G. EMPLOYERS/EMPLOYEES

1. Employer payroll cap
2. Caps on employer contributions
3. Employer/employee share
4. Employer-employee contributions
5. Treatment of worker's compensation
6. Grandfathering of large firms
7. How can we sell the plan to business?
8. Impact on large companies providing insurance
9. Effects on corporate location decisions
10. When employee may pay more than 20%
11. Procedures for collecting from employee
12. Tax treatment of employer-paid employee share
13. Unearned income only
14. Employer/employee share -- children
15. Employer/employee share -- working children
16. Temporary workers and consultants
17. Employee share for temporary workers
18. Nannies
19. Authority for Individual Mandate

EMPLOYER PAYROLL CAP

QUESTION:

Will employers always be capped at 7.9% of payroll?

ANSWER:

Yes, the employers' 80% share will always be capped at no more than 7.9% of payroll; however, these caps do not apply to corporate alliances. Contributions for employers with 50 or fewer employees are capped at a lower level, based on the average wage for the firm. There is no plan to phase-out these subsidies.

CAPS ON EMPLOYER CONTRIBUTIONS

QUESTION:

How did you arrive at the 7.9 percent cap? Did you do simulations for the size of the subsidies at higher cap amounts? How does the 7.9 percent compare with what employers are paying now?

ANSWER:

- Today, many small employers pay over 10 percent of their payroll for health insurance. These employers will be eligible for caps varying from 3.5 percent to 7.9 percent of payroll.

- Caps are important because they limit the amount any employer must pay for health care. Under the current system, premiums can double or triple, leaving employers exposed to health care premiums which can be devastating to overall solvency.

- Simulations were done at a variety of cap amounts. 7.9% was chosen as the best way to balance the costs of additional subsidies and employer protections.

EMPLOYER/EMPLOYEE SHARE

QUESTION:

Since firms pay the lower of 80% of the average premium or 7.9% of payroll, they could "game" the system by restructuring the company to put the low wage employees into a subsidiary. Is there any protection from such restructuring?

ANSWER:

The Department of Labor is taking the lead in developing ways to prevent this type of gaming. For example, we are looking at not counting subsidiaries as separate employers for purposes of calculating the wage base subject to the subsidy cap. In addition, we will avoid gaming that may arise through the hiring of contract workers. An employer is responsible for the health costs of any contracted workers who derive eighty percent or more of their income from that employer.

EMPLOYER-EMPLOYEE CONTRIBUTIONS

QUESTION:

Is it the intent that all Americans will be required to pay 20 percent even if their employer wants to pay more?

ANSWER:

No. Employees are free to pay 100 percent of premiums.

TREATMENT OF WORKER'S COMP.

QUESTION:

Wouldn't it be easier to limit premiums on workers' compensation rather than the complex way you are doing it in the plan? (Rep. Harriet Johnson)

ANSWER:

- Worker's compensation is a complex area.

- Our plan takes a first step towards simplifying workers compensation arrangements by requiring health plans to provide workers compensation services to injured workers. Employers will continue to pay health plans for these services. This assures that employees will receive coordinated care from the same health plan.

- Initially, our plan does not integrate the premium structure for workers compensation benefits. The workers compensation insurance program remains a separate plan. This separation is desirable in order to retain employer's incentives to reduce hazards in the workplace and to reduce the burden on regional Alliances, who would find the development of a community-rated premium structure which included workers compensation experience a significant challenge.

- Our plan calls for studying this complex issue, conducting pilot programs, and developing recommendations concerning the integration of workers compensation premiums at a later time.

GRANDFATHERING OF LARGE FIRMS

QUESTION:

If you are grandfathering large firms (greater than 5000 employees), why don't you also grandfather large unions?

ANSWER:

- In fact, large firms are not being "grandfathered" in. In order to form corporate alliances, firms will be required to meet a series of standards established by the federal government, such as providing universal coverage, a choice of plans and eliminating pre-existing exclusion clauses.

- For union members who belong to Taft-Hartley plans, these plans will have the option of forming their own corporate alliance, as long as they adhere to the federal standards described above.

HOW CAN WE SELL THE PLAN TO BUSINESS?

QUESTION:

How do we go about selling this plan to the business community when there is such skepticism about the numbers?

ANSWER:

- For the first time ever, businesses' outlays for their employees' health coverage will be capped at a maximum of 7.9% of their payroll costs. For small, low-wage firms, their contributions are capped at even lower rates. This is in contrast to the current situation, where health care costs can consume an even higher and unpredictable percentage of employers' payroll costs.

- Not only will businesses' total outlays for health coverage be capped, but annual increases in these outlays will decrease and become predictable. This is in contrast to the current situation where health costs for some businesses grow as much as 50 percent a year, and few businesses are able to plan how much they will need to pay for health care the following year.

- Large businesses will have the option of running their own alliance or joining regional alliances.

- The government will subsidize 80% of the premium costs of early retirees, providing significant financial relief for businesses with large obligations for retirees and older-than-average workforces.

IMPACT OF PLAN ON LARGE COMPANIES NOW PROVIDING INSURANCE

QUESTION:

How do we sell this plan to a company with 800 employees that has a good plan already, and a good preventive/wellness program too?

ANSWER:

In the example case, the plan virtually sells itself. From the employees' perspective:

- o Benefit package provided under the President's plan is equivalent to Fortune 500 companies' current coverage.

- o In addition, under the President's plan:
  - -- choice is expanded;
  - -- preventive benefits are guaranteed;
  - -- coverage is secure; and
  - -- lifetime benefit limits now found in virtually all current plans are eliminated.

- o The President's plan will control out-year growth in health care costs, so resources now drained to pay for surging health care costs can be shared as real wage increases.

From the employer's perspective:

- o Employee health care costs born by employers have been growing at a rate that's out of control. In 1970, these costs were equal to about one third (31.1%) of total after-tax business profits. By 1991, these costs were virtually equal to total (97.5%) after-tax profits.

  - -- President's plan will control health care cost growth.

- o Insuring employers are further disadvantaged by cost-shifting: they are subsidizing the costs of care for employees of competitors and others who do not have health care coverage.

  - -- President's plan levels the playing field among employers by making all responsible for their employees' coverage.
  - -- President's plan will end cost-shifting; costs to those now providing quality insurance will be reduced.

KEY INFORMATION

- o Between the early '60s and '90s, real health care costs grew by more than 450 percent but real wages by less than 7 percent.

EFFECTS OF PLAN ON CORPORATE LOCATION DECISIONS

QUESTION:

Will your health plan stimulate corporate migration across state lines? (Rep. Ackerman)

ANSWER:

No. Incentives for inter-state corporate migration will be slowed.

