private networks with federally approved standards and gateways.

6. Potential reductions in regulatory costs:

What can be done to cut regulatory complexity and duplication?

Options to explore: (a) standardization of utilization review across payers; (b) streamlining of hospital cost reporting; (c) elimination of overlapping government facility inspection and review.

C. Interim cost controls

The basic objective of this group is to identify cost containment measures that are distinct from the structure of the new system, though not in conflict with it. The task here is not to survey all cost containment measures, but specifically to examine options with a short-term pay-off.

Analytically, we can think of the impact of any option in terms of the following matrix:

MODE OF IMPACT	SPHERE OF IMPACT			
	<u>Public costs</u>		<u>Private costs</u>	
	Federal	Non-federal	Tax-subsidized	Unsubsidized
Prices	a	b	c	d
Quantities	e	f	g	h
Both	i	j	k	l

In other words, does a given cost-containment measure affect federal costs only, state and local costs, private but tax-subsidized costs, or unsubsidized out-of-pocket costs--or some combination? Does a given measure affect health care prices, the volume of services, or both? Strategically, where should we focus attention?

In addition, we can make a preliminary assignment of measures in the following matrix:

POTENTIAL IMPACT	MEASURABILITY OF IMPACT	
	<u>Quantifiable</u>	<u>Hard to quantify</u>
Large	a	b
Small	c	d

Most research will necessarily focus on "a," although we should not lose sight of "b."

Some options are as follows:

CAUTION: THE PRESENCE OF ANY OPTION ON THE FOLLOWING LIST DOES NOT MEAN THAT IT CAN BE REPORTED AS "UNDER CONSIDERATION." THIS IS MERELY A LIST OF POSSIBILITIES THAT INCLUDES, IN MY VIEW, SOME UNDENIABLY BAD IDEAS.

1. Freeze on health care prices;
 - 1a. General, temporary freeze.
 - 1b. Drug price controls.
2. All-payer rate regulation, based on Medicare rates;
 - 2a. Medicare rates at payer option.
 - 2b. Mandated extension of Medicare rate structure to private payors, with higher conversion factors.
 - 2c. Reinhardt's variation (doctors must use RBRVS but can choose conversion factor, which will be public; those exceeding some limit must write to patients explaining why);
3. Hospital revenue regulation (direct global budgeting of hospitals) and expenditure caps on doctors enforced through self-adjusting rate controls;
4. Premium caps.
5. Modification of Medicare rate-setting system.
 - 4a. Bundling post-hospital services.
 - 4b. Efficient pricing criteria.
 - 4c. Profiling of providers and targeted review of inefficient, high-cost providers.
 - 4d. Reduction in prices for overutilized

procedures.

Questions about interim cost controls:

The questions about each of the foregoing options involve the criteria for evaluating them:

1. Scoreable savings (including offsets for behavioral responses).
2. Side-effects on quality, access, choice, and efficiency.
3. Potential for gaming and fraud; monitoring and enforcement.
4. Impact on regulatory burdens.
5. Broader economic impact.
6. Impact on development of new system.
7. Transition route out of controls.

D. Program roll-out.

The task here is to formulate alternative strategies for short-term implementation of the reform program.

1. Least-cost roll-out.

What sequence of coverage extension via mandates and subsidies, federal program integration, and cost controls gets the most coverage at the lowest cost?

Options to consider: (a) up-front coverage to groups requiring least federal outlay; (b) recapture of savings to other levels of government and to private sector as federal subsidies and cost controls kick in.

2. Interim risks

During interim period--while coverage may not be universal--what are the risks to the still-uninsured and the institutions that serve them? How will private employers and states and localities respond to half-way measures?

Options to consider: (a) provide special pool for uncompensated care and aid to financially stressed institutions; (b) maintenance of effort requirements on unmandated employers; (c) maintenance of effort

requirements on the states and localities; (d) keep interim period short as possible!

3. The transition from the short- to the long-term programs:

Options to consider: (a) short-term controls end when state has established purchasing cooperatives, enrolling some target share of the population; (b) controls end when states submit an approved plan to meet expenditure caps or targets; (c) short-term controls end on a date certain.

4. Phase-in scenarios

Putting all the elements together, what are the likely, year-by-year scenarios for institutional development, coverage, and costs?

II. METHODS AND INFORMATION NEEDS.

A. Accelerating new system development

1. Survey and/or meeting of managers of HIPC prototypes:

Convene meeting of people who now run or are developing purchasing cooperatives or kindred organizations in such states as Minnesota, Florida, Arizona, Connecticut, Pennsylvania, California, Oklahoma, New Mexico, and Colorado, as well as officials from the federal employees plan and companies with managed-competition programs such as Xerox. Their experience could help inform policy and identify barriers to implementation. Specifically relevant here: they could help formulate timetables for implementation.

2. State-by-state survey of readiness for reform:

Survey would (a) identify the best platforms available for HIPCs in each state; (b) categorize the state's readiness for fast-track or regular-track HIPC and health plan development; (c) analyze the consolidation required in each state as HIPCs are formed; (d) categorize the states in terms of readiness for other cost containment measures.

Steps include: (a) inventory of basic information on health care delivery programs; (b) description of how the state employee program is managed, its history of contracting with managed care organizations, whether it covers other public groups (e.g. teachers, local government) and any private employers, and names of key

staff; (c) description of how the state's Medicaid program is managed, whether claims processing and information services are provided internally or contracted out, and names of key staff including any who have worked with managed care programs.

3. Inventory of available federal resources for development and support of purchasing cooperatives.

Brief paper summarizing potential resources in federal employees plan, CHAMPUS, and HHS.

4. Legal analysis of implementation barriers and accelerators

For the federal government and the states, the analysis would identify the key impediments to rapid implementation and the key mistakes to avoid that might produce complications and delays.

5. General strategic analysis of HIPC startup as a problem of organizational innovation.

6. General analysis of incentives and constraints facing the states.

B. Short-term steps toward administrative simplification.

1. Analysis of impact of HIPCs on insurance market consolidation and administrative costs.

Project for Quantitative Analytical Support; focus on effects on small-group market.

2. Review and extension of report of Working Group on Electronic Data Interchange.

Convene government-industry panel to propose steps for accelerated EDI development.

3. Analysis of potential reductions in regulatory costs.

C. Interim cost controls.

1. Analysis of impact of short-term control measures on costs and efficiency.

Specifications will be worked out with Quantitative Analytical Support.

2. Analysis of side-effects of short-term controls.

Review of available literature.

3. Analysis of modifications to Medicare rates.

D. Program roll-out.

1. Analysis of alternative scenarios.

Specifications will be worked out with Quantitative Analytical Support.

III. PEOPLE TO CONTACT/CROSS-LINKAGES WITH OTHER CLUSTERS.

People to contact: See Appendix.

Cross-linkages:

A. Accelerating new system development: Design of New System; Legal Audit.

B. Short-term steps toward administrative simplification: Quantitative Analytical Support.

C. Interim cost controls: Quantitative Analytical Support

D. Program roll-out: New System Design; Coverage; Health Policy Initiatives; Quantitative Analytical Support.

IV. OUTPUT AND SCHEDULE

Toll gates with expected output: synthesis of options (March 1); detailed options and draft recommendations (March 15); revised draft recommendations, ready for decisions (March 29); draft sections of program (April 19); final program (May 3).

Each task group will responsible for making a report by March 29 attempting, as much as is humanly possible, to answer the questions outlined above, presenting the required data in a concise and comprehensible manner.

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VII. PUBLIC FINANCING

PRELIMINARY WORK PLAN

February 10, 1993

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FINANCING

GENERAL -- The initial goal of the working group will be to obtain current data on where the health care financing system now stands. The group will also examine expenditures under options to reform the system. Then a comprehensive effort will be made to identify as many potential outlay reduction and revenue sources as possible, should they be needed to offset costs from other elements of health care reform. After these items are identified, each will be evaluated in light of the broader policy issues raised. Exchange of information with groups responsible for other components of the health care reform initiative is critical to the successful completion of work by the financing working group. In particular, timely information is needed from the groups who are designing the benefit package, the global budget/caps proposal and proposals to expand coverage.

QUESTIONS TO BE EXPLORED

- I. What are current expenditures on health care?
 - A. How much? -- Data to be obtained from OMB/HHS.
 - B. Who pays? -- Data to be obtained from OMB/HHS.
 - C. Who really pays? -- Discussion and background materials to be prepared by Treasury in consultation with CEA.
- II. What will total health expenditures be under the reformed system?
 - A. How much?
 - B. Who pays?
 - C. Who really pays?
- III. What will changes be in total costs between existing system and reformed system?
 - A. How much?
 - B. Who pays?
 - C. Who really pays?

Financing page 2

IV. If new money is needed, where will it come from?

A. Outlay Reductions (Direct care and financing)

1. Federal programs
2. State governments
3. Local governments

B. Revenues

1. Potential Targeted Sources

- a. Federal programs
- b. State governments
- c. Local governments
- d. Employers
- e. Providers
- f. Insurance companies
- g. Individuals
- h. Others

2. Broad-based revenue sources

INFORMATION RESOURCES -- Much of information needed will be available internally at Treasury from the quantitative analysis support group, and from HHS. In addition, we expect to utilize the deficit reduction options developed by others in the Administration, GAO and CBO. We will review information available from ACIR, the National Association of State Budget Officers, the City Management Association, the GAO. In addition, we will review health care financing sources used in other developed countries. We also expect that extensive contact with (and regular updates from) other working groups will be needed in order to fulfill these tasks. In particular, regular contact with the "new system" coverage group will be essential.

EXPECTED OUTPUT -- Develop and rigorously analyze an array of possible financing options for consideration by the Task Force. Review will include an analysis of each option (and illustrative combinations of options) on individuals and institutions.

