FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: _____ Date: _____

To:	From:
Chris Jennings	IRA Branch
Fax: _____	Fax: 202-690-8168 or 205-5157
Phone: _____	Phone: _____

REMARKS: Here's the info on OPD that you requested. Ann Scott prepared these

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

5.7 Percent Reduction in Payment for OPD Services

Reason for the 5.7 Percent Reduction

- Aggregate Amount of OPD Payments - Under the new OPD prospective payment system (PPS), the aggregate amount of OPD payments to hospitals in the first year of the new system is to be based on the sum of:

  (1) what Medicare would have otherwise paid to hospitals under the old system; and
  (2) the total amount of copayments estimated to be paid under the new system.

- Medicare Payments - The amount of Medicare payments under the new system are budget neutral with respect to what Medicare would have paid under the old system.

- Copayments - Copayment amounts under the new system, on the other hand, are considerably less than what they would have been under the old system.

  - This is because copayment amounts are based on 20 percent of median charges, and median charges are substantially lower than mean charges.

  - This copayment calculation causes hospital revenues for OPD services to decrease by 5.7 percent.

- Legal Interpretation by AHA - The legal interpretation submitted by the American Hospital Association suggests that HCFA could calculate the rates differently:

  - Instead of calculating aggregate payments to hospitals based on copayments that are estimated to be paid under the new system (based on the median), HCFA should estimate the total amount of copayments that would have been paid under the old system. This causes the fee schedule amounts and the aggregate payments to increase, eliminating the 5.7 percent reduction.

  - Actual copayment amounts paid by beneficiaries, however, would continue to be low, based on median charges.

  - Since the Medicare payment is the difference between the now higher fee schedule and the low copayment amount, the Medicare payments would be higher. Thus, this proposal would transfer the 5.7 percent cost from the hospitals to the Medicare program.

Increase in HCFA Estimate of OPD Reduction from 3.8 Percent to 5.7 Percent

- In the proposed rule issued in September of 1998, HCFA estimated that the reduction to hospitals from the copayment calculation would be 3.8 percent.

- In May 1999, HCFA met with the hospital industry and told them that this estimated reduction had increased to 5.7 percent. This was published in a correction notice on June 30, with a comment period closing on July 30.

- The estimated impact increased to 5.7 percent due to two factors:

  (1) Increase from 3.8% to 4.4%: Refinement of the data base - HCFA re-estimated the rates and the impacts based on further refined data. This caused the 3.8 percent to increase to 4.4 percent.

  (2) Increase from 4.4% to 5.7%: Correction of error regarding multiple procedures - The initial calculation of the rates had erroneously omitted a reduction in copayment amounts when multiple procedures are performed. Including this copayment reduction caused the overall reduction to hospitals to increase from 4.4 percent to 5.7 percent.

  [When multiple procedures are performed on the same day, the policy in the proposed rule states that the full fee schedule will be paid for the first procedure but only half the fee schedule for subsequent procedures (half the Medicare payment and half the copayment). This is consistent with the policy followed in ambulatory surgical centers and physician offices.]

7/13/99

To: Jack Lew
Sylvia Mathews
Larry Stein
Gene Sperling
Michele Balantyne
Joe Minarik
Barbara Chow
Daniel Mendelson
Michael Deich
Josh Gotbaum
Chuck Kieffer
Linda Ricci
Bob Damus
Dick Emery
Bruce Reed
Chris Jennings

From: Sandra Yamin

Subject: Final Treasury Letter on House Tax Bill

FYI. Attached is the final Treasury letter that was sent today on the House Tax bill.

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

July 13, 1999

SECRETARY OF THE TREASURY

The Honorable William Archer
Chairman
Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I write to express the Administration's strong opposition to the package of tax cut proposals contained in the Chairman's Mark (Joint Committee on Taxation, "Description of the Financial Freedom Act of 1999" (JCX-42-99), July 12, 1999), which your Committee will consider this week. If a bill encompassing these proposals were to pass the Congress this year, the President would veto it.

We have a strong economy because the Administration and Congress have followed the proper economic course over the past six years. We have focused on reducing deficits, paying down debt held by the public, bringing down interest rates, investing in our people, and opening markets. There is $1.7 trillion less debt held by the public today than was forecast in 1993. This has contributed to greater productivity growth, low inflation, low unemployment and broad-based growth in real wages.

The Chairman's Mark reverses the fiscal discipline that has benefited the American economy, thereby raising several concerns. First, the President has stated repeatedly that, before we consider using projected surpluses to provide a tax cut, we must put first things first and address the long term solvency of Social Security and Medicare. To date, the Congress has not acted on either of these issues.

Second, the magnitude of the tax cuts in the Chairman's Mark plus the associated debt service costs would be greater than the size of all of the on-budget surpluses the Congressional Budget Office projects for the next ten years. This leaves none of these surpluses available for addressing the long-term solvency of Medicare -- which is currently projected by its Trustees to be insolvent by 2015 -- and for necessary funding for our national security and for education, health and other domestic priorities.

Third, the Mark would cause the nation to forgo the unique opportunity to eliminate completely the burden of the debt held by the public by 2015 as proposed by the President in the Mid-Session Review of the Budget. The elimination of this debt would have a beneficial effect on interest rates, investment, and the growth of the economy. Moreover, paying down debt is tantamount to cutting taxes. Each one-percentage point decline in interest rates would mean a cut of $200 to $250 billion in mortgage costs borne by American consumers over the next 10

years. Also, if we do not erase the debt held by the public, our children and grandchildren will have to pay higher taxes to offset the higher federal interest costs on this debt.

Fourth, as many of the major tax cuts are phased-in over a period of years, the cost of the proposed tax cuts would explode beyond the 10-year budget window. This would pose even greater risks for the future, just as the first wave of the baby boom generation is retiring. For example, the amount of the revenue loss from this package in 2015, if not used for this tax cut, would go a long way towards paying for the approximately $250 billion increase in the projected annual cost of Social Security between 2010 and 2015, and it may even fully pay for that increase.

Fifth, budget projections for any period in the future are inherently uncertain. For example, in a study reviewing fiscal years 1988-98, CBO has reported that the average change between its estimates of annual deficits or surpluses five years into the future and the actual results was substantial. Projections of budget surpluses ten years into the future are even more uncertain. The prudent course of action in the face of these uncertainties is to avoid making financial commitments -- such as massive tax cuts -- that will be very difficult to reverse.

Sixth, the bill would not meet the existing pay-as-you-go requirements of the Budget Act, which has helped provide the discipline necessary to bring us from an era of large and growing budget deficits to the potential for substantial surpluses. It would also require an automatic sequester of mandatory programs, including Medicare.

Finally, we are also concerned with the priorities of the tax initiatives in the Chairman's Mark. We have previously expressed to you our strong concern regarding many of the specific elements of the package. Also, too small a percentage of the tax cuts address the needs of middle-income working families. We believe a better approach would be to include the high priority targeted tax incentives for middle-income families established in the President's budget -- helping them save for retirement, modernizing public schools for their children, and helping them care for their children or their relatives with long-term care needs.

I appreciate your consideration of the Administration's concerns. We look forward to working with you and other members of Congress in the coming months to address the solvency of Medicare and Social Security, to meet critical national priorities, and to provide fiscally responsible tax relief targeted at the needs of working families.

Sincerely,

Lawrence H. Summers

CONSORTIUM for CITIZENS with DISABILITIES

PRESS RELEASE

Consortium for Citizens with Disabilities Supports President Clinton's Efforts in Reforming Medicare

June 29,1999-The Consortium for Citizens with Disabilities (CCD) is a working coalition of approximately 100 national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. Since 1973, CCD has advocated for national public policy that ensures the self-determination and inclusion of children and adults with disabilities in all aspects of society; and that enhances the civil rights and quality of life of all people with disabilities and their families. For people with disabilities, Medicare provides health care services for 5 million beneficiaries and this population is expected to grow to 7 million in the next few years. A social insurance program like Medicare is particularly important to people with disabilities who are for the most part also low income beneficiaries.

For the past 15 months, an Informal Medicare Work Group comprised of CCD members has been tracking the Medicare reform debate both in Congress and with the Bipartisan Commission on the Future of Medicare. The Work Groups' initial response to the President's Medicare proposal is as follows:

- We commend the President for retaining the integrity of this very valued social insurance program.
- We commend the President for having the foresight and initiative to take on the challenge of restructuring the Medicare reform proposal into the next century.
- We commend the President for acknowledging the employment potential of Medicare beneficiaries under 65 with disabilities who wish to be employed and to make a contribution to this country.
- We commend the President for seeking methods in which to modernize the Medicare program while retaining the quality and level of health care benefits for the entire population.
- We commend the President for keeping the Medicare beneficiary population intact and not supporting a proposal that would weaken the current protections for people with disabilities.

1730 K Street NW, Suite 1212 • Washington, DC 20006 • PH 202-785-3388 • FAX 467-4179 • CCD@radix.net • www.c-c-d.org

- The CCD looks forward to actively working with the President to continue to re-structure the Medicare Program to meet the health care service and delivery needs of beneficiaries with disabilities.