- Current differences among states in the costs they impose upon employers for health care as a result of insurance benefit mandates and to fund hospital bad debt and care for the uninsured will virtually disappear. Similarly, differential scopes in costs, coverage, and benefits under Medicaid among states will be substantially reduced.

- Historic differences among states in patterns of employer-provided health insurance -- reflecting in part differential unionization -- will largely disappear.

CIRCUMSTANCES IN WHICH THE EMPLOYEE MAY PAY MORE THAN 20%

QUESTION:

Can the employee pay greater than 20 percent?

ANSWER:

- Yes, but only as a result of the employee freely exercising choice among plans.
  - -- The employer makes a fixed contribution equal to 80 percent of the weighted average premium of plans offered by the Alliance.
  - -- The employee, however, chooses freely among the plans offered by the Alliance. If the specific plan selected by the employee is more costly than the weighted average of all plans, the employee is responsible for the difference.
  - -- Employees may choose plans more expensive than the average for a variety of reasons, including a desire for access to specific physicians, hospitals or other providers who may be associated with those plans.

KEY INFORMATION

Self-employed persons are subject to paying 100 percent in their dual role as both the employer and the employee. In such cases, however, the entire cost of the plan is a tax deductible expense.

PROCEDURES FOR COLLECTING EMPLOYEE PREMIUM CONTRIBUTION

QUESTION:

How do you force employees who don't have their ~~twenty percent~~ contribution deducted from their paycheck to pay their fair share?

ANSWER:

Payment Procedures:

- Alliances must establish procedures for collecting funds - including payroll deduction. Procedures for direct payment will be needed for unemployed and self-employed individuals, and can apply to others as well.

- Amounts owed the Alliance are individual debts and are subject to collection procedures and court proceedings as are other business debts.

Subsidy Levels:

- The Alliance will establish a declaration system and rules of evidence (e.g., submit last year's tax return) for individuals who request low income subsidies.

- The Alliance must also establish procedures for determining whether people were in fact eligible for subsidies and for recouping money from those who were not.

TAX TREATMENT OF EMPLOYER-PAID EMPLOYEE SHARE

QUESTION:

For employers that currently pay 100%, once the plan is in effect will the 20% that the employee would have had to pay be taxable?

ANSWER:

No. Employer provided benefits for the guaranteed benefit package are always tax preferred.

UNEARNED INCOME ONLY

QUESTION:

What would a person who has only unearned income pay?

ANSWER: In general:

- A person with only unearned income is responsible for both the 80 percent employer share and the 20 percent employee share.

SUBSIDIES:

Individuals with unearned income contribute towards their premiums according to a sliding scale which increases as the amount of unearned income increases:

- Individuals with unearned income would be eligible for a subsidy on the 20 percent share of the premium if their unearned income is below 150 percent of the poverty line.

- Individuals with unearned income would be eligible for a subsidy on the 80 percent share of the premium if their unearned income was below 250 percent of the poverty line.

EMPLOYER/EMPLOYEE SHARE -- CHILDREN

QUESTION:

How will children be covered under the plan?

ANSWER:

- Children will be covered under a family policy. Premiums will be single parent and kids or two parents and kids. Annual premiums will be determined based on the category into which the family falls.

- Poor children will be enrolled in family plans like any other children. Subsidies will be available for those families with income under 150% of poverty.

- Public health initiatives will improve the health of the nation's children through adolescent clinics, immunization, violence prevention, etc.

- The uniform benefits package will cover well-baby care (immunizations, etc.), prenatal care, substance abuse for pregnant mothers to improve the health of babies and young children.

~~Dual~~
Both employers contribute to the cost of insurance for dependents of dual-working spouses.

EMPLOYER/EMPLOYEE SHARE -- WORKING CHILDREN

QUESTION:

If children are older and working, how will they be covered under the plan? Will that change if they earn higher incomes?

ANSWER:

- Dependent working children up to age 22 are part of ~~a family plan.~~ their parent's plan. They, and their employer, are not responsible for any contribution toward the premium because the entire premium is paid by the parents and their employers.

- ~~So long as a child is a dependent, his or her income and the number of hours worked is irrelevant to the employers contribution. That is taken care of by his or her parent's employer(s). Whether the dependent working child will contribute to the family's share is for the family to decide.~~ does not impact the subsidy the family might be eligible for

EMPLOYER/EMPLOYEE SHARE -- TEMPORARY WORKERS AND CONSULTANTS

QUESTION:

How will temporary workers and consultants be covered under the plan?

ANSWER:

- Any employer with an employee who works more than 10 hours a week must make ~~the appropriate~~ a prorated contribution toward ~~an~~ that employee's health premium.

- Temporary workers are generally employed by an agency which contracts their services to another company. The temporary agency would ~~then~~ be required to contribute toward the employer's share.

- Consultants are self-employed and are responsible for their entire premium. However, ~~if a consultant or contractor receives over 80% of their income from one source, that source is considered to be an employer and is responsible for the employer's contribution.~~

The rules for independent contractors ~~would~~ are consistent with the current Treasury definitions.

EMPLOYEE SHARE FOR TEMPORARY WORKERS

QUESTION:

How do you deal with temporary workers and what will the employee share be? (Rep. Mink)

ANSWER:

- Temporary workers join alliances ~~and~~ the ~~employer~~ employee pays 80 percent of the weighted average premium (or a prorated share if the temporary worker is only a part time employee).

- The employee is responsible for the difference between the employer contribution and the premium of the selected plan.

  -- If the temporary employee qualifies for a subsidy, that subsidy is provided.

EMPLOYER/EMPLOYEE SHARE -- NANNIES

QUESTION:

How will nannies be covered under the plan?

ANSWER:

- Nannies will be treated identically to any other employee. The employer (the family) will make a contribution toward the nanny's premiums based on the nanny's family status (e.g., single, couple, single parent, two parent)

- Full-time nannies get the full employer share paid on their behalf. Part-time nannies get a part-time employee contribution made on their behalf. They are responsible for paying the remainder of the plan's premium.

- Families may be eligible for government subsidies for their contribution toward the employers share as a small business (assuming they have less than 50 employees working for them).

- Nannies may be eligible for subsidies for their share if their income is less than 150% of poverty.

AUTHORITY FOR INDIVIDUAL MANDATE

QUESTION:

What is the constitutional authority for the individual mandate, and how will it be enforced?

ANSWER:

- Article I, Section 8 of the Constitution provides authority to promote the general welfare of the people and also to regulate interstate commerce, both of which apply to requiring individuals to have health insurance.