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VIII. HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS
PRELIMINARY WORK PLAN
February 10, 1993

DRAFTWork PlanCluster Team #8Short Term/Health Policy Initiatives for Underserved Populations and Preventive Health

This Cluster Team is charged with two important and unique tasks:

- Describing the needs of populations for whom disease prevention and access to and effective use of health services may not be achieved through financing reform and a standard insurance benefit package. In this sense, the Cluster Team advocates for those historically left out of the health care system.
- Developing and recommending initiatives that begin to deal with the most pressing of these needs in the short term and in some cases continue in the future as complements to financing reform. In this sense, the end result will be subject to analytic tests of need, efficiency and projected impact.

In order to assure a balance between advocacy and analysis, the work will proceed in two overlapping phases. Just as the overall plan of the Health Care Task Force seeks first to broaden and then to narrow the options considered, so the work of this team will be more inclusive at first and then more focused.

Phase I: Background Analysis on Needs of Specific Populations

Work on a population-based Background Analysis will begin immediately. Because of time constraints this analysis will not be complete when the first list of initiatives and options is submitted, but it will be used to broaden the topics to be considered and the options for each topic at a later stage, and to provide information for evaluation of options and formulation of recommendations. There will be an executive summary highlighting the types of unmet need and consequences; one matrix summarizing the information on each population and another summarizing which services are likely to be covered by insurance and a 1 page profile for each population answering a common set of questions.

- Groups to be Covered

At its first meeting the Cluster Team developed a list of populations whose health care problems and needs will be explored. The list is extensive and the groups are in many cases overlapping:

Residents of rural areas
Residents of inner cities
Minority groups
Low income persons/single parent families
Homeless persons
Migrant and seasonal farmworkers
New immigrants
Undocumented persons
Women of child bearing age
Infants
Children
Elderly persons
Persons with HIV infection
Persons with drug resistant TB
Persons with inadequate nutrition
People in need of mental health services
Substance abusers
Physically disabled persons
Developmentally disabled persons
Institutionalized/incarcerated persons
Veterans
Military dependents
Native Americans

• Questions To Be Answered

For each of these groups, an initial set of questions will be answered:

1. What is the size of the population using official estimates where available, and the prevalence of the condition, if relevant?
2. What are the population's particular health problems and what is the impact/cost of the problems? All of a particular population may have one set of problems (e.g., inadequate immunization affects children of all income levels) while only part of the population has other problems (e.g., lack of access to pediatric care disproportionately affects poor and minority children and those who live in underserved areas).
3. What activities and services are needed to address the needs? These may include population-based health promotion/disease prevention efforts, activities which facilitate timely/appropriate use of services; preventive health services; treatment services; custodial or home health care. The discussion will include

evidence of effectiveness of the activity or service, where it exists.

4. To what extent are these activities and services now provided, and by whom (private sector, Federal program, local program, private non-profit organization)? What are the revenue sources (patient payment, private insurance, Medicaid, Medicare, Federal grant, State grant, local grant, bad debt)? This will include information on services and financing from State and local governments and a matrix of Federal programs and which populations they serve.
5. What is the type (and magnitude, if possible) of unmet need?
6. Which, if any, of the populations will remain uncovered after implementation of health care financing reform? Which needed services are included in the proposed insurance benefit package? Which are not? This will include a matrix of types of activities and services and the extent to which they are likely to be covered.

The completion of this analysis will require interaction with other Cluster and Task Teams.

- We need to determine whether the full set of needs, covered by insurance or not, is being dealt with by the Mental Health Cluster (for mental health and substance abuse services); the Long Term Care Cluster (for services to the physically or developmentally disabled) and the Integration of Government Health Programs Cluster (for Military dependents, veterans and the Indian Health Service).
- We need to discuss with the New System Coverage Cluster the extent of coverage and benefits and the integration of Medicaid. The exclusion of needed activities or services from the proposed benefit package, or the exclusion of certain population groups, such as undocumented persons, from coverage, will trigger consideration by our Cluster Team for further recommendations.

• Organizations To Be Contacted and Data Sought

Cluster team members and HHS staff will provide information on the relevant non-financing programs operated by their respective departments and participate in gathering information on the needs of specific population groups.

Attachment A provides a preliminary list of organizations that may have useful information. We will determine the role of the Outreach or Liaison Team in this regard.

Generally we will be seeking information on the size of the population, its problems and its health care needs from the Census Bureau, Federal program managers and advocacy groups (e.g., National Homeless Coalition, AIDS Action Council, National Commission on Infant Mortality, CDF). Some of these groups may also have information on who provides and pays for services and what unmet needs remain. We will be looking for information on State and local programs, services and financing from groups such as NGA, ASTHO, APWA, NACHO, and the Conference of Mayors.

Phase II: Options and Recommendations

Work will also begin immediately to identify a preliminary set of topics for initiatives and options for each, for the revised work plan due February 15. The list will then be broadened, the options evaluated and recommendations formulated for the Final Report. In some cases the focus will shift from individual populations to interventions meeting the needs of several groups. There will be an executive summary highlighting the topics chosen and for each, the recommended initiative, and an implementation schedule, its projected impact in terms of cost and level of service for FY 1994 and future years. Priorities among the initiatives will also be recommended. The body of this report will consist, for each area, of a problem statement and a description of current efforts drawing on the background analysis and options with pros and cons, including how the options relate to the goals of health care reform.

• Possible Topics For Initiatives

Because of time constraints, simultaneously with Phase I the Cluster Team will begin to identify topics for initiatives. The areas for consideration will be refined by the toll gate process and also by the information on unmet need and public health impact that emerges from Phase I. Initially they will include at a minimum the possibilities identified in the Health Care Task Force Preliminary Work Plan:

- Immunization
- HIV prevention and treatment
- Rural areas and the programs that serve them, including but not limited to Community Health Centers and the National Health Service Corps
- Inner city areas and the programs that serve them, including but not limited to Community Health Centers and the National Health Service Corps
- Women's health (especially revitalization of reproductive health programs)
- Perinatal care
- Care for young children
- Other preventive health (possibly drug resistant TB)

It is important to remember that these initiatives will be far from exhaustive. Many valuable public health and health service efforts not proposed for initiatives will continue on an ongoing basis. Those chosen for initiatives will have special significance in terms of impact, persons helped and their ability to complement health care reform.

• Questions To Be Answered

There are some cross-cutting or threshold questions that will need to be answered:

1. What should be the mix of initiatives that build capacity and provide services to enhance or complement insurance benefits, on the one hand, and preventive public health efforts aimed at populations rather than service delivery systems (e.g., mass screening, mandatory immunization, accident prevention, needle transfer, distribution of birth control mechanisms), on the other?
2. What should be the mix of initiatives where

organizations as opposed to those where funding flows to States? To local governments?

3. How should the initiatives be paid for? The Federal government has traditionally supported public health activities through various grants and other assistance to States. Is there any reason for this to change?

For capacity building activities and health related services to individuals the relationship to the proposed financing system must be determined. There may be some services for targeted populations appropriate for insurance but not included in a standard benefit package. Other activities and services are not appropriate for an insurance package because they do not meet the traditional provider-patient paradigm.

- They could continue as a mix of project grants (to communities) and block grants (to States) appropriated individually each year by Congress.
- They could be part of a resource development fund established as an annual proportion of total health care plan expenditures, but then allocated by Congress to specific programs.
- There could be an enriched benefit package plus a lump sum adjustment for nonreimbursable services to providers based on the number or proportion of underserved and/or high risk patients enrolled.

4. What are the characteristics of a financing system that supports the proposed initiatives?

For each topic selected for consideration, the following questions will be answered:

1. What is the need for the proposed initiative in terms of health impact and number of persons affected?
2. What current Federal, State, local and private efforts aim to meet this need, and what is their level of funding and service? For Federal programs, this will include FY 1992 (FY 1993, if available) funding and persons served, and the legislative citation.

3. What has been proposed in this area by Congress or advocacy groups? Are there models on a State or local level or supported by foundations?
4. What are the options to address the identified need? These may include administrative improvements, changes or expansions in Federal programs (with or without legislative change), public-private partnerships such as use of military or VA facilities and technology transfers, and incentives for State, local and private action. They can be in the public health or individual services arena. They need not all be mutually exclusive except where the tradeoff is important (e.g., there could be an initiative that provides incentives to physicians to locate in rural areas and supports community health centers in some areas but there could be a tradeoff in terms of how health centers are supported and the level of support).

Finally, each option will be evaluated according to the following:

1. What is its cost in FY 1994 and the out years and how many people will be served? What will be the impact of increased insurance coverage on costs and service levels?
2. Is the program or model efficient, and what proportion of program dollars go for services as opposed to administration?
3. Has the program or model been found to reduce costs and/or improve health status?
4. Is the program or model consistent with managed competition? With the access and quality goals of health care reform? Does it have positive economic impact in disadvantaged communities?
5. Who benefits/supports the proposal vs. who stands to lose/oppose it?

• Organizations To Be Contacted and Data Sought

In identifying the full range of possible options, we will begin by reviewing work prepared during the Transition, going on to initiatives currently under preparation in the Executive Branch (e.g.,

immunization). Cluster Team members will canvass their departments for relevant proposals that have been developed. We will also look at Congressional proposals, and those of major advocacy groups.

For the programs featured, we will need not only funding levels but more detailed information on service levels. This should be available from Departmental budget justifications.

Finally, we will need to discuss with other Cluster and Task Teams our estimates of the impact of insurance expansion on program funding and service levels.

Timing

There will be four major outputs:

1. A preliminary list of topics and options for discussion by the Cluster Team and incorporation into the revised work plan (2/12).
2. The revised work plan itself (2/15)
3. A Background Analysis of each populations' problems, needed services, current efforts, unmet need and the relationship of services to insurance, for use by the Team in broadening initiatives and options and incorporation of relevant parts into the final report (2/22)
4. A Final Report which synthesizes parts of the Background Analysis, evaluates options and presents recommendations (3/15)

A flow chart (Attachment B) shows how this work relates to the tollgate process and internal Cluster Team meetings. The tollgate goals will be met, with the understanding that the list of topics for initiatives and possible options presented February 15 may change somewhat due to results of the Background Analysis and interaction with other Cluster and Task Teams. Any additional initiatives and options will be submitted by February 24.