Medicare Reform Proposal-Quotes

Shelley McLane (Co-Chair)-It is the right and appropriate role for government to protect the well being of its citizens. Today, the public good is often lost or placed at a low priority when the cost of health care coverage is discussed among policy makers. President Clinton's Medicare reform proposal acknowledges the terrible burden that many Medicare beneficiaries face in trying to meet their health care drug coverage costs. It is appalling that many beneficiaries have to choose between paying for food or utilities or getting their needed prescription drugs or other health benefits. This proposal will provide some "cost respite" to Medicare beneficiaries and will begin to diminish the fear that many Medicare beneficiaries live with every day when they try to meet their monthly bills.

Jeff Crowley (Co-Chair)-We are pleased the President has put out a sound proposal to reposition the Medicare reform debate to meet the needs of its beneficiaries. We will not rest, however, until a catatrosphic drug benefit is added to protect the millions of people with disabilities with high cost drug needs in which this proposal would not reach.

Bob Griss (Co-Chair)-Medicare reform provides an important opportunity to focus on government leverage in the health care system since Medicare is national health insurance for people over age 65 and some people with disabilities under age 65. The seniors can remind us all that Medicare reaches every family. The disability community can remind us what a health care system needs to have in order to keep people actively functioning.

Kathy McGinley (Co-Chair)-The President has taken an important step in the right direction. He is putting beneficiaries first. We hope his Administration and Congress can work in a bipartisan manner to maintain and improve the Medicare program for those who need it.

Contact Person: Shelley McLane, National Association of Protection and Advocacy Systems
Tel: 202/408-9514

Members of the CCD Informal Medicare Work Group

Shelley McLane (Facilitator)	National Association of Protection and Advocacy Systems
Jeffrey Crowley	National Association of People with Aids
Bob Griss	Center on Disability and Health
Kathy McGinley	The ARC
Martha Ford	The Arc
Mary Gennaro	National Association of Developmental Disabilities Councils

Mary Frances Laverdure	RESNA
Michael Losow	NISH
Thomas McCormack	Title II Community and National Network
Susan Prokop	Paralyzed Veterans of America
Sallie Rhodes	National Association of Protection and Advocacy Systems
Peter Thomas	Powers, Pyles, Sutter, and Verville
Steven White	ASHA

As POTUS said last night, Public prevail Confident that house will pass stronger bill continue to work

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages:_____ Date: _____

To:	From:
Chris Jennings	IRA BURNEY
Fax: _____	Fax: 202-690-8168 or 205-5157
Phone: _____	Phone: _____

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OFFICE OF SENATOR MAX BAUCUS

TELECOPIER TRANSMISSION COVER SHEET

Sender: Pat Bonsliman

Phone: 224-4353 *Date:* 7/16

****

Recipient: Chris Jennings

Phone:

Action: *FYI*___ *As You Requested* ___

Chris: Here's the lockbox andt. Thanks for taking a look.

Pat

Number of Pages to Follow: 1

DRAFT – 7/16/99 – DRAFT

Amendment by Senators Baucus and Conrad
Social Security and Medicare Lockbox

The tax cuts in the Chairman's mark will be reduced to allow a portion of the available on-budget surplus to be dedicated to Medicare as set forth below. The reductions in the tax cuts will be pro-rata, across-the-board, except that any extenders and pay-for items will be unaffected.

The Social Security and Medicare lockbox precludes any portion of the Social Security surplus *or* any portion of the surplus reserved for Medicare to be used for any purpose other than to strengthen and preserve these programs. Over the next 10 years, the lockbox will protect *100 percent* of the Social Security surplus in each year, and one-third of any available on-budget surplus for Medicare.

Amounts in Lockbox: The Social and Medicare lockbox contains: (1) the entire Social Security surplus in every year and (2) one-third of the available on-budget surplus in any year. The latter is reserved specifically to extend the life of the Medicare program and to provide Medicare beneficiaries with prescription drug coverage and adequate access to affordable, quality care.

Enforcement: The Social Security and Medicare lockbox will be enforced through new supermajority points of order that apply to the budget resolution, and all bills, amendments and conference reports.

Budget Procedures: Budget process procedures, including extension of the pay-go rules, should be included in legislation that protects Social Security and Medicare, and provides tax relief to working Americans.

U.S. Senator Ron Wyden

FAX TRANSMISSION

516 Hart Senate Office Building
Washington, D.C. 20510
(202) 224-5244
(202) 228-2717 (Fax)

Date:

To: Devora Adler

Fax:

From: Stephanie Kennan

Subject:

Pages:
(Including cover)

COMMENTS:

SENIOR PRESCRIPTION INSURANCE COVERAGE EQUITY (SPICE) ACT

Medicare Prescription Drug Coverage Options
Senators Olympia Snowe and Ron Wyden

Eligibility: All seniors who are currently eligible for Medicare Parts A and B will be eligible to receive prescription drug benefits. Seniors will choose from a menu of competing benefit plans, which will pay for prescription drug costs with varying deductibles, and co-pays, as well as offering additional services. As with the Federal Employees Health Benefit Plan, there will be an annual open enrollment period in which seniors can switch plans. As with Medicare Part B, beneficiaries who choose to delay obtaining coverage will see their share of costs rise proportionately.

Financial Assistance: Seniors earning below 150 percent of the poverty level (currently $12,075 for a single person, $16,275 for a couple) will pay no premiums for prescription drug insurance. Those earning between 150 percent and 175 percent (currently $14,088 for a single person, and $18,988 for a couple) will have their premium assistance phased down from 100 percent to 25 percent. All other seniors will have 25 percent of their premiums subsidized.[1]

Benefits: SPICE will provide coverage for outpatient prescription drugs, with enrollees responsible for co-pays and annual deductibles. The SPICE board will also establish a model plan, which will include prescription drugs and other items currently provided by the supplemental Medigap plans, which the new SPICE plans will replace.

Plan options: Beneficiaries will be able to choose from Medicare+Choice plans or supplemental drug plans. The supplemental plans will be offered by private-sector entities that will both design benefits and determine premiums, under guidelines set and approved by the SPICE board. Participating plans will be required to accept all beneficiaries who choose that plan, no matter their current state of health or level of risk.

Funding: SPICE will be funded through the increase in tobacco taxes proposed in President Clinton's budget, including a 55 cent increase and acceleration of a 15 cent increase already in law. In addition, the plan may draw from a reserve fund in the budget utilizing the non-Social Security on-budget surplus.

Administration: This benefit will be administered by the SPICE board, reporting to the Secretary of Health and Human Services. This board will be managed by an Advisory Board of Directors that will approve plan designs and premium submissions; approve and distribute consumer education materials; develop enrollment procedures; seek additional steps to insure fiscal discipline; and coordinate with the Health Care Financing Administration and the Social Security Administration.

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[1] Income figures are based on 1998 federal poverty guidelines set by the U.S. Department of Health and Human Services

SENIOR PRESCRIPTION INSURANCE COVERAGE EQUITY (SPICE) ACT

How Would It Work?

Example #1: Mabel Barnes is a 75 year old widow with an income of $11,000. and prescription drug costs that are about $1,000 a year.

Under this plan, Mabel will be able to choose from a range of plans -- for which she pays no premium. One plan might be a fee-for-service plan that covers all but a $5 or $10 co-pay for each of her prescriptions. Another might be a more comprehensive plan that requires higher co-pays or an annual deductible, but also helps pay for such services as eyeglasses or hearing aids. She could also choose a managed care plan that includes comprehensive prescription drug benefits.

Example #2: Milla Griffiths is a 69 year old widow with income of $15,000. Her prescription costs are around $600, and she pays a lot for new eyeglasses and hearing aids every year, and fears that her other costs will rise in the years to come.

Since Milla's income is over 150% of poverty, but is less than 175% of poverty, she should receive a premium of approximately 75%. Because of her hearing aid and glasses, she may want to opt for a plan that has a slightly higher prescription drug deductable, but covers the glasses and hearing aid. As she ages, she will could switch to coverage that provides more prescription drug benefits.

Example #3: Frank Smith is a 70 year old retiree who has $20,000 in income. His wife, Joanne, is a 68 year old retiree. Their prescription costs combined are about $1,250 a year.

Today, to get prescription drug coverage, the Smiths will have to buy a Medigap plan that could cost as much as $4,500 a year. Under the Snowe-Wyden plan, they would be eligible for a 25% subsidy for a plan that covers prescriptions. That alone will save them at least $1,000. Additional cost savings will be possible because of the negotiating power of the SPICE Board, and the fact that insurers, because this plan will expand the pool of covered seniors, will be able to spread risk thinner, bringing down costs for everyone.

<Note: The Snowe-Wyden bill does not specificy levels of co-pays, deducatables, or premiums by law. The SPICE Board will negotiate benefits with plans, and will establish guidelines for what is appropriate for various income groups.>

Fax Cover Sheet

DATE: 5/17/99

TO: Chris Jennings

FAX: 456-5557
PHONE:

FROM: Jeff Ricchetti

PHONE: 202.393.1010
FAX: 202.393.5510

CODE: 160

Number of pages, including cover sheet: 2

MESSAGE

1 G Street, NW
te 900 East
shington, DC 20001
02.393.1010
02.393.5510
ww.podesta.com

IF A PROBLEM OCCURS WITH THIS TRANSMISSION, PLEASE CALL 202.393.1010

History of FEP Outpatient Prescription Drug Coverage

mid-1960s - 1987 – Prescription drugs have always been a covered benefit. Initially they were handled under major medical coverage which was part of the supplemental benefit. Under this benefit, enrollees could receive services from any pharmacy, but were responsible for meeting a deductible and coinsurance. Enrollees would pay for the cost of the prescription and submit a claim to be reimbursed.