H. SUBSIDIES

1. Small Business Subsidy / Schedule
2. Small Business Subsidy / Eligibility
3. Small Business Subsidy / Criteria
4. Small Business Subsidy / Gaming the System
5. Small Business Subsidy / Adverse Impact
6. Unemployed from Corporate Plan
7. Dependent Coverage
8. Unemployed Subsidy / Low Income Subsidy
9. Low Income Subsidy / Entitlement
10. Low Income Subsidy / Too Low
11. Wages in Tips
12. Subsidy between Corporate Alliance and the Regional Alliance
13. Retiree Subsidy / Windfall for Companies
14. Retiree Subsidy / New Entitlement
15. Subsidies to Middle Income Workers?

SMALL BUSINESS SUBSIDY / SCHEDULE

QUESTION:

Describe the subsidies available for small business? What percent of small firms will get subsidies? (Rep. Synar)

ANSWER:

- To mitigate the cost of employee coverage for small business, a ~~subsidy~~ discount will be offered to firms with 50 and fewer employees that also have average annual wages less than $24,000.

- For these firms the employer contribution will be capped based on a sliding scale ranging from a low of 3.5 percent of payroll for firms with an average wage less that $10,000 up to the 7.9 percent cap ~~applicable to all firms once the employee wages reach $24,000~~.

- This ~~subsidy~~ discount will be paid by the Federal government and accounts for about $10 billion of the estimated $70 billion in total Federal subsidies in the plan.

- We believe a small business ~~subsidy is needed~~ discounts are needed to prevent an undue adverse economic impact on small businesses, while also ensuring that small employers pay their fair share. I believe that we can largely agree to that principle. We would be happy to work with your Committee on the specifics of the small business subsidy.

- Among the two-thirds of small businesses who contribute to employee health care plans, small businesses pay, on average, about 12 percent of payroll. We, therefore, ~~suspect that most small businesses will qualify for the subsidy~~. We will be estimating the number of small firms covered by the subsidy, but I do not have that figure at this time.

SMALL BUSINESS SUBSIDY / ELIGIBILITY

QUESTION:

Will individuals who own a number of small-employee franchise operations be eligible for the small business subsidy?

If a small town operates as a small employer of municipal workers, would the town be eligible for the subsidy?

ANSWER:

- As currently proposed, franchise owners could be eligible for the small business subsidy if they meet the employee and payroll criteria, but government entities are not eligible.
- We would be pleased to make changes in this provision to clarify the eligibility criteria and ensure that it as fair as possible to all entities.

SMALL BUSINESS SUBSIDY / CRITERIA

QUESTION:

Did you consider whether profit margin should be a factor in determining the subsidy for small businesses? Shouldn't there be some flexibility in setting the subsidy instead of relying solely on a schedule based on number of employees and average wage? (Rep. Ackerman)

ANSWER:

- We believe that the subsidy should be directed at small firms who hire predominately low wage employees. Our intent is to partially offset the increase in labor costs incurred by small firms for contributing their share to the health plan to cover their workers. The subsidy also should mitigate any layoffs that might otherwise occur among small businesses.

- While we believe that small business owners should pay their fair share, we are open to other ways for addressing this issue or other factors that should be considered in the subsidy criteria. However, I would be concerned that including firm profits as a factor in setting the subsidy may cause other problems and may also have a stifling impact on small firms.

SMALL BUSINESS SUBSIDY / GAMING THE SYSTEM

QUESTION:

Is the $24,000 salary cut-off for the small business subsidy an incentive for a firm to keep salaries low? (Rep. Pelosi)

ANSWER:

- We believe that firms would not artificially keep employee wages low in order to qualify for the subsidy, because this would lead to higher employee turnover, higher training and other costs ~~that would have a greater impact on the firm's~~ bottom line.

- However, we want to hear about improvements you think should be make to the small business subsidy proposal. Our proposal should be viewed as the starting point.

SMALL BUSINESS SUBSIDY / ADVERSE IMPACT

QUESTION:

What happens to a small business whose profit margin is only 1 percent and would have to pay 3.5 percent of payroll for health care even under the best conditions of the small business subsidy? (Sen. Robb)

ANSWER:

- If the firm has a 1 percent profit margin and is currently contributing to employee health plans, then it is on average paying over 11 percent of payroll now and switching to 3.5 percent under the plan would be an economic benefit.
- If the firm has a profit margin of only 1 percent and is not currently providing health coverage, it would have to cut costs in other areas of its operation to cover the health benefit.
- However, we believe that 3.5 percent, which is below the customary cost of living adjustment to wages, is a reasonable and affordable minimum contribution for small employers with low wage employees.

What we're proposing less would have less an impact than an increase in the minimum wage.

UNEMPLOYED FROM CORPORATE PLAN

QUESTION:

If a person is a member of a corporate alliance and they lose their job, what happens?

ANSWER:

- The person would stay in the corporate plan until the next enrollment period at which time they would be enrolled in the regional alliance. During this period the alliance would compensate the corporate plan for the employer's share of the premium.

- During the period of unemployment the person would be eligible for a subsidy for the individual's premium share if their total income is less than 150 percent of poverty and eligible for a subsidy to pay part or all of the employer's share if their unearned income is less than 250 percent of poverty.

DEPENDENT COVERAGE

QUESTION:

At what age do children lose coverage under their parents' plan and how are they then covered?

ANSWER:

Children are covered as family dependents through age 22 if attending college and through age 18 for those not attending college. At that point children make their own enrollment decisions within the regional alliance.

UNEMPLOYED SUBSIDY/LOW INCOME SUBSIDY

QUESTION:

What subsidies will be paid to unemployed individuals? What if they have unearned income such as interest from savings accounts, alimony, etc?

ANSWER:

- Unemployed persons and heads of working households with incomes below 150 percent of poverty are eligible for a subsidy or discount from the employee's share of the premium (20 percent share).

- In addition, unemployed individuals whose incomes are below 250 percent of poverty are eligible for a subsidy for the employer's share of premium (80 percent). Unearned income is counted and may be used to pay part or all of the employer's share.

- Unearned income includes the same non-wage components that would go into adjusted gross income. For example, these may include interest, dividends, royalties, rent, alimony, capital gains, recruitment and signing bonuses, and other similar receipts. VA educational benefits, educational grants and stipends would not be included.

LOW INCOME SUBSIDY / ENTITLEMENT

QUESTION:

Are the low income subsidies an entitlement? Will they be appropriated annually? What happens if an alliance refuses to subsidize a low income person?

ANSWER:

- **The low income subsidy is an entitlement in the sense that the dollars are guaranteed.**
- **Plans for the operation of the regional alliances must be approved by the Federal government. If an alliance refused to play by the rules and subsidize a low income person as required, the State government would have responsibility for correcting the situation and the Federal government would have an oversight role.**

Question for ~~How do those refused~~ By what mechanism are subsidy dollars actually transferred to the alliance

Answer — We'll work on this one

Welcome your views

LOW INCOME SUBSIDY / TOO LOW

QUESTION:

Why do subsidies cut off at 150 percent of poverty? What would be the estimated burden for a family of four at 151 percent of poverty? What is that income level? What would it cost to make the subsidies more generous?