ATTACHMENT A**Organizations Which May Be Contacted for Information
(Partial List)**

NGA
ASTHO
APWA
Conference of Mayors
League of Cities
NACHO
Congressional Caucus on Women's Issues
National Women's Health Network
Planned Parenthood
National Commission on Infant Mortality
Children's Defense Fund
National Organization Responding to AIDS
AIDS Action Council
National Coalition for the Homeless
APHA
NRHA
NACHC
AMH
ACOG
AAFP
AAP
AHA
National Association of Public Hospitals
COSSMHO
Urban League
GHAA
Washington Business Group on Health
AARP
National Association of Teaching Hospitals
Mental Health Resource Group
NASADAD

Flow Chart for Cluster Team #8: Short Term/Health Policy Initiatives

	of	2/8	2/15	2/22	3/1	3/8	3/15	3/22	3/29	4/5	4/12	4/19	4/26	5/3
Fall Dates		Draft Work Plan	Revised Work Plan		Options To President		Draft Recommendations		Proposals To President			Audited Program		Final Legislation
Cluster Team Meetings		■ After Task Force — Plan Work		■ Discuss Products & List of Options		■ Meet With Coverage Cluster; Discuss Recommend- ations				■ Discuss President's Decisions				
Work Products														
List of Initiatives & Options		[]												
Revised Work Plan		[]												
Background Analysis Population Profiles, Program inventories		[]												
Analysis of Options			[]											
Report & Recommend- ations				[]										
Revisions								[]						

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IX. MENTAL HEALTH
PRELIMINARY WORK PLAN

February 10, 1993

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2/8/93

MENTAL HEALTH WORKPLAN

I. Action Steps

<u>Action Step</u>	<u>Target Date</u>
1. Complete staffing up of working group	2/12
Still needed	
HHS kid	
HHS substance abuse	
HCFA person	
VA person (Larry Lehman)	
Outside possibilities (list of options)	
Richard Frank	
Howard Goldman	
Barbara Burns	
Sybil Goldman	
Marrissa Issaacs	
Special population concerns	
David Lewis (Brown)	
2. Issue Identification for	
(see attached paper for current listing)	
Outline or major issues area, and questions	2/8
for Toll Gate 1	
Revised outline of issues incorporating	2/15
Toll Gate input and further group review	
3. Development of options outline for Toll Gate 2	
-- Meeting with outside groups and review of	2/12 - 2/19
various benefit design approaches,	
and issue areas	
a. benefit design sessions	
(see listing on issue outline)	
b. long term care session (participants?)	
(member from LTC working group to attend)	
c. efficacy of mental health and substance abuse	
treatment; risks of coverage session	
(who?)	

3. Development of options Toll Gate 2 (cont.)
 - Issue area groups meet and prepare product for Toll Gate 2 (see attached list for work group assignments) 2/16 - 2/23
 - Work group meets to review issue group products and prepare revised work plan, issues, options, methodology for Toll Gate 2 2/23 - 2/24
 - Submit Toll Gate 2 product Give guidance to issue groups on options paper development 2/25
4. Options preparation for Toll Gate 3 2/25 - 3/9
 - issue groups develop options papers per direction from working group and from Toll Gate 2 review. Issue groups meet with working group on each issue paper
 - 1st draft to work group
 - revised draft to work group
 - prepare final options papers
 - data development/cost estimates to support options
5. Narrow options for Toll Gate 4 3/9 - 3/19
 - Working group meets to narrow options
 - Issue groups prepare papers with supporting analysis.
 - 1st draft to work group
 - Final paper on options to work group revise as needed
 - Data analysis to support selected options -- cost estimates and economic impact
6. Prepare draft recommendations for Toll Gate 5 3/19 -3/29
 - Develop draft recommendations
 - Identify issues which need resolution
 - work group level
 - task force level
 - Cost estimates

7. Develop draft legislative specification for drafting 3/29 - 4/19
- prepare detailed outline of legislative specifications
 - revise per contrarian review
 - data analysis in support of bill
 - 1st draft of bill
 - 2nd draft of bill
8. Prepare bill for Toll Gate 7 4/19 - 5/3

Working Group Member Assignments

Core benefit	Norquist, Stephens
Managed Competition for mental health	Norquist, Stephens
Role of Public System	English
Long Term Care	TBA
Children	Pires
Elderly	(? Gene Cohen)
Substance Abuse	TBA
Provider Coverage	Arons
Case Management and Utilization Control	Brock
Reimbursement Strategies	(? Richard Frank, Howard Goldman)
Populations with access problems	Hayes, Leshner
Data needs and analysis	Regier
Data	

II. Procedural / Methodology

A. The work group members are assigned to be responsible for a major issue area for which options need to be developed.

B. Outside experts will meet with the working group to present and discuss a full range of options, and issue areas.

C. Issue groups (predominantly made up of government staff and work group members) will work with the work group lead person to prepare the necessary materials.

D. Work group will meet with the issue group staff to review and revise products.

E. Where necessary mental health work group members will attend other working group meetings, or will invite a member from another working group to attend a mental health meeting (e.g., LTC)

F. Work Group data coordinator (Regier) will be working with data and economic analysis groups to assure that necessary analysis is done.

III. Group Expected Output

A. Decision papers (Toll Gates 4 & 5) on :

- o Who gets covered (nature and prevalence)
- o What gets covered (treatment efficacy)
- o What unique aspects of mental health and substance abuse need to be taken into consideration and how does this effect the program.
 - Benefits not typically covered (rehab, case management)
 - Need for linkages with other systems (e.g., child welfare, juvenile justice, criminal justice, housing)
 - Long term care
 - Access problems
 - Integration of existing delivery system (public system) - what's the delivery system going to look like and how will it be organized
 - How is it going to be financed, does there need to be anything different than that done for the rest of health (e.g., because of public sector role)
- o How will the utilization and quality control work
- o How much is it going to cost
- o What happens to the public that currently is dependent upon the public system.
- o What happens to the public system

B. Program specifications (Toll Gate 6)

C. Draft legislation (Toll Gate 7)

VI. Blank Slides

- A. Benefit
 - 1. Eligibility
 - 2. Coverage
- B. Structure
 - 1. Administrative
 - a. Quality assurance
 - b. Utilization management
 - 2. Financing
 - 3. Delivery system
 - a. Program eligibility
 - b. Provider eligibility
 - 4. Special considerations
 - a. case management
 - b. linkages with other systems
- C. Evaluation
 - 1. Utilization review
 - 2. Base line data
 - 3. Performance vs. projections/base line

ISSUE IDENTIFICATION

I. Core Benefit Package Issues

Underlying assumptions

1. Basic working assumption is that we are starting from a clean slate regarding benefit packages. The working group will be reviewing a variety of options to look at alternative approaches.
2. Mental health and substance abuse covers a wide range of severity that individuals with these disorders experience

A. Options -

- parity with overall proposal
- different in benefit design
 - limits in terms of utilization (days, visits)
 - limits in terms of year/life dollars
 - co-payments and deductibles (possibility of even varying co-pay with use)
 - prescription drug benefits (how is this being handled in overall benefit? should there be provision for particularly expensive drugs)
- Possible models to be examined: Frank et. al, Scheffler, Koyanogi, NAMI/Domenici, CHAMPUS, Medicare, various State Medicaid amount duration and scope -- MHPRC/Scheffler, Wellstone, NAPPH, Interest Groups, MH Liaison Group, Washington Business Group on Health (any others?)
- Are there particular benefits/designs now that are important to incorporate in a mental health specific approach, e.g., Alzheimers categorization, medication management, Medicaid case management, Medicaid rehab, are there other Medicaid benefits that need to be preserved, partial hospitalization
- Are there particular restrictions now that need to be changed? (e.g., IMD definition-- size issue on restricting benefits to those in supportive housing arrangement, 190 day lifetime limit)
- Are there particular design considerations in benefits to better encourage appropriate levels of care, e.g., avoid institutionalization bias
- Prevention services as part of benefit package

-- Administrative complexity, and consumer understanding

B. Eligibility

-- everybody vs. a more restricted approach (e.g., using disability or diagnosis)

-- should there be triaging with first priority for severely ill (is this an issue here or only under the public system?)

C. Benefits that may be particularly unique

-- are there benefits not included in the overall benefit that for example even under parity need to be included here? e.g., case management, rehabilitative, voc. rehab,

E. Role of benefit structure in influencing accessibility

-- are there particular designs which can make accessibility more or less of a problem

F. Collateral Services (other family members) Policy

-- in the presence of limitations both in overall policy of a mental health specific how will collateral services work? Does there need to be specific design related to this?

G. Should there be incentives or requirements for comprehensive integration so that a full range of needed services is delivered (e.g., comprehensive coordinated care including a range of services psychotherapy, pharmacologic management, housing assistance

H. Other Systems Interface

-- in cases of civil commitment or ordered treatment? Who pays? Relationship to any utilization controls, e.g., CHAMPUS experience

--Court ordered care for children

--Child welfare, juvenile justice, education

II. Long Term Care (also see public system below)

-- how is it being handled in overall proposal

-- how to define? e.g., long term institutionalization vs. diagnosis vs. duration of illness vs. expiration of benefit package if has lifetime or year limits

-- is it in or covered elsewhere, trade-off of Federal versus State versus private sector role

III. Role of Public System / Impact on Public System

A. What should be the role for publicly supported programs? How can

we best utilize the existing structure?