1987 – Mail service benefit was introduced where enrollees could purchase prescription drugs through the mail for a fixed copayment. Enrollees were not required to meet a deductible. This service was intended for enrollees with maintenance drug requirements (up to 90 days supply).

1993 – Retail pharmacy benefit was introduced where enrollees could receive prescription drugs from preferred pharmacies for a discounted price. Enrollees paid up front for the drugs and submitted paper claims for reimbursement. Enrollees were reimbursed for the cost of the drug minus any unmet deductible and applicable coinsurance.

1994 – Present – Paperless pharmacy benefit was introduced where enrollees could receive prescription drugs from any preferred pharmacy and pay only any unmet deductible and coinsurance at the point of sale. If an enrollee used a non-preferred pharmacy, the enrollee would pay for the prescription up front, submit a paper claim, and receive the reimbursement minus the deductible and coinsurance.

The current Standard Option retail pharmacy benefit is: $50 deductible ($100 for family) per year; the Plan pays 80 % of the preferred provider allowance at preferred pharmacies and 60 % of the average wholesale price at non-preferred pharmacies. (The deductible is waived if Medicare Part B is primary payer.)

The current Standard Option mail order benefit requires a flat $12 co-payment with no deductible. (Co-payment is waived if Medicare Part B is primary payer.)

FEP does not use a formulary or structured cost sharing for generic drugs. Under the retail program, since co-insurance is required, the enrollee saves money by purchasing generics. Under the mail order program, generics are substituted with permission of the prescribing physician.

There is no cap or maximum on prescription drugs.

CHRIS JENNINGS/DEVORA ADLER

FOR 3:00 TELECON WITH ED FLYNN

RE LONG TERM CARE LEGISLATION

This note transmits three pages of notes which indicate where HR 1111 would need to be changed (in our view) to make it acceptable. In some cases it's a matter of making a record of legislative intent as opposed to a change to legislative language per se.

This isn't as neat as I'd like, but we'll have a chance to walk through it at 3:00.

Call if you need copies of the underlying bills.

Frank Titus 606-0770

Modifications to H. R. 1111

§ 9001. Definitions

(1) EMPLOYEE – STRIKE SUBPARAGRAPH (E)

(3) QUALIFIED RELATIVE—strike "sponsoring", substitute "eligible"

(A) strike "sponsoring", substitute "eligible"
(B) strike "sponsoring", substitute "eligible"
(C) strike "sponsoring", substitute "eligible"

(4) **ELIGIBLE INDIVIDUAL – The term "eligible individual" refers to an individual described in paragraph (1), (2), (3), or (4) of section 9002(b).**

(5) Carrier—substitute definition in H. R. 110

(6) Qualified Long-Term Care Services O.K.

(7) Office O.K.

(8) Appropriate Secretary O.K.

§ 9002. Eligibility to obtain coverage

(1) Employee H. R. 110 definition

(2) Annuitant H.R. 110 definition

(3) Member of Uniformed Services O.K. Mary Ann checked references

(4) Retired Member of Uniformed Services O.K. Mary Ann checked references

(5) QUALIFIED RELATIVE – delete "sponsoring" INSERT "an eligible"

(e) DOCUMENTATION REQUIREMENT – As a condition for obtaining long-term care insurance coverage under this chapter based on one's status as a qualified relative, the applicant must provide documentation to demonstrate the relationship as prescribed by the Office

§ 9003. Contracting authority

(a) After a day's research, Mary Ann determined that section 3709 of the Revised Statutes is a precursor to section 5 of title 41, so use the H.R. 110 language. In general I would substitute our language.

(b) Qualified Carriers – O.K.

(c) Terms and Conditions O.K. RATES - - - AS DETERMINED BY THE OFFICE (SEE H.R. 110 - § 9002(d))

(d) Noncancelability – O.K.

(e) Payment of Required Benefits, Dispute Resolution – O.K. but add a note that (1) to pay or provide benefits means not only to provide benefits to those already insured, but also to provide insurance to applicants with the clear understanding that neither OPM nor a 3rd party administrator would have the authority to change the rules under which the contract operates. Harry: what we're getting at here is that the dispute resolution provision covers underwriting decisions as well as claims decisions.

The rest of the section is O.K.

§ 90004. Long-term care benefits

(B) I would delete since I don't know what it means

(C) Note for the record that cognitive impairment needs to be specifically defined in the contract.

(4) delete "cash" but add note to the record that the policy may include provision for family members to be compensated for services performed. Harry: We should have a copy of the UNIM contract from Kathy and we need to look at how they spell out the cash benefit.

(5) Inflation protection. Change to must be available.

© delete entire section including (1), (2), (3), (4), and (5) Substitute language that says that the benefits package will be designed to provide maximum flexibility regarding care modalities, to include at a minimum home care, assisted living, and nursing home.

~~(d)?~~

(e) O,K, except delete (except to the extent necessary to carry out subsection ©(5)

(f) O.K.

(g) O.K.

§ 9005. Financing

(a) O.K.

(b) O.K.

O.K. until (e) REIMBURSEMENTS – substitute H.R. 110 language on funding for OPM

~~(c) (d)~~ ?

§ 9006. Regulations

(c) Note for the record that those who do not enroll at first opportunity will have to undergo more extensive underwriting – this is not an open enrollment with guaranteed issue.

SEC. 3. EFFECTIVE DATE

CHRIS JENNINGS/DEVORA ADLER

FOR 3:00 TELECON WITH ED FLYNN

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Frank Titus 606-0770

Yes they are 25 pages

[DISCUSSION DRAFT]

106TH CONGRESS
1ST SESSION

H. R.____

IN THE HOUSE OF REPRESENTATIVES

Mrs. MORELLA introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Civilian and Uniformed Services Long-Term Care Insurance Act of 1999".

SEC. 2. LONG-TERM CARE INSURANCE.

Subpart G of part III of title 5, United States Code, is amended by adding at the end the following:

"Chapter 90—Long-Term Care Insurance

"Sec.
"9001. Definitions.
"9002. Eligibility to obtain coverage.
"9003. Contracting authority.
"9004. Long-term care benefits.
"9005. Financing.
"9006. Regulations.

"§ 9001. Definitions

"For purposes of this chapter:

"(1) EMPLOYEE.—The term 'employee' means—

"(A) an employee as defined by section 8901(1)(A)–(H); and

"(B) an individual described in section 2105(e).

"(2) ANNUITANT.—The term 'annuitant' has the meaning such term would have under paragraph (3) of section 8901 if, for purposes of such paragraph, the term 'employee' were considered to have the meaning given to it under paragraph (1) of this subsection.

"(3) QUALIFIED RELATIVE.—The term 'qualified relative', as used with respect to a sponsoring individual, means—

"(A) the spouse of such sponsoring individual;

"(B) a parent or parent-in-law of such sponsoring individual; and

"(C) any other person bearing a relationship to such sponsoring individual specified by the Office in regulations.

"(4) SPONSORING INDIVIDUAL.—The term 'sponsoring individual' refers to an individual described in paragraph (1), (2), (3), or (4) of section 9002(b).

"(5) CARRIER.—The term 'carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, qualified long-term care services under group insurance policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier.

"(6) QUALIFIED LONG-TERM CARE SERVICES.—The term 'qualified long-term care services' has the meaning given such term by section 7702B of the Internal Revenue Code of 1986.

"(7) OFFICE.—The term 'Office' means the Office of Personnel Management.

"(8) APPROPRIATE SECRETARY.—The term 'appropriate Secretary' means—

"(A) except as otherwise provided in this paragraph, the Secretary of Defense;

"(B) with respect to the Coast Guard when it is not operating as a service of the Navy, the Secretary of Transportation;

"(C) with respect to the commissioned corps of the National Oceanic and Atmospheric Administration, the Secretary of Commerce; and

"(D) with respect to the commissioned corps of the Public Health Service, the Secretary of Health and Human Services.

"§ 9002. Eligibility to obtain coverage

"(a) IN GENERAL.—Any eligible individual may obtain long-term care insurance coverage under this chapter for himself or herself, in accordance with applicable provisions of this chapter.

"(b) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means each of the following:

"(1) EMPLOYEE.—An employee who has completed 6 months of continuous service as an employee under other than a temporary appointment limited to 6 months or less.

"(2) ANNUITANT.—An annuitant.

"(3) MEMBER OF THE UNIFORMED SERVICES.—A member of the uniformed services on active duty for a period of more than 30 days or full-time National Guard duty (as defined in section 101(d)(5) of title 10) who satisfies such eligibility requirements as the Office prescribes under section 9006(c).