ANSWER:

- The low income subsidy is larger at lower income levels and declines to zero as income approaches 150 percent of poverty. However, we are continuing to look at alternative ways of scaling the subsidy and we are open to suggestions on this issue.

- To use your example, 150 percent of poverty for a family of four is approximately $22,000. The national average insurance premium under the plan for the family in this case would be $840 per year. We think this is a reasonable rate and offers them a far superior plan to what they can afford under the current system.

WAGES IN TIPS

QUESTION:

Will restaurant employees be required to include income from tips in determining whether they are eligible for subsidies? (Rep. Moran)

ANSWER:

Yes, income from tips is part of earned income and would be included in calculating whether a worker is eligible for the low income subsidy of the employee share of premium.

SUBSIDY BETWEEN CORPORATE ALLIANCE AND THE REGIONAL ALLIANCE

QUESTION:

Describe the subsidy that can occur between the regional alliance and a corporate plan. For example, suppose we have a two-worker family where one person is employed in a large self-insured corporation and the spouse is employed in a company covered within the regional alliance. What subsidies are involved and do they differ depending on the plan selected?

ANSWER:

The couple will be responsible for the employee share regardless of which plan they select. If they select a plan within the regional alliance, the corporation would pay an amount to the regional alliance equal to 80 percent of the ~~adjusted average~~ per worker premium ~~for one worker~~. If the couple chooses the corporate plan, the alliance would write a check to the corporate plan for the same amount.

regional alliance

The couple may be eligible for a subsidy for the family share of the premium if they are low income and enrolled in a regional alliance plan.

If they are in a Corporate plan their share of the premium would be subsidized. Because the Corp. Alliance must give credit to low income workers (below 15,000) the emp. ~~Corp~~ premi contri that is greater of 80% of the ave. prem or 95% of the lowest prem premium.

RETIREE SUBSIDY / WINDFALL FOR COMPANIES

QUESTION:

Won't the subsidy for early retirees create a windfall for corporations by covering their retirees that normally would have been covered under their retiree health plans?

ANSWER:

- (2) With the restructuring of the health care system, some employees may retire early who have not retired under the current system because they could not afford to or could not qualify for health care coverage on their own.

- (3) For employees who retire between the ages of 55 and 65, the employer premium share is fully subsidized. This will provide needed protection for workers, insuring that their health care insurance is secure in their retirement.

- (1A) ~~It also~~ gives relief to companies ~~helping them to~~ so they can hire new workers, make needed investments, and better compete in the global economy.

(1) Our large mfg companies are at a competitive disadvantage with their global competitors - and soaring health care costs are a prime contributor. By helping ease the burden of health care costs for early retirees, we're helping to level the playing field - !

Question
How does the retiree subsidy work?

Answer
- the early retirement subsidy is available to anyone between the ages of 55 & 65 who have at least 40 quarters of SS covered employment
- Under this subsidy the alliance will pay the 80% employer share of the premium on behalf of the individual. ~~[illegible]~~

Gov. offer retiree
health coverage
must contribute
the 50% family share
of the premium for the retiree.

Key info: i.e.

1 Technically any non working individual
~~meets~~ meeting these criteria (retiree or unemployed)
(whether retiree or unemployed
would be eligible for this subsidy

1 We are still considering whether to
this subsidy for indiv
cap ~~[illegible]~~ some income level
above

RETIREE SUBSIDY / NEW ENTITLEMENT

QUESTION:

Are you creating a totally new entitlement program for early retirees? Won't it provide an incentive to stop working and retire early? (Rep. Karen Shepherd)

ANSWER:

- The federal subsidy for retirees between 55 and 65 will offset the employer's share of the premium. It will not affect the cost of health care to the worker or change in any way who is eligible to retire.

- ~~However,~~ Employees who are eligible to retire in the 55-65 age group may retire in higher numbers. This may be encouraged by the guarantee of health coverage and the certainty of limited premium increases during the retirement years.

- We are aware of this potential impact on behavior and the resulting financial impact on pension systems. We are modelling alternative policies and a surcharge is being contemplated on corporations to take account of these factors.

SUBSIDIES TO MIDDLE INCOME WORKERS

QUESTION:

Because of regional differences in the cost of health care in high wage areas and because of the cap on payrolls will you be subsidizing middle income workers? (rep. Kennedy and rep. Levy)

ANSWER:

- It is true that in high cost areas, the payroll cap for employers will protect a higher level of wages. For example, in an area with an average wage of $20,000 the cap will take effect when premiums exceed approximately $1600 while in area with an average wage of $4,000 the cap will take effect when premiums exceed approximately ~~$320~~ $1,600. Thus firms will be subsidized for workers with higher wages in the first area than in the second area.

- However, high cost areas will not necessarily get a disproportionate share of subsidies beacuse high cost areas also tend to be high wage areas.

unrealistically low

Change first example to:
$30,000 average wage
$2400 premium

Change second example to
$20,000.

I. COST CONTAINMENT

1. How will the plan control cost using budget targets?
2. Respond to experts who say that the plan won't cut costs?
3. Preventing excess among plans within a single Alliance?
4. Reducing volume without rationing?
5. Will the plan lower costs in areas with sparse population?
6. May physicians absorb the 20% copayment?
7. How do budget targets work for corporate alliances?
8. What happens if the premium cap kicks in for fee-for- service?
9. Disparities in premium cap for high-cost & low-costs areas?
10. Plans to control costs for home health care?

COST CONTROL THROUGH BUDGET TARGETS

QUESTION:

Fixing premiums won't control costs - describe how the plan will control costs using budget targets.

ANSWER:

- The proposed system ~~is~~ are driven by market forces, not the government or a predetermined budget.

- Premium caps exist only as a backstop, ~~in case market forces do not limit premium growth rates to desired levels~~ -- an emergency brake on spending. If an alliance's average premium (weighted according to the number of people in each plan) is above its target, the alliance may either renegotiate premiums with its plans or impose an assessment on each plan whose premium is above the alliance target.

- This assessment will bring the alliance's average premium down to its target.

COST SAVINGS UNDER THE NEW SYSTEM

QUESTION:

Last week the New York Times said a wide range of experts say your plan won't cut costs nearly as much as you hope and will actually increase the deficit. The experts also said the only way you could achieve such savings would be through broad cuts in medical services, and that the Medicare cuts would be technically and politically impossible to achieve by the year 2000. How do you respond?

ANSWER:

Changing incentives in the health care market place will have a significant impact on health care costs. Evidence from around the country shows this can be accomplished by creating new rules for health plans, enabling plans to bid in large purchasing pools, and encouraging consumers to choose lower cost plans. Plans can get savings because we know that:

1. There are large amounts of fraud and abuse and waste in the current system.

2. There is a large amount of administrative waste in the current system.

3. There is a large amount of wasteful tests, defensive medicine, and unnecessary medical procedures in the current system.