- hospitals (State and county system)
- CMHCs and other publicly financed clinics
- infrastructure for community-based care

- B. Is there a role for the public sector in handling LTC? Are there trade-offs to be made (e.g., new system does acute care, public system LTC)
- C. Should there be triaging for use of the public system, e.g., safety net for severely ill, available when benefits are exhausted, should the public system only be available to some and if so who? Should there be priority in the public substance abuse programs for certain patients as is starting to happen now for injection drug use and pregnant women?
- D. What, if any, changes are needed in the public system to adapt to a new design?
- E. VA Role -- need to interface with integration of government programs group
- F. Eligibility for Public System

IV. Severely and Persistently Mentally Ill

- A. Care under managed competition
- B. Adults
- C. Children

V. Children

- A. Options
 - same or different from adult
 - different in benefit design
 - limits in terms of utilization (days, visits)
 - limits in terms of year/life dollars
 - co-payments and deductibles (possibility of even varying co-pay with use)
 - covered settings
 - Possible models to be examined: CHAMPUS, various State Medicaid amount duration and scope, (any others?)
 - Are there particular benefits/designs now that are important to incorporate, getting rid of bias toward institutional care
 - Are there particular restrictions now that need to be

changed?

- Are there particular benefits that need to be considered that promote approaches that are supportive of families

B. Eligibility

- everybody vs. a more restricted approach (e.g., using severity/ diagnosis, priority for kids in child welfare and juvenile justice)
- should there be triaging with first priority for severely ill (is this an issue here or only under the public system?)

C. Benefits that may be particularly unique

- are there benefits not included in the adult benefit that need to be included here? Can the same policy on collaterals work? Relationship to education and IEPs (who pays)?

D. Should there be incentives or requirements for comprehensive integration so that a full range of needed services is delivered, also coordination across service systems (child welfare, education, juvenile justice)

H. Other Systems Interface

- child welfare, juvenile justice, schools

VI. Elderly

A. What are the implications if the new benefit package is substantially different from current Medicare coverage (e.g., new is more generous, is this fair to the elderly and disabled covered by Medicare.

B. What are the human resources necessary to provide services to the elderly? Will health reform provide incentives to provide treatment to the elderly?

VII. Substance Abuse

A. Options

- parity with overall proposal
- same or different in benefit design from mental health
 - limits in terms of utilization (days, visits)
 - limits in terms of year/life dollars
 - co-payments and deductibles (possibility of even varying co-pay with use)
- Possible models to be examined: old NIAAA alcohol proposal, Medicare, various State Medicaid amount

duration and scope, (any others?)

- Are there particular benefits/designs now that are important to incorporate, e.g., Medicaid rehab, treatment for pregnant women
- Are there particular restrictions now that need to be changed? (e.g., IMD definition and residential treatment)
- Are there particular design considerations in benefits to better encourage appropriate levels of care, e.g., avoid institutionalization bias, discourage certain types of practices (e.g., detox only) Should there be incentives in substance abuse for longer term follow-up or retention in treatment

B. Eligibility

- are there similar eligibility issues here?

C. Benefits that may be particularly unique

- are there benefits not included in the overall benefit that for example even under parity need to be included here? e.g., case management, rehabilitative, voc. rehab,

D. Role of benefit structure in influencing accessibility

- are there particular designs which can make accessibility more or less of a problem

E. Co-Morbidity

- how will benefit structure work for co-morbid patients

F. Collateral Services (other family members) Policy

- in the presence of limitations both in overall policy or ADM specific how will collateral services work? Does there need to be specific design related to this?

G. Should there be incentives or requirements for comprehensive integration so that a full range of needed services is delivered (e.g., comprehensive coordinated care including a range of services psychotherapy, pharmacologic management, housing assistance

H. Criminal Justice Interface -- in cases of ordered treatment? Who pays? Relationship to any utilization controls, e.g., CHAMPUS experience

I. Role of Public Sector -- what should be the public sector role; e.g., longer term cases -- methadone maintenance

VIII. Provider Coverage -- Which professionals and what facilities

A. Mental Health

- B. Substance Abuse
- C. Gate-keeper, referral or direct access, psychiatrist referral screening

IX. Case Management and Utilization Control

- A. Relationship to those developed for new system
- B. Use of case management and utilization control to address concerns about appropriate utilization? Administrative feasibility on a large scale basis? Who is responsible (insurer, government)? CHAMPUS experience.
- C. Does substance abuse require anything different?
- D. Possible Models to be explored: CHAMPUS, (?other private sector)

X. Data needs

- A. Community Prevalence -- Eligibility
 - 1. Disorders
 - 2. Impairment
- B. Treated Prevalence -- Service Utilization
 - 1. Percent of population treated by diagnosis/impairment
 - 2. Location of service delivery
 - 3. Volume of services
- C. Cost / Expenditures for services
 - 1. Source of funds for all health care
 - 2. Source of funds for mental health and substance abuse care
- D. Effect of benefit structure on utilization
- E. Sources for data
 - 1. Private insurance data
 - 2. Medicaid
 - 3. Medicare
 - 4. Indian Health Service
 - 5. DOD
 - 6. VA
 - 7. NIMH/SAMHSA

XI. Reimbursement strategies (PPS, TEFRA, capitation)

XII. Particular areas of access concern

- A. Homeless
- B. Minorities
- C. Children, including schools and foster care
- D. Criminal Justice
- E. Substance abusing pregnant women and women with children

- XI. What does managed competition mean for mental health and substance abuse?
- How does mental health and substance abuse fit into the overall design?
 - Role for capitation arrangements
 - Should insurers and or providers in a new system be required to provide mental health or SA in a certain way, for example integrated into primary care settings, or separate; is there a need to deal with contracting out arrangements?
 - Potential for different strategies in a managed care arrangement versus a non-managed care arrangement
 - Should there be a separate global budget for mental health and substance abuse?

Issues for other clusters

1. How does a child get coverage

2. How is that coverage transportable? Children coverage when not with parents, e.g., foster care, or care of other relatives

3. Mental Health/SA group needs to touch base with several other groups:

New System Coverage / benefit

Long Term Care

Integration of Government Programs
VA, DOD, IHS

Budget Caps

Economic Impacts

Quantitative Analytic Support

DRAFT

X. LONG-TERM CARE
PRELIMINARY WORK PLAN
February 10, 1993

MAJOR ISSUES AND QUESTIONS

I. OVERARCHING ISSUES

Questions

A. What are the goals of long-term care reform? Is the goal to:

- **Promote choice in long-term care services?**
- **Prevent dependence on welfare for financing long-term care?**
- **Create a system responsive to the needs of particular groups (e.g., minorities)?**
- **Reduce the care burden of families who are now the principal providers of long-term care?**
- **Improve access to formal services, particularly home and community-based care, including supportive housing arrangements?**
- **Protect people who need long-term care against catastrophic costs?**
- **Help people prefund their long-term care so they can better afford it when they need it?**
- **Create a system of services that are of better quality and a better value for the consumer?**
- **Make the system more efficient while maintaining quality?**
- **Reduce the financial pressure on the states and federal government?**

B. What are the implications for long-term care if there is major restructuring of the overall health care system? For example:

- **If the acute care components of Medicaid are absorbed in a new program, leaving only long-term care, will Medicaid be redesigned as a "new" long-term care program?**
- **How does long-term care fit into the managed competition model?**

C. Will the system be primarily public or private?

- D. Given that comprehensive public solutions are very expensive, what are the budget boundaries of this initiative?

II. DEFINING THE PROBLEM

Questions

- A. What is long-term care? How does it differ from acute care?
- Who needs it? Who gets it?
 - What services are provided? Where are they provided?
- B. What is the current system for financing, delivering and monitoring long-term care? What are the roles of the public and private sectors?
- C. What are the strengths and weaknesses of the current system; why do we need reform?
- D. In the absence of reform, what will be the nature and magnitude of the problem in the future?

What We Know/Don't Know

- A. We know a lot about the problems of the current long-term care system, particularly for the elderly. There has been much written on the rationales for reform.
- B. Much less is known about the nonelderly disabled. With respect to long-term care settings, most of the attention has focused on nursing home and home care. Much less is known about the utilization of supportive housing/assisted living arrangements.

Methodology

- A. Review and synthesis of the literature and relevant policy documents.
- B. Analysis of current data bases.
- C. Contacts with providers and policy people, particularly related to supportive housing issues.

Resources

A. The following national data bases:

The 1982, 1984, 1989 National Long-Term Surveys, the National Health Interview Survey, including the 1984 Supplement on Aging and the 1984-1986 Longitudinal Study; the 1985 National Nursing Home Survey; the 1986 National Mortality Followback Survey; the Survey of Income and Program Participation; the 1987 National Medical Expenditure Survey; the 1986 National Long-Term Care Channeling Demonstration; the 1991 National Health Provider Inventory; the 1990 Decennial Census; the Current Beneficiary Survey.

B. Major studies and reports from the Pepper Commission; the Advisory Council On Medicare and Social Security; DHHS Long-Term Care Task Force; World Institute on Disability; National Rehabilitation Hospital; Rivlin and Wiener; Friedland.

C. Resource persons agency staff; Beth Jackson (SysteMetrics); Charlie Lakin (University of Minnesota); Mitch LaPlante and Paul Newachek (UCSF); Gerben DeJong (National Rehab Hospital); David Mechanic (Rutgers).

Outputs

A. Background piece on these issues.

III. TARGET POPULATION

A. What is the size and characteristics of the various potential target populations; what are the income distributions; what are their service utilization patterns?

B. Who do we plan to cover in this initiative?

- Disabled elderly
- Physically disabled nonelderly
- Mentally retarded, developmentally disabled
- AIDS
- People who need post-acute care for short period after hospitalization?
- Only the severely disabled?

- C. Should we target only to those who cannot afford to pay? How do we define affordability?
- D. Should we target to people who have unmet needs (e.g., not receiving care or receiving inadequate care)?