"(4) RETIRED MEMBER OF THE UNIFORMED SERVICES.—A member of the uniformed services entitled to retired or retainer pay (other than under chapter 1223 of title 10) who satisfies such eligibility requirements as the Office prescribes under section 9006(c).

"(5) QUALIFIED RELATIVE.—A qualified relative of a sponsoring individual.

"(c) CERTIFICATION REQUIREMENT.—As a condition for obtaining long-term care insurance coverage under this chapter based on one's status as a qualified relative, certification from the applicant's sponsoring individual shall be required as to—

"(1) such sponsoring individual's status, as described in paragraph (1), (2), (3), or (4) of subsection (b) (as applicable), as of the time of the qualified relative's application for coverage; and

"(2) the existence of the claimed relationship as of that time.

Any such certification shall be submitted in such time, form, and manner as the Office shall by regulation prescribe.

"(d) DISQUALIFYING CONDITION.—Nothing in this chapter shall be considered to require that long-term care insurance coverage be made available in the case of any individual who would be immediately benefit eligible.

"§ 9003. Contracting authority

"(a) IN GENERAL.—The Office may, without regard to section 3709 of the Revised Statutes or other statute requiring competitive bidding, contract with qualified carriers to provide group long-term care insurance under this chapter, except that the Office may not have contracts in effect under this section with more than 3 qualified carriers as of any given time.

"(b) QUALIFIED CARRIERS.—To be considered a qualified carrier under this chapter, a company must be licensed to issue group long-term care insurance in all the States and the District of Columbia.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Each contract under this section shall contain a detailed statement of the benefits offered (including any maximums, limitations, exclusions, and other definitions of benefits), the rates charged (including any limitations or other conditions on their subsequent adjustment), and such other terms and conditions as may be mutually agreed to by the Office and the carrier involved, consistent with the requirements of this chapter.

"(2) RATES.—The rates charged under any contract under this section shall reasonably reflect the cost of the benefits provided under such contract.

"(d) NONCANCELABILITY.—The benefits and coverage made available to individuals under any contract under this section shall be guaranteed to be renewable and may not be canceled by the carrier except for nonpayment of charges.

"(e) PAYMENT OF REQUIRED BENEFITS; DISPUTE RESOLUTION.—Each contract under this section shall require the carrier to agree—

"(1) to pay or provide benefits in an individual case if the Office (or a duly designated third party

administrator) finds that the individual involved is entitled thereto under the terms of the contract; and

"(2) to participate in administrative procedures designed to bring about the expeditious resolution of disputes arising under such contract, including, in appropriate circumstances, one or more alternative means of dispute resolution.

"(g) DURATION.—

"(1) IN GENERAL.—Each contract under this section shall be for a term of 5 years, but may be made automatically renewable from term to term in the absence of notice of termination by either party. However, the rights and responsibilities of the enrolled individual, the insurer, and the Office (or duly designated third party administrator) under any such contract shall continue until the termination of coverage of the enrolled individual.

"(2) TERMINATION OF INDIVIDUAL COVERAGE.—Group long-term care insurance coverage obtained by an individual under this chapter shall terminate only upon the occurrence of any of the following:

"(A) DEATH.—The death of the insured.

"(B) EXHAUSTION OF BENEFITS.—Exhaustion of benefits, as determined under the contract.

"(C) INSOLVENCY.—Insolvency of the insurer, as determined under the contract.

"(D) CANCELLATION.—Any event justifying a cancellation under subsection (d).

"(3) PRESERVATION OF RIGHTS AND RESPONSIBILITIES.—Each contract under this section shall include such provisions as may be necessary so as, except as provided in paragraph (2)—

"(A) to effectively preserve all parties' rights and responsibilities under such contract notwithstanding the termination of such contract (whether due to its nonrenewal under the first sentence of paragraph (1) or otherwise); and

"(B) to ensure that, once an individual becomes duly enrolled, long-term care insurance coverage obtained by such individual pursuant to that enrollment shall not be terminated due to any change in status (as described to in section 9002(b)), such as separation from Government service or the armed forces, or ceasing to meet the requirements for being considered a

qualified relative (whether due to divorce or otherwise).

"§ 9004. Long-term care benefits

"(a) IN GENERAL.—Benefits under this chapter shall be provided under qualified long-term care insurance contracts, within the meaning of section 7702B of the Internal Revenue Code of 1986.

"(b) SPECIFIC MATTERS TO BE INCLUDED IN ALL CONTRACTS.—Each contract under section 9003 shall, in addition to any matter otherwise required under this chapter, provide for the following:

"(1) Adequate consumer protections (including through establishment of sufficient reserves or reinsurance).

"(2) Adequate protections in the event of carrier bankruptcy (or other similar event).

"(3) Availability of benefits upon appropriate certification as to an individual's—

"(A) inability (without substantial assistance from another individual) to perform at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity;

"(B) having a level of disability similar (as determined under regulations prescribed by the

Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of disability described in subparagraph (A); or

"(C) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

"(4) Choice of cash or service benefits (such as the expense-incurred method or the indemnity method).

"(5) Inflation protection (whether through simple or compounded adjustment of benefits).

"(6) Portability of benefits (consistent with subsections (d) and (g) of section 9003).

"(c) ADDITIONAL SPECIFIC MATTERS TO BE INCLUDED IN AT LEAST ONE CONTRACT.—To the maximum extent practicable, as of any given time, at least 1 of the policies being offered under this chapter shall, in addition to any matter otherwise required under this chapter, provide for the following:

"(1) Length of benefit options.

"(2) Options relating to the provision of coverage in a variety of settings, including nursing homes, assisted living facilities, and home and community care.

"(3) Options relating to elimination periods.

"(4) Options relating to nonforfeiture benefits.

"(5) Availability of benefits upon appropriate certification of medical necessity (as defined by the Office in consultation with the Secretary of Health and Human Services) not satisfying the requirements of subsection (b)(3).

"(d) GOVERNMENTWIDE PLAN.—

"(1) IN GENERAL.—The Office shall take all practicable measures to ensure that, of the long-term care benefits plans available under this chapter as of any given time, at least one of them shall be a Governmentwide long-term care benefits plan.

"(2) DEFINITION.—For purposes of this subsection, the term 'long-term care benefits plan' means a group insurance policy or contract, or similar group arrangement, provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for qualified long-term care services.

"(3) CLARIFICATION.—Neither subsection (c)(5) nor the exception set forth in the parenthetical matter under subsection (e) shall apply with respect to any Governmentwide plan under this subsection.

"(e) COORDINATION WITH INTERNAL REVENUE CODE OF 1986.—Nothing in this chapter shall be considered to permit or require the inclusion, in any contract, of provisions inconsistent with section 7702B or any other provision of the Internal Revenue Code of 1986. ~~(except to the extent necessary to carry out subsection (e)(5)).~~

"(f) COORDINATION WITH STATE REQUIREMENTS.—If a State (or the District of Columbia) imposes any requirement which is more stringent than the analogous requirement imposed by subsection (b)(1), the requirement imposed by subsection (b)(1) shall be treated as met if the more stringent requirement of the State (or the District of Columbia) is met.

"(g) DEFINITIONS.—For purposes of this section:

"(1) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(F) Continence.

"(2) NURSING HOME.—The term 'nursing home' has the meaning given such term by section 1908 of the Social Security Act.

"(3) ASSISTED LIVING FACILITY.—The term 'assisted living facility' has the meaning given such term by section 232 of the National Housing Act.

"(4) HOME AND COMMUNITY CARE.—The term 'home and community care' has the meaning given such term by section 1929 of the Social Security Act.

"§ 9005. Financing

"(a) NO GOVERNMENT CONTRIBUTION.—Except as provided in subsection (b)(2), each individual having long-term care insurance coverage under this chapter shall be responsible for 100 percent of the charges for such coverage.

"(b) WITHHOLDINGS—

"(1) IN GENERAL.—The amount necessary to pay the charges for enrollment shall—

"(A) in the case of an employee, be withheld from the pay of such employee;

"(B) in the case of an annuitant, be withheld from the annuity of such annuitant;

"(C) in the case of a member of the uniformed services described in section 9002(b)(3), be withheld from the basic pay of such member; and

"(D) in the case of a member of the uniformed services described in section 9002(b)(4), be withheld from the retired pay or retainer pay payable to such member.

"(2) VOLUNTARY WITHHOLDINGS FOR QUALIFIED RELATIVES.—Withholdings to pay the charges for enrollment of a qualified relative may, upon election of the sponsoring individual involved, be withheld under paragraph (1) in the same manner as if enrollment were for such sponsoring individual.

"(3) DIRECT PAYMENTS.—All amounts withheld under paragraph (1) or (2) shall be paid directly to the carrier.

"(c) OTHER FORMS OF PAYMENT.—An employee, annuitant, or other individual whose pay or annuity is insufficient to cover the withholding required for enrollment (or who is not receiving any regular amounts from the Government from which withholdings may be made) shall pay the charges for enrollment directly to the carrier.

"(d) SEPARATE FUND REQUIREMENT.—Each carrier participating under this chapter shall maintain all amounts received under this chapter separate and apart from all other funds.