4. An emphasis on preventive medicine will also lower costs.

E.g. Mayo Clinic has held it cost increases to 3.9%.

COST CONTAINMENT -- EXCESS CAPACITY

QUESTION:

How will your plan prevent excess capacity among competing plans within a single Alliance? (Sen. Bingaman)

ANSWER:

•Anti-trust reform will make it easier for hospitals to merge and for physician networks to form. If the hospitals are sufficiently small, mergers meeting certain tests will be presumed to meet the requirements of the anti-trust laws. For larger hospitals, the Justice Department will give advisory opinions to hospitals considering such mergers.

•Plans themselves will have incentives to contract only with those hospitals that do not have excess capacity, in order to reduce their premium bids to the Alliance. In this manner, the Alliance structure will create disincentives to excess capacity.

COST CONTAINMENT -- OVERUTILIZATION

QUESTION:

How do you plan to reduce volume without rationing?

ANSWER:

- Each health plan will be responsible for controlling utilization and for keeping their premiums competitive with other health plans within the Alliance structure.

- Currently, as much as 30% of all medical services provided are unnecessary services. Eliminating these unnecessary services will reduce volume while maintaining access to necessary services (avoiding rationing)

- Deductibles in high cost sharing plans and copayments in low cost sharing plans will make consumers more cost conscious about their health care decisions.

- The share of the premium paid by consumers will make consumers more costs conscious about the plans in which they choose to enroll. Consumers will want to enroll in the health plan that delivers the best care at the best price. This will induce plans to monitor carefully both the quality of the care provided to consumers and the costs involved in managing their plans. By making plans manage care more efficiently with an emphasis on maintaining quality, appropriate services will be provided.

- Outcomes research will continue in an effort to better understand which services are most appropriate under given medical circumstances. As more is learned about the appropriateness of services, those services will be provided instead of other less appropriate services. A more efficient health delivery system will result.

COST CONTAINMENT -- RURAL AREAS

QUESTION:

How will managed competition lower costs in areas with sparse population?

ANSWER:

- States have the flexibility to adopt a health reform model appropriate to their circumstances. They can select a single payor system for their entire state or a part of the state.

- Public health initiatives will serve to increase the number of health care providers in rural areas and to enhance the capabilities of those providers to deliver effective health care.

~~Do~~ Costs will be lowered through administrative streamlining - standardizing reimbursement forms, standardizing the benefits package; an emphasis on primary and preventive services; and ~~insurance~~ better information about the effectiveness and costs of different treatments.

COST CONTAINMENT -- COPAYMENTS

QUESTION:

Currently, some physicians absorb the 20 percent copayments rather than collect from poor people or from supplemental plans. Will your plan prohibit that? (The assumption is that it has no effect on utilization if covered by supplemental plans.)

ANSWER:

- We are considering permitting physicians to forgive individuals coinsurance in fee-for-service plans if they so desire. This would amount to their voluntarily lowering their fee. We are allowing this in the Medicare program

BUDGETS FOR CORPORATE ALLIANCES

QUESTION:

How do the budgets work for corporate alliances? Are there separate targets for corporate alliances?

ANSWER:

- Corporate alliances ~~also have~~ must also meet the premium targets, set nationally.
- Corporate alliances that fail in two of three years to meet the budget target will be required to join a regional alliance.

COST EFFECTIVE FEE-FOR-SERVICE PLANS

QUESTION:

What happens if the premium cap kicks in for fee-for-service?

- The premium caps function the same way for the fee-for-service plans as for all other health plans. Plans which become subject to a premium cap will have to lower their premiums in proportion to the amount they are causing the alliance to exceed its budget. In the case of fee-for-service plans, however, the fee schedules for providers will be lowered.

VARIATIONS IN PREMIUM CAPS ACROSS THE COUNTRY

QUESTION:

How will the premium cap work between high-cost areas and low-cost areas of the country? Do you plan to even out these disparities?

ANSWER:

- Initially, there will be no attempt to even out these disparities; rather, premium caps will be set as a rate of increase in premiums, not an absolute premium.

- As incentives change and information becomes available, we expect the variation among areas to narrow over time.

- The National Board will has the responsibility to develop a plan to reduce regional disparities in health spending and report its recommendations to the Congress.

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CONTROLLING HOME AND COMMUNITY-BASED CARE COSTS

QUESTION:

What plans do you have to control costs for the home and community-based care system?

ANSWER:

- The long term care proposal will greatly expand access to home and community-based care for the severely disabled. But it is a capped system.

J. FINANCING

1. Will the system pay for itself?
2. Cost of the new system
3. Financing from current system
4. Will there be adequate coverage of costs?
5. Source of subsidies
6. Will corporate assessments fund subsidies?
7. Can providers absorb more Medicare reductions?
8. How will "sin" taxes be used?

WILL THE SYSTEM PAY FOR ITSELF?

QUESTION:

Will the financing be sufficient to completely cover all of the costs, or will some of the costs still be financed through deficit financing i.e., will the system pay for itself?

ANSWER:

- The system does more than pay for itself. It will actually reduce the deficit by $91 billion, (as a result of lower federal spending for health programs).

COST OF THE NEW SYSTEM

QUESTION:

What is the cost of the current system versus what you want to implement? Are we talking about paying more in the next five to ten years?

ANSWER:

- In the first few years of the new system (1994-97), there will be a short term increase in national health care expenditures of approximately $100 billion relative to what we would pay without reform.

- After full implementation of the new system, a combination of market driven competitive forces and back-stop limits on the growth of premiums will limit the rate of increase in national health expenditures to a level well below what it would be without reform.

- By the end of the century, national health will be at a lower level and at a lower rate of growth than it would have been without reform.

- By the year 2000, $91 billion in deficit reductions will be obtained from lower health care cost growth.

FINANCING FROM THE CURRENT SYSTEM

QUESTION:

Overall, how much of the financing will come from "squeezing out" excesses in the current system?

ANSWER:

- New provisions specific to health reform will be financed through a combination of Medicare and Medicaid savings, savings from other federal programs such as the Federal Employees Health Benefits Program, sin taxes, and revenue gains.

- Savings realized due to "squeezing out" excesses will not be used to finance new aspects of the health system; rather, they will be passed on to consumers in the form of lower rates of growth in premium costs.

WILL THERE BE ADEQUATE COVERAGE OF COSTS?

QUESTION:

How confident are you that the dollar amounts dedicated to the subsidy fund are sufficient to cover anticipated costs?

ANSWER:

- Each month, the federal government will transfer to the health alliances adequate funds to cover their subsidy costs; therefore, there will always be adequate funding to cover the alliances' responsibilities.