What We Know/Don't Know

- A. We know a great deal about the elderly long-term care population, including the post-acute and chronically disabled (physically and/or cognitively disabled). We also have some estimates of the nonelderly disabled population.
- B. Our measures of unmet needs among the disabled elderly population are inadequate. Information about the nonelderly disabled is limited. There are problems concerning comparability of definitions of disability across subpopulations. The major knowledge gaps include data on the AIDS population and disabled children.

Methodology

- A. Synthesis of data from existing reports to describe the size and characteristics of the potential target populations.
- B. Analyses of relevant data bases to obtain national estimates of size of the subpopulations and utilization patterns.

Resources

- A. The following national data bases:

The 1982, 1984, 1989 National Long-Term Surveys, the National Health Interview Survey, including the 1984 Supplement on Aging and the 1984-1986 Longitudinal Study; the 1985 National Nursing Home Survey; the 1986 National Mortality Followback Survey; the Survey of Income and Program Participation; the 1987 National Medical Expenditure Survey; the 1986 National Long-Term Care Channeling Demonstration; the 1991 National Health Provider Inventory; the 1990 Decennial Census; the Current Beneficiary Survey.
- B. Major studies and reports from the Pepper Commission; the Advisory Council On Medicare and Social Security; DHHS Long-Term Care Task Force; World Institute on Disability; National Rehabilitation Hospital.

- C. Resource persons include agency staff; Beth Jackson (SysteMetrics); Charlie Lakin (University of Minnesota); Mitch LaPlante and Paul Newachek (UCSF); Gerben DeJong (National Rehab Hospital); Lenny Gruenberg (LTC Data Institute); Ann Scitovsky (UCSF); David Braddock (Univ. of Minnesota).

Outputs

- A. Eligibility criteria for policy options.
- B. Data to estimate expected participation in proposed program, who is excluded, and costs.

IV. PROGRAM DESIGN

BASIC DESIGN ISSUES

- Will the system be primarily public or private?
- If primarily public, what is the role of the private sector and vice versa?
- How do the incentives of the public system impact the private system and vice versa?

PRIVATE PROGRAM DESIGN ISSUES

Questions

- A. Philosophical Approach
- Should it be mandatory that people provide for financing for their long-term care needs (e.g., by saving or purchasing insurance)?
 - Should private insurance or saving for long-term care be subsidized? If so, should the subsidy be universal or targeted to low income groups.
- B. Regulatory Reform
- How could an improved regulatory structure promote wider usage of private insurance?
 - How can consumer protection be improved?

- How can regulation reduce selection and information problems?
- Does private insurance create a distortion in favor of or against certain services? If so, should coverage of some services be mandatory or prohibited?
- Should benefits be standardized? If so, what would be the basic benefit package?

C. Subsidizing Private Insurance

- Should people who purchase private long-term care be given easier access to Medicaid (e.g., RWJ proposal)?
- Should the development of the private markets be encouraged by clarifying the tax status of long-term care insurance?
- Should employer or individual contributions to long-term care insurance be tax exempt or partially tax exempt?
- What mechanisms should be used to integrate low-income people (e.g., vouchers, other public subsidies; public program)?

D. Prefunding Long-term Care with Private Savings

- Should savings for long-term care be subsidized through tax incentives (e.g., individual medical accounts or IRAs)?
- Should the savings be used to purchase insurance or to directly cover expenses for long-term care?

E. Relation to Managed Competition

- What aspects of long-term care can be incorporated into the managed competition model?
- Should alternative insurance models (e.g., social health maintenance organizations, continuing care retirement communities) be promoted?

F. Distributional Issues

- Who would benefit from these initiatives? Who would be left out?
- What special provisions would be necessary for the non-elderly?
- How would insurance be financed for the current elderly and disabled in a system ultimately financed through small premium payments collected over a longer period?
- How would premiums be subsidized for people not able to afford to purchase?

G. Regulation and Oversight

- Should regulation remain a state responsibility, or should national standards be enacted?
- If long-term care were included in the managed competition model, would a separate board be appointed to deal with long-term care?
- How would quality be ensured?

What We Know/Don't Know

- A. We know a great deal about the size of the current market, the barriers to greater participation, and problems in existing regulations of private long-term care insurance and continuing care retirement communities.
- B. Since there have been no governmental efforts to promote private sector initiatives, other than through recent demonstration projects, we have no empirical evidence to indicate the effectiveness of these initiatives, or the costs of these efforts. Substantial analysis has been done, however, using simulation techniques. There has been no research on the inclusion of long-term care in a managed competition model.

Methodology

- A. Review of existing documents that have examined alternative private sector options for the financing of long-term care.
- B. Analyze the cost and impact of tax proposals; estimate the impact of specific, rather than general, proposals to promote private sector options; analysis of the

potential market for employer-sponsored or voluntary purchase of insurance for the nonelderly disabled.

Resources

- A. Studies on long-term care options conducted by the Pepper Commission, Wiener et al., the Health Insurance Association of America, ASPE; proceedings from Congressional hearings on long-term care insurance regulation, and reports by GAO, Consumers Union and Stone et al.
- B. Review of key legislation including insurance regulation and tax clarification components of bills introduced by Bentsen, Kennedy, Waxman and Gradison.
- C. Resource people include Susan Van Gelder (HIAA); Carol Gates (NAIC); Stan Wallack (LifePlans, Inc.); Jay Greenberg (LTC, Inc.); Gail Shearer (Consumer's Union); David Kennell (Lewin/VHI); Rep. Earl Pomeroy; Marilyn Moon (Urban Institute); John Rother (AARP); Phyllis Torda (Families USA); Robert Friedland (NASI).

Outputs

- A. Projections of participation rates for private insurance usage in a mixed public/private system for the various public programs considered.
- B. Options for an insurance-based long-term care program in a managed competition framework.
- C. Cost estimates for various private sector options.

PUBLIC PROGRAM DESIGN ISSUES

Questions

- A. Philosophical approach
 - Do we want to pursue incremental changes to the current system or comprehensive reform?
 - Should the public initiative be provided through open-ended entitlement programs like Medicare or Medicaid or through close-ended categorical or block grant programs like the Social Services Block Grant? Is there a way to combine the concept of entitlement with closed-ended funding?

- Should the public initiative be provided on a means-tested or universal basis without regard for financial need?
- Should benefits be provided on a sliding scale based on financial status?

B. Organization and administration

- How should a public long-term care program be organized at the federal, state and local level?
- What are the implications of organizing a centrally administered program with uniform benefits? How will this impact the ability to provide the necessary range of long-term care services, and to support and complement family-provided care?
- Should states administer a public long-term care program? What are the implications of organizing a state-administered long-term care program which provides considerable flexibility to states to determine eligibility and service benefits? What is the capacity of states to administer efficient and effective long-term care systems?
- What are the most innovative and effective models of organizing and delivering long-term care services now in operation at the state and local level? What makes them effective?
- What organizational models and incentives have proved most effective in redistributing long-term care resources away from institutional services and toward home and community-based services?
- Are there lessons to be learned from effective and efficient service delivery models in other countries?
- What are the organizational and administrative implications of having a single funding source for long-term care versus multiple sources?
- What organizational mechanisms and practices best promote the most efficient use of long-term care resources?

C. Benefits

- What services should be included (e.g., medically-related services, nursing homes, supportive housing, personal assistance and home maker

services in the home, adult day care, respite care, employment-related supports for the nonelderly disabled, case management)?

- How much flexibility should there be in covered services?
- Should nursing home benefits cover the front end, back end, or the total nursing home stay?
- Should benefits be provided as services, cash, or vouchers?
- Should services be agency-directed or client-directed?

D. Who should provide the services?

- Who are acceptable providers under the program?
- How is the family treated as a provider?
- For home care services, what are the relative advantages and disadvantages of an agency v. an independent provider model?

E. Eligibility Determination

- Who should determine eligibility? Does the agency that makes the determination bear any financial risk? What is the recourse for dissatisfaction with the determination?
- Should there be a single point of access for determining eligibility for a new long-term care program? If so, where would it be located and how would it operate?

F. Service Authorization, Coordination and Management

- Who should authorize the use of the services? Does the agency assume any financial risk? What is the recourse for dissatisfaction with the authorization?
- Should case management be required as a way of coordinating and managing a long-term care service delivery system? Should case management agencies also authorize services?
- Should agencies providing direct services also be responsible for case management? Should case management agencies be responsible for quality of services? Who should provide case management?

G. Coordination with other programs

- How should long-term care service systems be coordinated with other related service systems (e.g., acute care; income security; housing; mental health)?
- Should the long-term care delivery systems operated by the Department of Veterans Affairs be integrated with those currently operated by DHHS or folded into a new consolidated system?

H. Rate Setting

- Who will set the rates for reimbursement of providers? States under loose federal guidelines? Local Agencies? Federal government? Individuals?
- Should reimbursement rates be more generous than Medicaid, Medicare rates?
- What reimbursement methodologies should be used? Does the technology exist to risk-adjust capitated payments?

What We Know/Don't Know

- A. Previous long-term care research efforts (e.g., Pepper Commission, DHHS Long-Term Care Task Force, Transition Group) have provided cost estimates and examined the distributional impact of prototypes for most major policy options. We have considerable demonstration and state experience with expanded home care programs. We have a fair amount of information about nursing home and home care utilization.
- B. Little systematic work has been done on costing out policy options for the nonelderly population. We do not know how the demand for home care and nursing home care will respond to insurance coverage. We do not know the optimum amount or types of services for persons with particular disability levels. We do not have an adequate measure of cognitive impairment to use in determining eligibility. We do not know how nursing home and home care prices will respond to insurance coverage.

Methodology

- A. Review of major documents that have already examined key public policy options.