"(e) REIMBURSEMENTS—Contracts under this chapter shall include appropriate provisions under which each

carrier shall reimburse the Office or other administering entity for the administrative costs incurred by such entity under this chapter (such as for dispute resolution) which are allocable to such carrier.".

"§ 9006. Regulations

"(a) IN GENERAL.—The Office shall prescribe regulations necessary to carry out this chapter.

"(b) ENROLLMENT.—The regulations of the Office shall prescribe the time at which and the manner and conditions under which an individual may obtain long-term care insurance under this chapter, except that, under the regulations, an open enrollment period shall be afforded at least once each year (similar to that afforded under section 8905(f)).

"(c) CONSULTATION.—Any regulations necessary to effect the application and operation of this chapter with respect to an eligible individual described in paragraph (3) or (4) of section 9002(b), or a qualified relative thereof, shall be prescribed by the Office in consultation with the appropriate Secretary.".

SEC. 3. EFFECTIVE DATE.

The amendments made by this Act shall take effect on the date of enactment of this Act, except that no coverage may become effective before the first calendar year

1 beginning after the expiration of the 18-month period be-
2 ginning on the date of enactment of this Act.

I

106TH CONGRESS
1ST SESSION

H. R. 110

To amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 1999

Mr. CUMMINGS introduced the following bill; which was referred to the Committee on Government Reform

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A BILL

To amend title 5, United States Code, to provide for the establishment of a program under which long-term care insurance is made available to Federal employees and annuitants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Group Long-Term Care Insurance Act of 1999".

SEC. 2. LONG-TERM CARE INSURANCE.

Subpart G of part III of title 5, United States Code, is amended by adding at the end the following new chapter:

"Chapter 90—Long-Term Care Insurance

"Sec.
"9001. Definitions
"9002. Contracting authority.
"9003. Minimum standards for contractors.
"9004. Long-term care benefits.
"9005. Financing.
"9006. Preemption.
"9007. Studies, reports, and audits.
"9008. Claims for benefits.
"9009. Jurisdiction of courts.
"9010. Regulations.
"9011. Authorization of appropriations.

"§ 9001. Definitions

"For the purpose of this chapter—

"(1) 'annuitant' means an individual referred to in section 8901(3);

"(2) 'employee' means an individual referred to in subparagraphs (A)–(D), and (F)–(I) of section 8901(1); but does not include an employee excluded by regulation of the Office under section 9011;

"(3) 'other eligible individual' means the spouse, former spouse, parent or parent-in-law of an employee or annuitant, or other individual specified by the Office;

"(4) 'Office' means the Office of Personnel Management;

"(5) 'qualified carrier' means an insurer licensed to do business in each of the States and meeting the requirements of a qualified insurer in each of the States;

"(6) 'qualified contract' means a contract meeting the conditions prescribed in section 9002; and

"(7) 'State' means a State or territory or possession of the United States, and includes the District of Columbia.

"§ 9002. Contracting authority

"(a) The Office may, without regard to section 5 of title 41 or any other statute requiring competitive bidding, purchase from one or more qualified carriers a policy or policies of group long-term care insurance to provide benefits as specified by this chapter. The Office, however, shall ensure that each resulting contract is awarded on the basis of contractor qualifications, price, and reasonable competition to the maximum extent practicable.

"(b) The Office may design a benefits package or packages and negotiate final offerings with qualified carriers.

"(c) Each contract shall be for a uniform term of 5 years, unless terminated earlier by the Office.

"(d) Premium rates charged under a contract entered into under this section shall reasonably reflect the cost of

the benefits provided under that contract as determined by the Office.

"(e) The coverage and benefits made available to individuals under a contract entered into under this section are guaranteed to be renewable and may not be canceled by the carrier except for nonpayment of premium.

"(f) The Office may, based on open season participation rates, the composition of the risk pool, or both, withdraw the product.

"§ 9003. Minimum standards for contractors

"At the minimum, to be a qualified carrier under this chapter, a company shall—

"(1) be licensed as an insurance company and approved to issue group long-term care insurance in all States and to do business in each of the States; and

"(2) be in compliance with the requirements imposed on issuers of qualified long-term care contracts by section 4980C of the Internal Revenue Code of 1986.

"§ 9004. Long-term care benefits

"The benefits provided under this chapter shall be long-term care benefits which, at a minimum, shall be compliant with the most recent standards recommended by the National Association of Insurance Commissioners.

"§ 9005. Financing

"(a) The amount necessary to pay the premium for enrollment of an enrolled employee shall be withheld from the pay of each enrolled employee.

"(b) Except as provided by subsection (d), the amount necessary to pay the premium for enrollment of an enrolled annuitant shall be withheld from the annuity of each enrolled annuitant.

"(c) The amount necessary to pay the premium for enrollment of a spouse may be withheld from pay or annuity, as appropriate.

"(d) An employee, annuitant, or other eligible individual, whose pay or annuity is insufficient to cover the withholding required for enrollment, shall, at the discretion of the Office, pay the premium for enrollment directly to the carrier.

"(e) Each carrier participating in the Program established by this chapter shall maintain the funds related to this Program separate and apart from funds related to other contracts and other lines of business.

"(f) The costs of the Office in adjudicating a claims dispute under section 9008, including costs related to an inquiry not culminating in a dispute, shall be reimbursed by the carrier involved in the dispute or inquiry. Such funds shall be available to the Office for the administration of this chapter.

"§ 9006. Preemption

"The provisions of this chapter shall supersede and preempt any State or local law which is determined by the Office to be inconsistent with—

"(1) the provisions of this chapter; or

"(2) after consultation with the National Association of Insurance Commissioners, the efficient provision of a nationwide long-term care insurance program for Federal employees.

"§ 9007. Studies, reports, and audits

"(a) Each qualified carrier entering into a contract under this chapter shall—

"(1) furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this chapter; and

"(2) permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to carry out the purposes of this chapter.

"(b) Each Federal agency shall keep such records, make such certifications, and furnish the Office, the carrier, or both, with such information and reports as the Office may require.

"§ 9008. Claims for benefits

"(a) A claim for benefits under this chapter shall be filed within 4 years of the date on which the reimbursable cost was incurred or the service was provided.

"(b) The Office shall adjudicate a claims dispute arising under this chapter and shall require the contractor to pay for any benefit or provide any service the Office determines appropriate under the applicable contract.

"(c)(1) Except as provided in paragraph (2), benefits payable under this chapter for any reimbursable cost incurred or service provided are secondary to any other benefit payable for such cost or service. no payment may be made where there is no legal obligation for such payment.

"(2) Benefits payable under the following programs shall be secondary to benefits payable under this chapter:

"(A) The program of medical assistance under title XIX of the Social Security Act; and

"(B) Any other Federal or State programs that the Office may specify in regulations that provide health benefit coverage designed to be secondary to other insurance coverage.

"§ 9009. Jurisdiction of courts

"A claimant under this chapter may file suit against the carrier of the long-term care insurance policy covering such claimant in the district courts of the United States, after exhausting all available administrative remedies.

"§ 9010. Regulations

"(a) The Office shall prescribe regulations necessary to carry out this chapter.

"(b) The regulations of the Office may prescribe the time at which and the conditions under which an eligible individual may enroll in the Program established under this chapter.

"(c) The Office may not exclude—

"(1) an employee or group of employees solely on the basis of the hazardous nature of employment; or

"(2) an employee who is occupying a position on a part-time career employment basis, as defined in section 3401(2).

"(d) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, former spouses, and other eligible individuals under this chapter, and any requirements for continuation or conversion of coverage.

"§ 9011. Authorization of appropriations

"There are authorized to be appropriated such sums as may be necessary for the purposes of carrying out sections 9002, and 9010.".

SEC. 3. EFFECTIVE DATE.

The amendments made by this Act shall take effect on the date of enactment of this act, except that no cov-

Note for Chris Jennings:

Chris, as we discussed, attached to this note is a summary of the changes in prescription drug and preventive care benefits in the Blue Cross and Blue Shield program since 1965.

As I mentioned in my note to you the other day, the major question was whether or not prescription drugs were covered in 1965; that answer was yes. In fact, prescription drug coverage was part of the original legislation in 1959-60.

I hope you fine this useful. After you or your staff have had a chance to review, don't hesitate to call if you want to discuss the paper or if you have any questions about it.

Ed Flynn
April 29, 1999

Attachment

Note for Chris Jennings:

Chris, as we discussed, attached to this note is a summary of the changes in prescription drug and preventive care benefits in the Blue Cross and Blue Shield program since 1965.

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Ed Flynn
April 29, 1999

Attachment

Cost of Buy-in to FEHBP?

Separate Pool

Same pool. (If not subsidized, will only get sick population, right?) What kind of impact?