- If an alliance exceeds its budget, the following year there will be a premium adjustment to cover the excess.

SOURCE OF SUBSIDIES

QUESTION:

What is the source of the $70 billion in government subsidies, and what is the breakdown of Medicare and Medicaid savings in the $70 billion?

ANSWER:

- In the aggregate, the health reform plan is self-financing, with total revenues equalling total expenditures plus a small amount of deficit reduction.

- Government subsidies are only one part of health care reform. We will also be making investments in long term care, Medicare drug coverage and public health improvements.

- This reform will be financed through several sources, including:

    - savings from Medicare and Medicaid,
    - "sin" taxes, including tobacco taxes
    - assessments from corporate alliances
    - contributions from businesses and individuals who currently do not pay for health insurance
    - additional federal tax revenues resulting from increases in businesses' profits and individuals' wages due to health reform

- The amount of subsidies is roughly equal to the amount which will be paid by those who do not contribute for health insurance at the present. Medicare savings will mainly be redirected to finance the new prescription and long-term care benefits. However, specific savings dollars have not been targetted for specific new uses, such as employer and individual subsidies.

We also will make investments in CR, Medicare drug coverage, PH improvement.

SOURCE OF SUBSIDIES (REDO)

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(2)

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This is being redone

WILL CORPORATE ASSESSMENTS FUND SUBSIDIES?

QUESTION:

What percent of the subsidy fund will come from corporate assessments?

ANSWER:

- Corporations who choose to form their own health alliances will be asked to pay a 1% assessment. This charge will generate approximately $105 billion of revenues a year combined with taxes on tobacco.
- These funds will be added to funds contributed by regional alliances. Together, they will be used to support general systems costs, such as:
  - expanding the public health infrastructure
  - training physicians
  - supporting health research

?

check

Isn't the $105 B what we project as a 7-yr. figure for tobacco tax alone, not inc. surcharge?

CAN PROVIDERS ABSORB MORE MEDICARE REDUCTIONS?

QUESTION:

Won't taking another $124 billion out of Medicare cause more practitioners to abandon Medicare patients?

ANSWER:

- The Health Security plan will control health care costs throughout the system, and this will enable government to slow Medicare growth in provider payments without jeopardizing the access of Medicare beneficiaries to providers.
- Medicare providers will not be placed under any disproportionate burden relative to other providers.

HOW WILL SIN TAXES BE USED?

QUESTION:

What percent of the financing will come from "sin taxes," and will they be phased in?

ANSWER:

- The Administration estimates that taxes on tobacco and corporate alliances will raise approximately $105 billion, which will be about one-seventh of all revenue generated for health reform and deficit reduction.

- These taxes will not just raise revenue. More importantly, they will encourage healthy behavior on the part of all Americans.

- Sin taxes will be implemented relatively early. They will provide revenue both for starting the new system and for maintaining it once it is in place.

K. STATE PROGRAMS

1. Single Payer
2. Corporate Alliances
3. Fee-For-Service Option
4. Insurance Companies
5. State Flexibility
6. Revenue Source
7. Cost-Sharing
8. Low-Income Persons
9. Consumer Choice
10. Any-willing-provider?
11. Penalties
12. Plan Approvals

STATE PROGRAMS - SINGLE PAYER

QUESTION:

If States choose to establish a single payer plan, can they have an expanded richer benefit package?

ANSWER:

- Yes, any State may provide health benefits in addition to those guaranteed under the comprehensive national package.
- However, in order to expand benefits, a State must appropriate revenue from sources other than those established by the Health Security Act to support delivery of the nationally guaranteed benefit.
- A State may not rely on employer contributions or another revenue source applicable solely to corporations or payroll.

STATE PROGRAMS - CORPORATE ALLIANCES

QUESTION:

Would corporations over 5000 continue to be allowed to self-insure if the State chooses a single payer approach?

ANSWER:

- Yes, but only for those employees not living in the State choosing the single payer approach. Those employees will have to enroll in the single payer system.

STATE PROGRAMS - FEE-FOR-SERVICE OPTION

QUESTION:

How can you have one fee-for-service option in each State and a single payer option? (Sen. Daschle)

ANSWER:

- Under a single payer plan, the State or designated agency makes all payments to health care providers with no intermediaries assuming financial risk.

- That is essentially a fee-for-service option although payments may also be made to HMO's, networks of physicians and hospitals.

STATE PROGRAMS - INSURANCE COMPANIES

QUESTION:

In a single payer State, what would happen if they choose only one insurance company?

ANSWER:

- They can't. But single payer states may contract with health plans organized by providers.

STATE PROGRAMS - STATE FLEXIBILITY

QUESTION:

How much flexibility will States have to design their own programs? There are some innovative programs out there both on the State and community level.

ANSWER:

- Within a Federal framework, States will have substantial flexibility to design and implement reform, including a single payer system. States will have the flexibility to structure alliances to best meet local needs.

- Federal legislation will establish a framework for health reform, including a comprehensive benefit package, budgets, quality standards, insurance reform, and employer and individual mandates to purchase health insurance.

- States will be able to choose their approach to cost containment and meeting budget targets. They will have the responsibility of certification of health plans, monitoring quality of and access to care and implentation of insurance and malpractice reform.

STATE PROGRAMS - REVENUE SOURCE

QUESTION:

If a State chose to establish a single payer program why couldn't it raise revenues through whatever source it wanted instead of through an employer mandate?

ANSWER:

- In order to achieve universal access and offer the same basic benefits package to everyone it is important to have uniformity across States with the revenue sources as well.

- In determining what our revenue source would be we looked at several options and decided that the employer mandate was the fairest and least disruptive since under the existing system most people are insured by their employer.

- Finally, if we allowed one State to choose another form of revenue, there could be incentives for companies to move from a State which might have an employer mandate.

STATE PROGRAMS - COST-SHARING

QUESTION:

Can States propose a cost-sharing arrangement that differs from the national plan?

ANSWER:

- No, the guaranteed benefits package, including cost-sharing are nationally defined.

STATE PROGRAMS - LOW-INCOME PERSONS

QUESTION:

Are there sources of subsidies for the cost share portion born by low-income persons? Can the State opt to pay for it?

ANSWER:

- Low-income families, with incomes below 150 percent of the poverty line, have cost-sharing reduced to the levels in the "low cost-sharing plans" if there is no low cost-sharing plan available.

- People who qualify for SSI are guaranteed that level of cost-sharing in a fee-for-service plan regardless of whether a low cost-sharing plan is available.

- Yes, the State can opt to pay for it, but it must appropriate revenue from sources other than those established by the Health Security Act to support delivery of the nationally guaranteed benefit.