- B. Analyze strengths and weaknesses and provide participation and cost estimates using the ICF/Brookings Long-Term Care Financing Model. Data analysis of the 1989 National Long-Term Care Survey to determine the most recent use of home care services by the elderly. Impacts on the nonelderly must be estimated separately with limited information.
- C. Review of the literature on federal demonstration and state experiences with public program expansion.
- D. Contacts with key resource persons at federal and state policy levels.

Resources

- A. Major data include the ICF/Brookings Long-Term Care Financing Model and the HIAA/Lifeplans Model.
- B. Documents include studies by the Pepper Commission; Wiener et al.; Lifeplans, Inc.; Ball; Moon; Consumer's Union; ASPE. Congressional bills introduced by Pepper, Waxman, Stark, Rockefeller, Mitchell, Kennedy, and Packwood.
- C. Resource persons include agency staff; Korbin Liu and Marilyn Moon (Urban Institute); Gerben DeJong (NRH); Brian Burwell (SysteMetrics); Bob Gettings (National Association of State Mental Retardation Directors); Dave Kennell (Lewin/ICF); Simi Litvak (WID); (?); Diane Justice (NASUA); Trish Riley (National Academy of State Health Policy); Donna McDowell (Wisconsin State Government); Richard Ladd (Texas State Government); Robert and Rosalie Kane (University of Minnesota); John Capitman (Brandeis University); Sarah Watson (Berkeley Planning Associates); Mike Rogers (AAHA); Bob Deane (AHCA); Val Halamandaris (NAHC).

Outputs

- A. Projections of participation rates and indication of who is excluded in various public program options.
- B. Cost estimates of various public program options.
- C. Details of major program design concerns.

V. SUPPLY

QUESTIONS

- A. Is there an adequate supply of institutional, community and home-based services?
- B. What could be done to increase the supply of services in short supply (e.g., assisted housing)?
- C. Is the supply of long-term care workers sufficient to meet demand now and in the future? How can we attract and maintain a quality labor force? Is participation in the long-term care market a potential career track for persons now on welfare?

What We Know/Don't Know

- A. There has been some work done at Penn State and UCSF on the supply of nursing homes, and at U. of Minnesota on ICF/MRs. There are also several current studies examining long-term care labor force issues, particularly regarding paraprofessional workers.
- B. There currently is little information on the supply of assisted living and non-Medicare certified home health agencies or other home care providers.

Methodology

- A. Synthesis of existing documentation examining supply issues.
- B. Discussions with State and local program administrators and providers.

Resources

- A. Studies of long-term care worker issues by Brandeis U., Feldman, and Stone; Studies of supply conducted by ASPE, National Academy of State Health Policy, Charlene Harrington (UCSF), Charlie Lakin (U. of Minnesota).
- B. Resource people include Charlene Harrington and Bob Newcomer (UCSF); Penny Feldman (Harvard); Mick Smyer (Penn State); Catherine Hawes (RTI); representatives from the various provider groups and advocacy groups.

Outputs

- A. Estimates of long-term care supply.
- B. Estimates of long-term care workforce.

VI. QUALITY AND ETHICAL CONCERNS

Questions

- A. Do we want to maintain the quality assurance strategy for nursing homes embodied in OBRA 87 and 90?
- B. Should federal quality regulation be extended to other residential care settings (e.g., assisted living, board and care) and nonskilled home care?
- C. How do we define "quality" in long-term care? What are the best measures? Which specific elements or aspects should be included or especially emphasized in the design of a formal quality assurance system (e.g., adequacy of services, promotion of desirable outcomes, quality of life, promotion of independence and autonomy)?
- D. Who should define and judge the adequacy of quality--clients and their families? professionals and "experts"? payers?
- E. Is there a way to balance client/family autonomy and "empowerment" with the responsibility of government to safeguard the taxpayers' interest as well as those care recipients who are unable to look after their own interests?
- F. What should be the principal mechanisms of a quality assurance system?
 - A traditional regulatory model? (survey and certification, strong emphasis on provider credentialing, etc.)?
 - A "grievance/complaint" system, emphasizing ombudsmen?
 - Case managers who monitor clients' service according to a combination of formal standards but also fulfilling an "ombudsman" and "quality advocate" role?
 - An "information system" model, where computerized data are used to establish "norms" and acceptable ranges of performance, as well as trace the relationship of "inputs" and "processes" of care to desirable and undesirable outcomes?
 - Incentives built into the financing system to promote quality of care?
- G. Should long-term care preferences be an explicit component of Advance Directives for Medicare beneficiaries?

- H. What are the ethical considerations of rationing long-term care services for the disabled?

What We Know/Don't Know

- A. We know that quality of care in nursing homes is a problem.
- B. We know very little about quality of care in residential facilities and in home care. We don't know how to measure quality of long-term care very well.

Methodology

- A. Synthesis of documents on quality of care.
- B. Discussions with researchers in this area, organizations involved in assessing quality of care.

Resources

- A. There are few "databases" in this area apart from Medicaid's computerized nursing home survey and certification information system on nursing homes' compliance with regulatory standards. However, the group could draw upon quality-related research funded primarily by ASPE and HCFA/ORD (e.g., HCFA's quality of care projects done by Peter Shaughnessy and Rosalie Kane, ASPE's board and care study; studies employing the nursing home minimum data set).
- B. Resource people include agency staff, Rosalie Kane, Catherine Hawes, representatives from the State Survey and Certification Directors, JCAH and the League of Nursing; representatives from the key stakeholders/ interest groups including NCCNR, AHCA, AAHA, Assisted Living Association, National Association for Home Health/Home Care, Alzheimer's Association.

Outputs

- A. Assessment of the need for changes in current strategies for ensuring quality of long-term care in different settings.

VII. Cost Containment

Questions

- A. Why is cost containment in long-term care so uniquely difficult and uncertain?

- B. What are the strategies for controlling costs? How well do they limit utilization (demand) under public programs; cost per person (efficient case mix); and prices of long term care services?

- Case management

Is case management an effective mechanism for controlling costs by limiting utilization, cost per person, or prices?

What are the various models? What does it cost?

What is the current capacity to provide case management in the states?

- Cost-sharing

To what extent would cost-sharing (deductibles, coinsurance, copayment) discourage utilization? What empirical evidence exists? What has been the states' experience?

Should cost-sharing vary by income or assets?

Should there be a catastrophic limit on out-of-pocket costs?

- Strict targeting

How effective is strict targeting in limiting utilization?

To what extent is disability likely to be overstated to gain eligibility so that participants "come out of the woodwork"?

- Risk-based capitation

Is risk-based capitation effective in controlling costs? What has been the experience of the SHMOs and CCRCs in achieving this goal?

- Global population-based budgets

How would global budgets affect utilization, cost per person, and prices?

What incentives would it create to control costs?

- C. What strategies could be used to limit long-term care prices independent of broader cost containment strategies?

What We Know/Don't Know

- A. We know a considerable amount about case management, the number of disabled elderly persons at different eligibility levels, the use of nursing home care by length of stay, and the rate setting for nursing homes.
- B. We know little about the price elasticity of demand for nursing home and home care, whether case management agencies could prevent the "woodworking" effect, how to set rates for capitated providers or the ability of these providers to supply care, the utilization of home care, how states or local agencies would behave if faced with a fixed long-term care budget, or whether an appropriated budget would fail to keep pace over time with need.

Methodology

- A. Review of documents on different cost containment strategies.
- B. Contacts with state officials and experts familiar with the experience of state programs.
- C. Case management and global population-based budgeting will be analyzed somewhat more intensively because of the complexity of the implementation issues surrounding them.

Resources

- A. Studies by Kemper, Wiener, Stone, Lewin/ICF; Leutz; Newcomer and Harrington; Moscovice; Rowland.
- B. Resource people include agency staff; Donna McDowell, Trish Riley, Richard Ladd, Diane Justice, Walter Leutz, Robert Newcomer, Robert and Rosalie Kane, John Nyman, Richard Brodie, Marilyn Moon, Bill Scanlon.

Outputs

- A. Array of cost containment strategies, with relative advantages and disadvantages, and appropriateness under each of the policy options

VIII. COSTS OF THE POLICY OPTIONS

Questions

- A. What are the costs of each of the proposals?

- B. How much would be paid by federal, state, and individuals in the future under current programs? Could these funds be used as an offset to future expenses in an expanded program?
- C. What are the distributional effects of the costs among:
- Public and private payers
 - Federal and state governments
 - Low, middle, and high income persons
 - Persons with heavy and low care needs
 - Persons with and without family caregivers
- Persons with catastrophic out-of-pocket costs

Methodology

- A. Estimate the size and cost of serving different groups over the near term and through 2040 for each option.
- B. Use models and agency estimates of long-term care to estimate the current and future expenses of existing long-term care programs.

Resources

- A. Data source for the elderly is the Brookings/ICF model. Data for the nonelderly disabled are limited.

Outputs

- A. Cost estimates for each of the options
- B. Estimates of the distributional effects for different populations.

IX. FINANCING THE INCREASED COSTS OF A NEW PROGRAM

Questions

- A. What sources of funds will be used to pay for the increased expenditures (e.g., general revenues, estate taxes, payroll taxes, employer mandate, dedicated long-term care IRA, private insurance)?
- B. Should the increase in taxes be borne by the biggest users of the services (i.e., the elderly) or should they be borne by the general population? Should there be cross-subsidization across age/income groups?
- C. How much of the increase should be paid by a co-payment or the recipient's family? By state or local governments?
- D. Should there be a dedicated trust fund for the new program or should the federal costs be paid out of general revenues? Should the trust fund be on a pay-as-you-go basis or actuarially solvent on a long-term basis?

Methodology

- A. Models at OMB, Treasury and the private sector will be used to examine the sources of funds and revenues.
- B. Analyses of the advantages and disadvantages of a dedicated trust fund relying on the experience of the social security and medical trust funds. Estimates of revenues and expenses of a trust fund will be made to the year 2040.