1965

Drug Benefit
BASIC HOSPITAL BENEFITS; Covered Hospital Services – Drugs and medicines for use in the hospital when listed in official formularies
SUPPLEMENTAL BENEFITS; Covered Services and Supplies – Drugs and medicines obtainable only by written prescription

High Option	Low Option
80% UCR	75% UCR
after $100	after $150
Calendar Year	Calendar Year
Deductible per person	Deductible per person

Preventive Benefit
Both Options
- Exclusion: For routine or periodic physical examinations, screening examinations, immunization shots, the removal of corns or calluses, or the trimming of nails
- Exclusion: Physicians' visits for the routine care or examination of a newborn child

1966
No change

1967
No change

1968
Drug Benefit – No change

Preventive Benefit – (Wording) 2nd Exclusion: Routine physician's care or examination of a newborn child

1969
No change

1970
No change

1971
No change

1972
No change

1973

Drug Benefit – SUPPLEMENTAL BENEFITS; Covered Services and Supplies – (Wording) Drugs, medicines obtainable only by written prescription

Preventive Benefit – (Wording) 1st Exclusion: For routine examinations, periodic physical examinations, immunization shots, the removal of corns or calluses, or the trimming of nails

1974

Drug Benefit – SUPPLEMENTAL BENEFITS; Covered Services and Supplies – (Wording) Drugs and medicines which by law require a doctor's prescription

1975

Drug Benefit – SUPPLEMENTAL BENEFITS; Covered Services and Supplies – (Wording) Drugs and medicines which by law require a doctor's prescription, except that insulin is covered for known diabetics

1976

Drug Benefit

BASIC HOSPITAL BENEFITS; Covered Hospital Services – Prescription Drugs Changes Page: Medically necessary prescriptions provided and billed for by institutions that are not "hospitals" are covered.

SUPPLEMENTAL BENEFITS; Covered Services and Supplies – (Wording) Drugs and medicines which by law of the United States requires a physician's prescription, except that insulin is covered for known diabetics

Preventive Benefit – (Wording) 1st Exclusion: For routine examinations, periodic physical examinations, immunization shots, the removal of corns or calluses, or the trimming of nails; however, the initial routine in-hospital examination of a new-born infant covered by a family enrollment is not excluded

2nd Exclusion: Deleted. ChangesPage: Basic Surgical-Medical Benefits now cover the initial in-hospital examination of a newborn child covered by a family enrollment

1977

Drug Benefit

BASIC HOSPITAL BENEFITS; Covered Hospital Services – Drugs and medicines for use in the hospital when listed in official formularies (No explanation for returning to original verbiage.)

High Option	Low Option
80% UCR	75% UCR
after $100	after $200
Calendar Year	Calendar Year

Deductible per person Deductible per person

1978

Drug Benefit

BASIC HOSPITAL BENEFITS; Covered Hospital Services – Drugs and medicines
(No explanation for the change to Drugs and medicines)

SUPPLEMENTAL BENEFITS: Covered Services and Supplies – (Wording) Drugs and medicines (including generic drugs) which by a federal law of the United States require a physician's prescription; and insulin
Changes page: Brochure clarification to clarify – That second surgical opinions and generic drugs are covered

Preventive Benefit

(Wording) 1st Exclusion: For routine examinations, periodic physical examinations, immunization shots, the removal of corns or calluses, or the trimming of nails
(No explanation of the partial deletion, but it's probably based on the "reorganization" of the brochure that was mentioned on the Changes page).

1979

Drug Benefit

BASIC HOSPITAL BENEFITS; Covered Hospital Services – Drugs (No explanation of change)

1980

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
SUPPLEMENTAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $100 Calendar Year Deductible per person	75% UCR after $200 Calendar Year Deductible per person, subject to $150,000 Lifetime Maximum for Supplemental Benefits

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Both Options
- Well Child Care for first routine inhospital examination of a newborn covered by a family enrollment

Changes from 1979

No Change
High Option – Supplemental Benefits $500,000 Lifetime Maximum eliminated

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1981

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
SUPPLEMENTAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $150 Calendar Year Deductible per person	75% UCR after $200 Calendar Year Deductible per person, subject to $150,000 Lifetime Maximum for Supplemental Benefits

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Both Options
- Well Child Care for first routine inhospital examination of a newborn covered by a family enrollment

Changes from 1980

No Change
High Option – Supplemental Benefits CYD increased to$150

1982

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
SUPPLEMENTAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $500,000 Lifetime Maximum for Supplemental Benefits

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Both Options
- Well Child Care for first routine inhospital examination of a newborn covered by a family enrollment

Changes from 1981

Well Child – "inhospital" requirement removed
High Option – Supplemental Benefits CYD raised to $200
Std Option – Supplemental Benefits CYD raised to $250; Lifetime Maximum raised to $500,000

1983

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
SUPPLEMENTAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $1 Million Lifetime Maximum for Supplemental Benefits

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Both Options
- Well Child Care for first routine examination of a newborn covered by a family enrollment

Changes from 1982

No Change
Standard Option – Supplemental Benefits Lifetime Maximum increased to $1 Million

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1984

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
SUPPLEMENTAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $500,000 Lifetime Maximum for Supplemental Benefits

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Both Options
- Well Child Care for first routine inhospital examination of a newborn covered by a family enrollment

Changes from 1983

No Change

1985

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
MAJOR MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $1 Million Lifetime Maximum

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Child Care for first routine examination of a newborn covered by a family enrollment

High Option	Standard Option
80% UCR	75% UCR after $250 Calendar Year Deductible

Changes from 1984

"SUPPLEMENTAL" BENEFITS becomes "MAJOR MEDICAL"

1986

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital.
Both Options – In Full
OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $500,000 Lifetime Maximum

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits, routine physical exams, and immunizations for children up to age 1 year

Changes from 1985

Standard Option - Well Baby Care expanded to include routine physicals and immunizations for children up to age 1 year; payment increased to 100% (no deductible).
"MAJOR MEDICAL" BENEFITS becomes "OTHER MEDICAL"

1987

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full after $50 per admission deductible	In Full after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR after $200 Calendar Year Deductible per person	75% UCR after $250 Calendar Year Deductible per person, subject to $2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$3 copay	$5 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

Both Options
- Excludes routine examinations, periodic physical examinations,

immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests and immunizations for children up to age 6 years

Changes from 1986

Both Options – Mail Order Rx Drug Program added
Standard Option - Well Baby Care expanded to include children up to age 6 years; laboratory tests

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1988

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full	In Full
after $50 per admission deductible	after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR	75% UCR
after $200	after $250 Calendar Year
Calendar Year Deductible	Deductible per person, subject to
per person	$2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$3 copay	$5 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

Both Options

- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests and immunizations for children up to age 6 years

Changes from 1987

No Change

1989

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full	In Full
after $50 per admission deductible	after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR	75% UCR
after $200	after $250 Calendar Year
Calendar Year Deductible	Deductible per person, subject to
per person	$2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$5 copay	$7 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

Both Options

- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 6 years

Changes from 1988

Mail Order Rx Copays increased from $3 to $5 (High)/ from $5 to $7 (Std)

1990

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full	In Full
after $50 per admission deductible	after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR	75% UCR
after $200	after $250 Calendar Year
Calendar Year Deductible	Deductible per person, subject to
per person	$2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$5 copay	$7 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

Both Options

- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 6 years

Changes from 1989

No Changes

1991

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full	In Full
after $50 per admission deductible	after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR	75% UCR
after $200 Calendar Year Deductible per person	after $250 Calendar Year Deductible per person, subject to $2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$5 copay	$10 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

Both Options

- Excludes routine examinations, periodic physical examinations, immunization shots, or removal of corns/calluses or trimming of nails

Well Baby Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 6 years

Changes from 1990

Standard Option – Mail Order Drug copay increased from $7 to $10

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
In Full	In Full
after $50 per admission deductible	after $100 per admission deductible

OTHER MEDICAL BENEFITS: Drugs which by Federal law of the United States require a physician's prescription, and insulin.

High Option	Standard Option
80% UCR	75% UCR
after $200 Calendar Year Deductible per person	after $250 Calendar Year Deductible per person, subject to $2 Million Lifetime Maximum

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$5 copay	$7 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

Both Options

-Excludes routine examinations, periodic physical examinations, immunization shots, or x-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness, injury, set of symptoms, or maternity care, except:

Routine (Screening) Mammograms, per schedule: 1 between age 35-39; 1 every two years age 40-49; 1 every calendar year age 50-64; 1 every two years age 65 and over

High Option	Standard Option
80% UCR	75% UCR
after $200 Calendar Year Deductible	after $250 Calendar Year Deductible

Well Child Care

High Option	Standard Option
80% UCR	100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 13 years

Changes from 1991

Both Options – Coverage added for adult routine mammograms, and for office visits associated with routine mammograms & PAP smears

Standard Option – Well Child Care expanded to include children up to age children up to age 13; "Well Baby Care" becomes "Well Child Care"

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of charges	NonPPO – 60% of charges

(Rx deductible and coinsurance waived if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B is primary)

Preventive Benefits

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
PPO - 95% PPA	PPO – 95% PPA
NonPPO – 80% UCR	NonPPO – 75% UCR

Mammogram – 1 between age 35-39; 1 every two years age 40-49; 1 every calendar year age 50-64; 1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older
(Associated office visit covered only for PPO physician – $10 copay, both Options)

WELL CHILD CARE

High Option	Standard Option
PPO – 95% PPA	PPO – 100% PPA
NonPPO- 80% UCR	NonPPO – 100% UCR
First routine newborn exam	First routine newborn exam, and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 13 years

Changes from 1992

"National" PPO added – PPO benefit 95% allowable/ NonPPO 75% allowable charge
PPO Retail Pharmacy Program added – separate $50 pharmacy deductible; 20% coinsurance differential PPO/NonPPO
Mail Order Rx Copay increased from $5 to $8 (High)/ from $10 to $12 (Std)
Inpatient deductible increased from $50 to $100 (High)/ from $100 to $250 (Std).
Additional routine screenings added: PAP smear, mammogram, fecal occult blood test for colorectal screening PSA test for prostate (Associated office visit covered for PPO only)

1994

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of Billed charge	NonPPO – 60% of billed charge

(Rx deductible and PPO coinsurance waived if Medicare Part B primary
(15% (High)/ 20% (Std) coinsurance required for Non-PPO pharmacy if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $10 copayment, each home and office visit for a routine physical examination, including history and risk assessment, is covered in full when provided by a Preferred physician or a Preferred facilityon an outpatient basis:

General Health Screening- (History and risk assessment 1 per three years through age 64; 1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every two years age 40-49; 1 every year age 50-64; 1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% UCR	NonPPO – 75% UCR

Mammogram – 1 between age 35-39; 1 every two years age 40-49; 1 every calendar year age 50-64; 1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit covered only for PPO physician – $10 copay, both Options)

WELL CHILD CARE

Pays 100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations for children up to age 2 (High Option) or up to age 13 (Standard Option).