STATE PROGRAMS - CONSUMER CHOICE

QUESTION:

What happens to consumer choice of plans in a single payer State?

ANSWER:

- In a single payer State - States pay providers directly. "Providers" may include HMOs or physician networks, therefore a choice of plans could exist in a single payer State.

STATE PROGRAMS - ANY-WILLING-PROVIDER?

QUESTION:

Does the any-willing-provider clause apply in single payer states?

ANSWER:

- Yes, single payer systems must allow any "qualified" provider that is offering services under the guaranteed benefit package and who is willing to accept payment under the fee schedule to receive payment for services provided to beneficiaries.

STATE PROGRAMS - PENALTIES

QUESTION:

Will States be penalized, in effect, if they wait for the last possible date to establish their reform programs?

ANSWER:

- States can begin implementation of the new system as early as January 1, 1995 and all must have implementation plans approved by the National Board by January 1, 1997.

- The Board may extend the deadline for six months for States that have made a good faith effort to begin implementation of the new system.

- Incentives are offered for States implementing reform prior to January 1, 1997. The incentives include:

  - access to special start-up funds

  - access to subsidies

  - expedited federal consideration, with federal disapproval of State plans only if failure to comply with statutory requirements.

STATE PROGRAMS - PLAN APPROVALS

QUESTION:

How long will it take for the National Board to approve State reform plans? Doesn't our recent experience with the long Medicaid waiver application process suggest this will take a great deal of time?

ANSWER:

- For States implementing reform prior to January 1, 1997 their plan amendments will receive expedited federal consideration, with federal disapproval of State plans **only** if failure to comply with statutory requirements.

L. MEDICARE

1. Shift Between Medicare and Alliances
2. Why a Separate Premium for Medicare Enrollees?
3. End Stage Renal Disease Program
4. Will Providers Have to Absorb Medicare Savings?
5. Will Medicare Savings Close Rural Hospitals?
6. Medicare Savings or Cuts?
7. Medicare vs. Alliance Coverage
8. Changes to Medicare Out of Pocket Limits
9. Are Early Retirees Better Off than Medicare Recipients?
10. Are you Dismantling Medicare?
11. Medicare High Rate of Spending Growth
12. Are You Capping Medicare?

WHY A SEPARATE PREMIUM FOR MEDICARE ENROLLEES?

QUESTION:

If your goal is to have an integrated system, why a separate premium for Medicare enrollees? (Ways & Means staff)

ANSWER:

- Plans negotiate rates with alliances for participants over age 65 choosing to remain in the alliance; these rates are separate from those covering young participants.
- Because the Medicare benefit package is different that the guaranteed benefit package, a separate rate is required.
- Any plan providing coverage through an alliance must bid to cover the older population to continue operating as an alliance plan.

END STAGE RENAL DISEASE PROGRAM

QUESTION:

What happens to the end-stage renal disease program under Medicare? (Ways and Means staff)

ANSWER:

- There are no changes in the end-stage renal disease program under Medicare.

WILL PROVIDERS HAVE TO ABSORB MEDICARE SAVINGS?

QUESTION:

Since you are generating Medicare and Medicaid savings that cannot be shifted, doesn't this mean that providers will have to absorb these savings? (Sen. Levin)

ANSWER:

- Under the Plan, savings will be derived from slowing the rate of growth of the Medicare program, not cutting Medicare payments.

- Costs will not be shifted to the private sector because the Health Security Plan will replace Medicare savings with additional payments for the uninsured and underinsured populations.

- We do expect providers to change and become more efficient.

- However, it is unfair to characterize this reform as a loss to providers.

  1) In guaranteeing a comprehensive benefit package to all, we are adding ~~$80 billion~~ money to the system.

  2) We are removing enormous paperwork/administration costs from the system.

  3) We are providing incentives and financial assistance for providers to organize into more effective networks and live within the budget.

WILL MEDICARE SAVINGS CLOSE RURAL HOSPITALS?

QUESTION:

Will the $124 billion Medicare savings cause rural hospitals to close?

ANSWER:

- Under the Plan, savings will be derived from slowing the rate of growth of the Medicare program, not cutting Medicare payments.

- In addition, many rural hospitals will be designated as "essential community providers". During a five-year transition phase, health plans in underserved areas are required to contract with and reimburse established community-based providers that are designated as essential community providers.

- Additionally, the reform proposal would provide new grants and loans to underserved areas to support capacity expansion and to provide access to health care for low-income, underserved, hard-to-reach, and otherwise vulnerable populations.

BACKGROUND:

- At the end of the five years, health plans either demonstrate their capacity to provide access for all participants or continue contracting arrangements with essential providers. Providers become integrated into health plans or join together to create new, community-based health plans.

MEDICARE SAVINGS OR CUTS?

QUESTION:

What you are calling $124 billion in savings, my constituents will call cuts, how do you respond to them? (Rep. Kennedy and Richardson)

ANSWER:

- Remember, we are talking about $124 billion on a base of $1.4 trillion.
- We are not cutting Medicare benefits; we want to reduce the growth in Medicare.
- Medicare beneficiaries will see their benefits enhanced under our plan with the addition of prescription drug benefits.
- In addition, Medicare benefits will be enhanced with a new long-term care/home and community-based service program for the severely disabled-including the elderly.

MEDICARE VS ALLIANCE COVERAGE

QUESTION:

Will Medicare coverage be as good as the coverage offered by the alliances?

ANSWER:

- No, benefits differ primarily because Medicare cost sharing is higher. However, we are adding substantial new coverage for prescription drugs.
- Medicare beneficiaries who choose to remain in an alliance plan when they reach 65 will continue to get the nationally guaranteed comprehensive benefit package available to younger individuals. However they will pay a premium for these added benefits equal to the difference between the plans premium - Medicare Contribution
- Fee-for-service Medicare benefits will not be as comprehensive as fee-for-service benefits in alliance plans.
- In addition, Medicare benefits will be enhanced with a new long-term care/home and community-based service program for the severely disabled-including the elderly.

BACKGROUND:

- The current Medicare program has no protection against catastrophic illness expenses unless the beneficiary is enrolled in an HMO.

CHANGES TO MEDICARE OUT-OF-POCKET LIMITS?

QUESTION:

Will there be changes to the Medicare out-of pocket limits and what are the projections?

ANSWER:

- Currently there are no out-of-pocket limits in Medicare, and this would not change under the reform plan.
- Under the new prescription drug benefit, the annual out-of-pocket limit will be $1,000.00.

ARE EARLY RETIREES BETTER OFF THAN MEDICARE RECIPIENTS?