Resources

- A. OMB, Treasury and private sector models
- B. Reports from the Advisory Council on Medicare and Social Security.

SCHEDULE

Week of:

- February 1**
- Hold first meeting of the Long-Term Care Work Group for orientation and discussion of goals and objectives
 - Review transition documents related to long-term care
 - Begin to identify available resources
 - Organize tentative policy analysis subgroups
 - Prepare draft work plan
- February 8**
- Present draft work plan and revise based on Task Force comments and recommendations
 - Finalize policy analysis subgroups and establish liaison with other work groups
 - Subgroups meet to lay out and assign major tasks, identify appropriate resources including information needs, key informants, and schedule for talking to outside groups, and outline specific tasks to be accomplished
 - Subgroups begin information gathering and identify options to bring to work group
 - Convene options meeting to identify major reform approaches to be "put on the table" and to outline criteria for evaluation of policy options and selecting target groups
- February 15**
- Present revised work plan to the Task Force
 - Subgroups continue information gathering
 - Target population subgroup prepares initial estimate of size of potential target populations

- Cost estimates subgroup prepares specifications for costing out selected options
 - Convene one work group meeting to review progress of the subgroups
 - Subgroup on public options meets with work group addressing low-income health needs in new system coverage group
- February 22
- Options are costed out and evaluated based on criteria established by the work group members
 - Subgroups continue information gathering and begin policy analyses
 - Subgroups hold two weekly status meetings
 - Preparation of briefing materials on the range of options for the Task Force
- March 1
- Formal presentation of the broad long-term care options to the President and Task Force
 - Subgroups continue policy analyses
 - Convene two subgroup progress meetings
- March 8
- Work group holds meetings with audit and legal teams to review the analyses of proposed options
 - Work group develops recommendations to Task Force
- March 15
- Based on recommendations from the Task Force, work group members narrow range of options and identifies option(s) that will form the basis for the long-term care proposal
 - More refined analyses of proposal are conducted, including more detailed cost estimates
 - Subgroups continue policy analyses of issues related to design and implementation of the recommended proposal

- Subgroup meets with low-income group
 - Convene two subgroup progress meetings
- March 22
- Policy analyses continue
 - Proposal is further refined based on numbers and legal audits and input from outreach people
 - Subgroups working on design and implementation issues submit reports for incorporation into draft long-term care proposal
 - Preparation of draft long-term care proposal, including discussion of how it fits into larger health plan and identification of key issues for decision by Task Force
 - Critique of proposal by work group "murder board"
- March 29
- Presentation of draft proposal to the Task Force
 - Further analyses of implementation issues and preparation of backup reports by subgroups
- April 5
- Further refinements of the long-term care proposal based on comments from President, outreach people, etc
- April 12
- Preparation of revised draft long-term care proposal, incorporating information from additional analyses of implementation issues
 - Work group meets with legislative group to draft legislative specifications
- April 19
- Final draft of proposal prepared for presidential review
- April 26
- Legislative specifications finalized

- Subgroup meets with low-income group
 - Convene two subgroup progress meetings
- March 22**
- Policy analyses continue
 - Proposal is further refined based on numbers and legal audits and input from outreach people
 - Subgroups working on design and implementation issues submit reports for incorporation into draft long-term care proposal
 - Preparation of draft long-term care proposal, including discussion of how it fits into larger health plan and identification of key issues for decision by Task Force
 - Critique of proposal by work group "murder board"
- March 29**
- Presentation of draft proposal to the Task Force
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- Further refinements of the long-term care proposal based on comments from President, outreach people, etc
- April 12**
- Preparation of revised draft long-term care proposal, incorporating information from additional analyses of implementation issues
 - Work group meets with legislative group to draft legislative specifications
- April 19**
- Final draft of proposal prepared for presidential review
- April 26**
- Legislative specifications finalized
- May 3**
- Home free

DRAFT

XI. ECONOMIC IMPACTS

PRELIMINARY WORK PLAN

February 10, 1993

Economic Analysis Module of Health Care Taskforce

I. Background Paper (ready by Tollgate 2)

o Analysis and description of trends in health care spending

Aggregate

- real growth of per capita health care spending
- share of GDP devoted to health care
- projections of spending
- growth of managed care institutions
- lack of insurance coverage

Breakdowns of Aggregate Spending

- prices, volumes, and intensity, by payer
- health care spending by provider type
- health care spending by payer type
- distribution of spending by State
- rates of growth in spending by State

Government

- Federal spending by program
- effect on deficit
- projections of effect on deficit
- prices, volumes, intensity, aging effects
- studies on welfare persistence
- intergenerational distribution
- State governments

Private Sector

- wages/productivity
- personal savings
- total employment
- income growth
- corporate profits
- international competitiveness (imports/exports)
- investment (infrastructure/human capital)
- job mobility
- hours of work
- insurance coverage by firm size
- non-wage benefits

Health Care Sector

- employment
- earnings
- efficiency
- R&D

- o **Economic rationale of health care problems**
 - inefficiencies from fee-for-service reimbursement
 - too many unnecessary procedures
 - bias towards cost-increasing technology
 - selection by insurers
 - insurance too heavily experience-rated
 - incomplete coverage over time
 - limits on job mobility
 - lack of information about health care providers
- o **Other background issues**
 - state-level distributions
 - firm/establishment size
 - HMO/PPO distribution
 - specialty mix by State
 - studies of economic incentives
 - price responsiveness of medical care demand
 - price responsiveness of insurance demand
 - adverse selection literature
 - other concerns
 - minimum wage workers and health insurance
 - administrative expenses and total expenses
 - interpretation of medical care prices
 - comparison to other countries
- o **Side-by-side of health care reform proposals**
 - assess important proposals based on list of issues developed below

II. Economic Analysis of Proposals (continuous work)

- o Assess the magnitude and distribution of the effects of proposed policy reforms on the private and public sectors:**
 - effects in the long run
 - effects during the transition period
 - effects on aggregate health care spending
- o Develop a list of issues for qualitative analysis of reform proposals**

Governments

- effect on Federal budget, by program
- effect on State budgets
- effect on local budgets
- intergenerational distribution
- intergovernmental transfers
- welfare persistence

Private Sector I: Individuals

- wages
- income growth
- non-wage benefits
- part-time/full-time employees
- job mobility
- illegal immigrants
- skilled/unskilled workers
- youth employment
- retirement decision
- seasonal workers
- unemployment duration
- dual income families
- moonlighting workers

Private Sector II: Firms

- corporate profits (levels and variability)
- large firms/small firms
- new business formation
- small business
- self-employed
- noncompliance
- discrimination against families, disabled, etc.
- current health insurance providers/non-providers
- self-insured/non-self-insured
- cyclical employment patterns

- workers compensation programs
- contract/leased employees
- industries: manufacturing/service/agriculture
- offshore labor (job flight)
- retiree benefits

Private Sector III: Macroeconomic Effects

- personal savings
- R&D/Technological Change
- aggregate employment
- output growth

Health Sector

- administrative costs
- choice of treatment
- adverse selection and risk selection

Distribution of Benefits/Costs by Group

- age
- race
- region (state)
- urban/rural
- income
- union/non-union
- family size

III. Methods and Data

- o Summarize existing documents from CEA, OMB, HHS, CBO, JCT, HCFA, DOL, and published economic literature**
- o Interact with quantitative analysis group in use of microeconomic and macroeconomic models**

NEW SYSTEMS ORGANIZATION STAFFING

I. NEW SYSTEM ORGANIZATION

Chair: Walter Zelman

Outside Consultants:

Gary Claxton, Rick Kronick, Lois Quam, Lynn Etheredge, Larry Levitt, Rick Curtis, Shoshana Sofaer, Pete Welch, Sen.

Mitchell: Christine Williams, Rep. Gephardt: Andie King

A. Budgets and Caps

<u>Department</u>	<u>Contact</u>
Veterans	Patricia O'Neill
OMB	Randy Lutter Panashar Patel
HHS	George Schieber Nancy Delew
CEA	Sherry Glied
Treasury	TBD

B. HIPC Organization

<u>Department</u>	<u>Contact</u>
Veterans	Patricia O'Neill
OMB	Steve Bandeian
Treasury	Randy Hardock
HHS	Peter Hickman Jim Lubitz Leslie Greenwald

C. Organization, Boards, Federal and State Oversight

<u>Department</u>	<u>Contact</u>
OMB	Jack Langenbrunner
Treasury	Alicia Munnell

D. Insurance Reform

<u>Department</u>	<u>Contact</u>
Treasury	TBD
HHS	Leslie Greenwald Peter Hickman Jim Lubitz
Justice	Greg Vistnes
Labor	Bette Briggs Dan Maguire Robert Copeland
CEA	Debbie Lucas

NEW SYSTEM COVERAGE STAFFING

II. NEW SYSTEM COVERAGE

Chair: Judy Feder - HHS, Atul Gawande - HHS

A. Benefits

<u>Department</u>	<u>Contact</u>
Treasury	Robert Gillingham
Veterans	Bob Roswell
Labor	Steve Finan
Commerce	John Edgell
HHS	Pam Short Linda Bergthold
OPM	TBD
Outside Consultants	Diane Rowland Bob Valdez Shoshanna Sofaer Linda Bergthold

B. Coverage for Working Families

<u>Department</u>	<u>Contact</u>
HHS	Alan Monhait
Treasury	Randy Hardock
Labor	Dan Maguire
CEA	Darryl Wills
OMB	Bob Anderson
Commerce	TBD
Outside Consultant	Alan Kreuger

C. Coverage For Families Without Work Connection Populations

<u>Department</u>	<u>Contact</u>
HHS	David Cooper Julia Paradise Elmer Smith Steve Clauser Don Johnson
VA	Beth Smith
Treasury	Randy Hardock
OMB	Cheri Rice
CEA	Andrew Lyon
Labor	Joe Hight John Beverly
Outside Consultants	Diane Rowland Shoshanna Sofaer Bob Berenson Carolyn Handy
Commerce	Sherry Courtland