Changes from 1993

Retail Rx coinsurance (15% High/20% Std) required fir Non-PPO if Medicare Part B is primary
Rx coverage added for diabetic testing supplies and disposable syringes
PPO (only) benefit added for history and risk assessment - $10 copay (both Options)
Routine screenings paid in full when rendered by PPO provider
Added High Option coverage for Well Child Care, to age 2 years

1995

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of Billed charge	NonPPO – 60% of billed charge

(Rx deductible and PPO coinsurance waived if Medicare Part B primary;
(15%(High)/ 20%(Std) coinsurance required for Non-PPO pharmacy if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $10 copayment, each home and office visit for a routine physical examination, including history and risk assessment, is covered in full when provided by a Preferred physician or a Preferred facilityon an outpatient basis (does not include associated x-ray and laboratory tests except those noted below):

General Health Screening- (History and risk assessment 1 per three years through age 64; 1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every two years age 40-49; 1 every year age 50-64; 1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

Immunizations – for influenza (1 per year) and pneumonia (1 per year) paid in full under both Options

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% UCR	NonPPO – 75% UCR

Mammogram – 1 between age 35-39; 1 every two years age 40-49; 1 every calendar year age 50-64; 1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit not covered, except by PPO under Additional Benefits above)

WELL CHILD CARE

100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations recommended by American Academy of Pediatrics, for children up to age 22.

Changes from 1994

Coverage added for immunizations for influenza and pneumonia, in full after $10 PPO copay
Well Child Care benefits expanded to include children up to age 22, under both Options
Rx Drug Prior Approval requirement added
Retail Rx now limited to 90 day supply per prescription or refill

1996

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of Billed charge	NonPPO – 60% of billed charge
(Non-PPO coinsurance 15% for	(Coinsurance not waived for
Medicare B enrollees)	Medicare B enrollees)

(Rx deductible waived if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $10 copayment, each home and office visit for a routine physical examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, complete blood count (CBC), and 19-channel chemistry test, is covered in full when provided by a Preferred physician or a Preferred facility:

Routine physical exam- (1 per three years through age 64;1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every two years age 40-49;
1 every year age 50-64; 1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

Immunizations – paid in full under both Options, for:
influenza (1 per year) and pneumonia (1 per year)
Tetanus-diphtheria booster, (1 every ten years)

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% PAR or NPA	NonPPO – 75% PAR or NPA

Mammogram – 1 between age 35-39; 1 every two years age 40-49;
1 every calendar year age 50-64; 1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit not covered, except by PPO under Additional Benefits above)

WELL CHILD CARE

Pays 100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations recommended by American Academy of Pediatrics, for children up to age 22 (both Options)

Changes from 1995

TD booster immunizations and Routine Physical lab tests added toPPO Preventive Benefit
Standard Option: Retail Pharmacy coinsurance not waived for Medicare enrollees;
PPA/PAR/NPA allowances

1997

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of Billed charge	NonPPO – 60% of billed charge
(Non-PPO coinsurance 15% for Medicare B enrollees)	(Coinsurance not waived for Medicare B enrollees)

(Rx deductible waived if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $10 copayment, each home and office visit for a routine physical examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, complete blood count (CBC), and 19-channel chemistry test, is covered in full when provided by a Preferred physician or a Preferred facility.

Routine physical exam- (1 per three years through age 64;1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every two years age 40-49;
1 every year age 50-64; 1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

Immunizations – paid in full under both Options, for:
influenza (1 per year) and pneumonia (1 per year)
Tetanus-diphtheria booster, (1 every ten years)

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% PAR or NPA	NonPPO – 75% PAR or NPA

Mammogram – 1 between age 35-39; 1 every two years age 40-49;
1 every calendar year age 50-64; 1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit not covered, except by PPO under Additional Benefits above)

WELL CHILD CARE

Pays 100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations recommended by American Academy of Pediatrics, for children up to age 22 (both Options)

Changes from 1996

No Changes

1998

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of Billed charge	NonPPO – 60% of billed charge
(Non-PPO coinsuance 15% for Medicare enrollees)	(Coinsuance not waived for Medicare enrollees)

(Rx deductible waived if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $10 copayment, each home and office visit for a routine physical examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, complete blood count (CBC), and 19-channel chemistry test, is covered in full when provided by a Preferred physician or a Preferred facility.

Routine physical exam- (1 per three years through age 64;1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every year age 40-64;
1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

Immunizations – paid in full under both Options, for:
influenza (1 per year) and pneumonia (1 per year)
Tetanus-diphtheria booster, (1 every ten years)

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% PAR or NPA	NonPPO – 75% PAR or NPA

Mammogram – 1 between age 35-39; 1 every year age 40-64;
1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit not covered, except by PPO under Additional Benefits above)

WELL CHILD CARE

Pays 100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations recommended by American Academy of Pediatrics, for children up to age 22 (both Options)

Changes from 1997

Mammogram screening schedule changed – 1 every year ages 40-64

1999

Rx Benefits

BASIC HOSPITAL BENEFITS: Drugs and medicines for use in the hospital

High Option	Standard Option
PPO - In Full	PPO - In Full
NonPPO - In Full	NonPPO - In Full
after $100 per admission deductible	after $250 per admission deductible

RETAIL PHARMACY PROGRAM

High Option	Standard Option
after $50 Rx Deductible,.	after $50 Rx Deductible,
PPO - 85% PPA	PPO – 80% PPA
Non-PPO – 65% of AWP	NonPPO – 60% of AWP
(Average Wholesale Price)	(Average Wholesale Price)
(Non-PPO coinsuance 15% for Medicare enrollees)	(Coinsuance not waived for Medicare enrollees)

(Rx deductible waived if Medicare Part B primary)

MAIL ORDER DRUG PROGRAM

High Option	Standard Option
$8 copay	$12 copay

(Copay waived if Medicare Part B Primary)

Preventive Benefits

ADDITIONAL BENEFITS

Both Options – After a $12 copayment, each home and office visit for a routine physical examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, complete blood count (CBC), and 19-channel chemistry test, is covered in full when provided by a Preferred physician or a Preferred facility.

Routine physical exam- (1 per three years through age 64;1 every year, age 65 and over)
Cholesterol tests (1 per three years, through age 64; 1 per year, age 65 and over)
Fecal occult blood tests (1 per year ,over age 40)
Mammograms (1 between age 35-39; 1 every year age 40-64;
1 every two years age 65 and over)
PAP smears (1 every year, women age 18 and over)
PSA tests (1 every year, men age 40 and over)

Immunizations – paid in full under both Options, for:
influenza (1 per year) and pneumonia (1 per year)
Tetanus-diphtheria booster, (1 every ten years)

OTHER MEDICAL BENEFITS - coverage for routine (screening) tests:

High Option	Standard Option
After the $150 CYD,	After the $200 CYD,
NonPPO – 80% PAR or NPA	NonPPO – 75% PAR or NPA

Mammogram – 1 between age 35-39; 1 every year age 40-64;
1 every two years age 65 and over
PAP smear- 1 every year for women age 18 and older
Fecal occult – 1 every year for members age 40 and older
PSA – 1 every year for men age 40 and older

(Associated office visit not covered, except by PPO under Additional Benefits above)

WELL CHILD CARE

Pays 100% Allowable Charge for the first routine newborn exam (inpatient or outpatient), and physician office visits for routine physical exams, laboratory tests, and immunizations recommended by American Academy of Pediatrics, for children up to age 22 (both Options)

Changes from 1998

PPO Office Visit charge raised from $10 to $12
Retail Rx Non-PPO Allowable Charge - Average Wholesale Price (from Billed Charge)

Ed Flynn

FAX TRANSMITTAL SHEET

U. S. OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
1900 E STREET, N.W., ROOM 4A10
WASHINGTON, D.C. 20415

Telephone (202) 606-0600

Number of Pages 3
(Including Cover Sheet)

TO: Chris Jennings DATE: 5/18/99

Telephone Number 9565560 Fax Number 456-5557

FROM: Ed Flynn DATE: _____

Telephone Number _____ Fax Number _____

COMMENTS:

Note for Chris Jennings:

Chris, following our conversation the other day, we prepared the attached table depicting the likely premiums that would be charged if uninsured 55-64 year olds and uninsured 65+ individuals participated in the Federal Employees Health Benefits Program as a separate risk pool.