QUESTION:

Aren't early retirees better off under your plan than Medicare beneficiaries? (Rep. Shepard)

ANSWER:

- Unclear - The situations are not exactly comparable. It would depend on the availability and price of Medigap policies.
- Early retirees will still be required to cover 20% of their premiums and will be covered through the alliance.
- Medicare beneficiaries will have the choice to continue in the Medicare system enhanced with prescription drug coverage and long-term care/home and community based services or move into the alliance system - and pay a premi for the non Medicare benefits

ARE YOU DISMANTLING MEDICARE?

QUESTION:

I presume the Administration is knowingly dismantling Medicare by providing no incentive for beneficiaries to stay with the program. If it is dismantled, what happens to the payroll tax? (Rep. Stark)

ANSWER:

- We are not dismantling Medicare. The program is maintained as a separate system with additional choices offered to beneficiaries.
- Medicare beneficiaries will see their benefits enhanced under our plan with the addition of prescription drug benefits and long-term care/home and community-based service program for the severely disabled.
- At age 65, an individual may choose to enter the Medicare program or remain in his/her current health alliance plan. If a person remains in a health alliance plan, Medicare pays its share of the premium using Part A and Part B funds.
- Individuals may choose to remain in an alliance, those who do will have to pay a premium. It is unclear how this will affect their behaviors.

The Medicare Trust Funds are held harmless.

MEDICARE HIGH RATE OF SPENDING GROWTH

QUESTION:

Why is the Medicare budget rate of spending growth higher than that for the private sector?

ANSWER:

- Medicare budet rate of spending growth is higher because the elderly population is growing at a faster rate than the under 65 population. In addition, expenses grow faster among this older and sicker population.

ARE YOU CAPPING MEDICARE?

QUESTION:

Are you proposing a hard cap on Medicare?

ANSWER:

- We are committed to slowing the growth in Medicare. The ~~$125~~ billion savings figure is the one that would result from applying a hard budget to Medicare. We have then identified specific policy changes that would produce this level of slower Medicare spending growth.

- An alternative approach would be to apply an enforceable cap on Medicare.

- Both of these approaches are under consideration.

M. MEDICAID

1. Welfare Recipients under the Plan
2. Treatment of Medicaid Eligibles under the Plan
3. Supplemental Services Under Medicaid
4. Low-income -- Separate Plans
5. Disproportionate Share
6. State Maintenance of Effort
7. Long Term Care
8. Medicaid Subsidies SSI

M. MEDICAID

1. Welfare Recipients under the Plan
2. Treatment of Medicaid Eligibles under the Plan
3. Supplemental Services Under Medicaid
4. Low-income -- Separate Plans
5. Disproportionate Share
6. Per Capita Medicaid Spending -- Premiums
7. State Maintenance of Effort

WELFARE RECIPIENTS UNDER THE PLAN

QUESTION:

What happens to people who move off and on the welfare rolls?

ANSWER:

- All individuals, whether they receive cash assistance from a Federal program or are employed will be enrolled in an Alliance and will have a choice of plans.

- Once an individual leaves a cash assistance program for employment, they may choose to continue in their health plan but will be required to pay the 20% share of the premium if their income is above 150% of the poverty level. If they have income at or below 150% of poverty, their premiums will be subsidized.

- When an individual is on Welfare, Medicaid pays the premium. When the individual leaves Welfare they pay the premium, subject to subsidies.

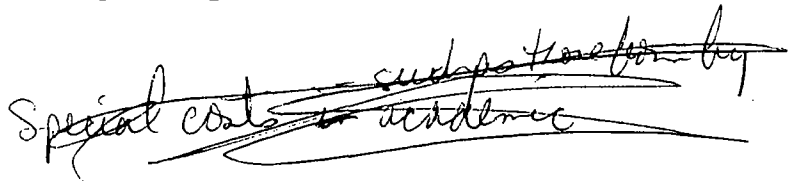
DISPROPORTIONATE SHARE

QUESTION:

What happens to the disproportionate share program under the Plan?

ANSWER:

- Disproportionate share payments will be phased out over time.
- The purpose of the disproportionate share payments was to compensate hospitals for patients they were forced to subsidize. Once the uninsured and underinsured receive coverage for the comprehensive set of benefits it will negate the need for the government to continue these payments.
- Some DSH funds may be retained and targetted to institutions serving the poor.



SUPPLEMENTAL SERVICES UNDER MEDICAID

QUESTION:

What happens to supplemental services under Medicaid, such as EPSDT or transportation?

ANSWER:

- Individuals receiving cash assistance will continue to receive the supplemental benefits they currently receive under the Medicaid program.

TREATMENT OF MEDICAID ELIGIBLES UNDER THE PLAN

QUESTION:

How do the different Medicaid populations get treated under the Plan? Will Medicaid beneficiaries be treated the same as everyone else?

ANSWER:

- Medicaid beneficiaries will have the same security of coverage as everyone else. Their insurance card will be identical to the general population.
- The plan in which they are enrolled will be unable to identify the Medicaid population from the general population.
- Individuals receiving cash assistance will enroll in an Alliance just like the general population, but their full premium will be subsidized.
- Individuals who are currently Medicaid eligible, but not receiving cash assistance, will pay their 20% share of the premium if their income is at or above 150% of poverty.

FOLLOW-UP

Reallistically: Medicaid eligibles cannot afford the full range of choice of plans, especially fee-for-service.

ANSWER: Correct, but they will be guaranteed coverage in plans in which quality is assured.

LOW INCOME -- SEPARATE PLANS

QUESTION:

Will the subsidy scheme segregate low-income people into separate plans?

ANSWER:

- The important thing to remember is that low-income people are guaranteed access to a quality plan.
- States can require plans to serve populations in all areas.
- We are continuing to model other subsidy schedules to explore their impact on patient choice and program costs and will work with you on this.

PER CAPITA MEDICAID SPENDING -- PREMIUMS

QUESTION:

How is it possible that per capita Medicaid spending is larger than the amount needed for the average weighted premium for Medicaid beneficiaries?

ANSWER:

- Medicaid individuals in general are less healthy than the general population and can be expected to have higher utilization rates. Increased utilization drives up the per capita costs.

- Premiums paid to the Alliance will be adjusted upward to reflect these higher utilization rates.

STATE MAINTENANCE OF EFFORT

QUESTION:

Will States continue to be allowed to tax providers to comply with their maintenance of effort requirement?

ANSWER:

- States will have the flexibility to apply broad-based and uniform taxes on their providers to raise revenues to maintain their ongoing effort for the Medicaid program.

MEDICAID SUBSIDIES - SSI

QUESTION:

Is the Medicaid subsidy different for the SSI disabled?

ANSWER:

- Yes, the Medicaid disabled are subsidized up the cost of the fee-for-service plan (not just the average cost plan).

QUESTION:

Why is that?

ANSWER:

- Because the new system will take time to develop networks and other managed care plans to serve the severly disabled. We want to assure continued access to services in the fee-for-service system where these people are served today.