NEW SYSTEM INFRASTRUCTURE AND SUPPORT STAFFING

Quality Measurement

III. NEW SYSTEM INFRASTRUCTURE AND SUPPORT

Chair: Tom Pyle

A. Quality Measurement

Task Group Leader: Arnold Epstein; Special Consultant:
David Eddy

<u>Department</u>	<u>Contact</u>
HHS	Henry Krakauer Goldfield Risa Lavizzo- Mourey Barbara Gagel Linda Demlo
DOD	COL Timothy McKee CPT Paul Tibbits, M.D.
Veterans	John Williamson Bill Mudd
Outside Consultants	Alan Hillman Kathy Lohr Arnold Epstein

NEW SYSTEM INFRASTRUCTURE AND SUPPORT STAFFING

Information Systems

III. NEW SYSTEM INFRASTRUCTURE AND SUPPORT

Chair: Tom Pyle

B. Information Systems

Task Group Leader: David Eddy

<u>Department</u>	<u>Contact</u>
OMB	Paul Kuzmack Bruce McConnell Shannah Koss McCollum
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Justice	Greg Vistnes
DOD	John Silva
PPRC	Roz Lasker
Commerce/NIST	Dennis Steinauer David Eddy William Jews

NEW SYSTEM INFRASTRUCTURE AND SUPPORT STAFFING

Malpractice and Tort Reform

III. NEW SYSTEM INFRASTRUCTURE AND SUPPORT

Chair: Tom Pyle

C. Malpractice and Tort Reform

Task Group Leader: Bob Berenson; Special Consultant: Dan Creasey

<u>Department</u>	<u>Contact</u>
HHS/ASPE	Beth Hadley
Justice	TBD
HHS/AHCPR	Kathleen Hastings Jacqueline Besteman
HHS	Caroline Taplin Glen Aukerman Nancy Baum
Outside Consultants	Alan Hillman Bob Berenson

NEW SYSTEM INFRASTRUCTURE AND SUPPORT STAFFING

Facilitating Professional Development for a Health Care System

III. NEW SYSTEM INFRASTRUCTURE AND SUPPORT

Chair: Tom Pyle

D. Facilitating Professional Development for a Health Care System

Task Group Leader: FitzHugh Mullen, Linda Aikens; Special
Consultant: David Satcher

<u>Department</u>	<u>Contact</u>
HHS	Fitzhugh Mullen Marc Rivo Marla Solomon Marcy Gross
Labor	Frank Wilson
Veterans	Elizabeth Short Fortunato Kennedy
DOD	Lucretia McClenney-Elliott
Medicare	Tom Ault
Outside Consultants	Linda Aiken David Satcher

**INTEGRATION OF GOVERNMENT HEALTH PROGRAMS
INTO NEW SYSTEMS STAFFING**

Medicare

IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS

Chair: Steve Bandeian - OMB

Outside: Josh Weiner, Aaron Shirley

A. Medicare

<u>Department</u>	<u>Contact</u>
OMB	Andy Swire Bob Kazden
HHS	Barbara Cooper Ira Burney Tom Hertz Peter Hickman
Outside Consultants	Mike Hix Pete Welch

**INTEGRATION OF GOVERNMENT HEALTH PROGRAMS
INTO NEW SYSTEMS STAFFING**

DOD

IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS

Chair: Steve Bandeian - OMB

B. DOD

<u>Department</u>	<u>Contact</u>
OMB	Jim Fish
DOD	Steve Lilly Joel Slackman COL Ed Miller, M.D. COL Robert Claypool COL Vernon Spaulding, Jr. M.D.
VA	Art Hamerschlag Jose Coronado
HHS	Barbara Cooper
Outside Consultants	Chuck Phelps (?) Mike Hix

**INTEGRATION OF GOVERNMENT HEALTH PROGRAMS
INTO NEW SYSTEMS STAFFING**

Veterans

IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS

Chair: Steve Bandeian - OMB

C. Veterans

<u>Department</u>	<u>Contact</u>
OMB	Todd Grams
Veterans	Alline Norman Karen Walters
DOD	Ken Cox

**INTEGRATION OF GOVERNMENT HEALTH PROGRAMS
INTO NEW SYSTEMS STAFFING**

Federal Employees (FEHB)

IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS

Chair: Steve Bandeian - OMB

D. Federal Employees (FEHB)

<u>Department</u>	<u>Contact</u>
Labor	Diane Svenonius Bob Copeland
OMB	Bob Wyler
OPM	Curt Smith Abby Block
VA	Kendall Posey

SHORT-TERM COST CONTROLS STAFFING

VI. SHORT-TERM COST CONTROLS

Chair: Paul Starr

<u>Department</u>	<u>Contact</u>
CEA	Howard Leathers Kim O'Neill
OMB	Len Nichols Randy Lutter Jack Langenbrunner Shannah Koss Rich Kuzmack
Labor	Bette Briggs Mark Wilson
Justice	TBD
HHS/HCFA	Steve Sheingold Ira Burney Kathy Buto George Greenberg Nancy McCall Ken Thorpe Tim Hill
Treasury	James Ukockis
Veterans	Louise Rodriguez
MIT	Peter Diamond Steve Zuckerman
DOD	John Silva
Commonwealth Fund	Karen Davis
Congress	CBO, PPRC, PROPAC, CRS Lisa Potetz

PUBLIC FINANCING STAFFING

VII. PUBLIC FINANCING

Chair: Marina Weiss - Treasury

<u>Department</u>	<u>Contact</u>
Treasury	Randy Hardock Alicia Munnell Jim Duggan
CEA	Kevin Berner
HHS	Fred Hellinger Roland King Joe Antos Paul Jackson
OMB	Andy Swire Parashar Patel
Veterans	Victor Raymond
External	Vic Miller (?)

**HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS
AND PREVENTIVE HEALTH STAFFING**

**VIII. HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS AND
PREVENTIVE HEALTH**

Chair: Bonnie Lefkowitz, Mark Smith

<u>Department</u>	<u>Contact</u>
Veterans	Susan Mather
OMB	TBD
HHS	Bonnie Lefkowitz Ron Carlson
Labor	Ruth Shinn
White House	Sarah Rosenbaum
Commerce	Nampeo McKenney
CEA	Lucy Allen
Veterans	Ken Link
DOD	Larry Sobel
Outside Consultants	Diane Rowland Mark Smith Richard Veloz Aaron Shirley

MENTAL HEALTH STAFFING

IX. MENTAL HEALTH

Chair: Dr. Bernie Arons - OVP; Mrs. Gore

<u>Department</u>	<u>Contact</u>
Veterans	TBD
DOD	Peter Brock
HHS	Alan Leshner Sharman Stephens Mike English
HUD	TBD
OVP	Charlotte Hayes
Media Affairs	Bob Boorstin
Mrs. Gore's Office	Skila Harris
NIMH/NIH	Darrel S. Regier Grayson Norquist
Human Services Collaborative	Sheila A. Pires

LONG-TERM CARE STAFFING

X. LONG-TERM CARE

Chair: Robyn Stone - HHS

A. Background

<u>Department</u>	<u>Contact</u>
HHS	Mary Harahan Nancy Miller
VA	Mary E. Smith Marsha Goodwin
Outside Consultant	Richard A. Veloz

LONG-TERM CARE STAFFING

Public

X. LONG-TERM CARE

Chair: Robyn Stone - HHS

B. Public

<u>Department</u>	<u>Contact</u>
HHS	Mary Harahan Jennie Harvell Peter Kemper
VA	Mary E. SMith
CEA	Debbie Lucas
Outside Consultants	Steve McConnell Josh Wiener

LONG-TERM CARE STAFFING

Private

X. LONG-TERM CARE

Chair: Robyn Stone - HHS

C. Private

<u>Department</u>	<u>Contact</u>
HHS	Peter Kemper Jennie Harvell
VA	Marsha Goodwin Mary E. Smith
CEA	Debbie Lucas
OMB	Mark Wasserman
Outside Consultants	Steve McConnell Josh Wiener

LONG-TERM CARE STAFFING

Cost & Revenue

X. LONG-TERM CARE

Chair: Robyn Stone - HHS

D. Cost & Revenue

<u>Department</u>	<u>Contact</u>
HHS	Steve Clauser
Treasury	Terry Jacobs
OMB	Mark Wasserman
CEA	Debbie Lucas
Outside Consultant	Josh Wiener

ECONOMIC IMPACTS STAFFING

XI. ECONOMIC IMPACTS

Chair: David Cutler - CEA

<u>Department</u>	<u>Contact</u>
CEA	Sherry Glied
Treasury	Bill Dinkelacker
OMB	Len Nichols Bob Anderson
Labor	Mark Wilson
HHS	Ken Thorpe Amy Taylor
Commerce	David Kass
Outside Consultants	Alan Kreuger

QUANTITATIVE ANALYSIS STAFFING

XII. QUANTITATIVE ANALYSIS

Chair: Ken Thorpe - HHS

<u>Department</u>	<u>Contact</u>
HHS	Office of Actuary AHCPR National Center for Health Jim Mays Gordy Trapnell Jonathan Witter John Moeller Dean Farley Holly Harvey Darrel S. Reiger Pat Doyle Karen Beauregard Donald Goldstone
CEA	David Cutler Sherry Glied
Treasury	Janet Holtzblatt
OMB	Ron Nichols Bob Anderson Randy Lutter Len Nichols Steve Bandeian
Labor	Richard Hinz
Commerce	David Kass
Outside Consultants	Urban Institute Rand
Congress	CBO - Chuck Seagrave, Nancy Gordon, Paul Vanderwater Joint Tax - Louise Sheiner
VA	George Sheldon