The one thing we have not yet been able to do is predict participation at different premium price points. This is the case because our actuaries have not been able to come across any reliable information that would suggest how people in these age groups would behave and what their demographic and health characteristics might look like. If you know of anyone we should talk with who has done some work in this area, that would be helpful.

Give me a call if you want to discuss. You can reach me at (202) 606-0600.

Ed Flynn
May 18, 1999

Attachment

Attachment 3

Annual Cost of FEHBP with Uninsured in Separate Risk Pools

SOURCE: OPM \ RIS \ Office of Actuaries *12-May-99*

(With No Government Contributions to Uninsured)

	Self Contracts			Family Contracts			Total / Average			
	Cost	EE Prem	Count	Cost	EE Prem	Count	Cost	Govt Prem	EE Prem	Count
Current FEHBP	$ 2,828	$ 792	1,752,552	$ 6,291	$ 1,761	2,366,629	$ 4,818	$ 3,469	$ 1,349	4,119,181
Uninsured 55-64	$ 5,486			$ 8,556			$ 7,250			
Uninsured 65+	$ 5,967			$ 9,940			$ 8,250			

Program Cost For Current Enrollees

	Total Gov't	Total Enrollee	Total Program
Current FEHBP	$ 14,288,169,668	$ 5,556,510,427	$ 19,844,680,095
Uninsured 55-64			
w/ 100K	$ -	$ 724,983,214	$ 724,983,214
w/ 250K	$ -	$ 1,812,458,036	$ 1,812,458,036
w/ 500K	$ -	$ 3,624,916,072	$ 3,624,916,072
w/ 1M	$ -	$ 7,249,832,144	$ 7,249,832,144
w/ 3M	$ -	$ 21,749,496,433	$ 21,749,496,433
Uninsured 65+			
w/ 100K	$ -	$ 824,954,999	$ 824,954,999
w/ 250K	$ -	$ 2,062,387,498	$ 2,062,387,498
w/ 500K	$ -	$ 4,124,774,997	$ 4,124,774,997
w/ 1M	$ -	$ 8,249,549,993	$ 8,249,549,993

FEHBP & Medicare Buy-In

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Number of Pages 7
(Including Cover Sheet)

TO: Chris Jennings DATE: 5/6/99

Telephone Number 4565560 Fax Number 45655557

FROM: Ed Flynn DATE:

Telephone Number Fax Number

COMMENTS:

Federal Family Health Coverage Act of 1999

Preliminary Analysis
May 1999

This analysis provides preliminary views on draft legislation, the Federal Family Health Coverage Act of 1999. This bill would amend title 5 of the United States Code to make dependent parents of Federal employees and annuitants eligible for health benefits coverage under the Federal Employees Health Benefits Program. Under this bill, otherwise uninsured dependent parents of Federal employees and annuitants would be eligible family members for health insurance purposes.

Our initial analysis shows that this bill is objectionable for a number of policy, cost and administrative reasons. Also, given consideration of proposals to extend health insurance coverage under the Federal Employees Health Benefits Program more broadly, we have added a brief discussion of those broader issues.

Policy Concerns

The bill would create a policy framework for coverage in the Federal Employees Health Benefits Program that is fundamentally unsound. The Federal Employees Health Benefits Program provides coverage as a component of a benefits package that enables the Government to recruit and retain the workforce it needs to carry out its varied and complex functions. Because health insurance is intrinsic to the overall compensation package, the Government makes a substantial employer contribution to premiums -- an average of 72 percent of the total premium. Federal employees and annuitants pay the balance.

In addition, the bill would put the Government and it employees in the unique position of subsidizing, through their employer-provided health insurance program, the health costs of individuals who have never had a relationship to the Federal government as an employer. Such an approach is outside the mainstream of private employer benefit practices. One of the Federal Employees Health Benefits Program's strengths has been its similarity, in broad terms of structure and financing, to programs offered by non-Federal employer sponsors. We are unaware of any major employer in this country that provides health insurance to its employees' parents.

The Program currently covers as family members only spouses (including some former spouses) and dependent children. This is a long-standing, accepted practice in both the public and private sectors, and therefore is in keeping with the Program's basic objective. Besides providing a benefit that competitors in the labor market do not provide, the addition of dependent parents would mean that the

Government would provide richer benefits to employees whose parents are dependent and uninsured. This structural change would not enhance the Program's ability to meet its basic objective. To the contrary, benefits would be mis-aligned with contemporary practice, and employees and annuitants would pick up the cost.

While it is of course true that Federal employees and annuitants may need help in caring for dependent parents who do not have health insurance, there are other family members in similar circumstances. The Program now provides coverage to dependent children, but generally only until age 22. At that time the child may convert to private coverage, but cannot continue to receive a Government-subsidized group insurance benefit, even if he or she remains fully dependent upon the employee or retiree. It would be unjustified to provide Program coverage to dependent parents but not to dependent adult children. Moreover, while the current Program makes group coverage available to former spouses of employees and annuitants under certain conditions, the former spouse does not receive any Government contribution toward the premium payment. This full-premium approach is also true of certain temporary employees and COBRA-type coverage under the Program.

In addition, the proposal would extend Program coverage to "dependent" parents who "are uninsured." While these terms may be precisely and narrowly defined, in practice they would be problematic. To qualify as an "uninsured" parent, he or she might be able to cancel more expensive or less comprehensive coverage. Alternatively, "uninsured" status might be tied to an inability to obtain other insurance. Such a determination would be problematic in itself. In either case, or under any of several other possibilities, the question of whether a parent is "uninsured" would be the determining factor in deciding eligibility for coverage under this Program. An important question will be whether the system will be perceived as fair if individuals who have cancelled or perhaps not attempted to acquire private health insurance should be allowed to obtain this Government employee benefit while those similarly situated, but who have prudently obtained coverage that may be both more expensive and less comprehensive, would be barred from the Program. In addition, making a parent's dependency a qualifying factor – which would produce incentives to create a dependency relationship for the purpose of obtaining Government health insurance – presents similar issues of access and fairness.

Cost Concerns

Our preliminary cost analysis demonstrates that insuring the parent group would increase Government costs substantially, and increase the enrollee share of premiums as well. This would distort the Government's costs as an employer for providing benefits to its workforce.

The effect on both the Government and employees is compounded because benefits utilization is typically higher for older age groups, but premiums for health insurance, unlike life insurance or long-term care insurance, are not age based. As a result, adding parents to the risk pool increases average costs and, therefore, average premiums. Also those parents not eligible for Medicare coverage at age 65 would be able to continue FEHB coverage indefinitely, further exacerbating the impact on average premiums.

While we do not have actual data on the number of uninsured parents of Program enrollees, we estimate there are 75,000 who are in the range of age 55 through 64. As shown in Attachment 1, the total annual Government cost increase would be $391 million if these parents enrolled in the Program. If the Program were available to parents who cancel other insurance we expect that the number of new enrollees would increase by about 300,000 and Government costs would increase by about $1.6 billion per year.

Administrative Concerns

While not by themselves reasons for objecting to passage of the bill as proposed, there are important administrative issues that must be considered. The Federal Employees Health Benefits Program offers a broad choice of health plans to eligible individuals. There is an annual open enrollment period during which participants receive comprehensive information to help them make informed plan selections. While information is available on the Internet for those who have access, most people still rely on printed materials. Federal agencies are an integral part of the distribution system and OPM oversees the distribution of enrollment materials to Federal annuitants. Enrollment itself is handled through agencies or OPM, not directly with the carriers, and premiums are generally deducted from pay or annuity.

Given the many and varied aspects of program administration handled by Federal employing agencies or OPM, complicating factors and their associated costs would be introduced by extending health insurance to a group with no direct relationship to the Federal Government. While all of these issues could be overcome, it is important to point out the fact that different administrative strategies would be necessary for this group.

Expanded Coverage under the Federal Employees Health Benefits Program

Some might argue that a more general approach would be appropriate. Under such a scenario, all uninsured people in the country above a specified age would be eligible to enroll in the Federal Employees Health Benefits Program at their own

cost. Such an approach would also have a substantial cost impact on the Government and the Federal workforce, as shown in the cost analysis below. Of particular concern would be the potential for adverse selection because enrollees would pay the total premium plus some administrative service charge.

As shown in Attachment 2, if the estimated 3 million uninsured people in the country between the ages of 55 and 64 are included in the Program, the projected increase in the yearly premium would be $1025 per enrollee. This increase would be due to the increased costs associated with the age of this population. Even if the new enrollees were required to pay the full premium, the Government share of the increased premium for current enrollees would increase over $3 billion each year after enactment. For each enrollee the Government share of the premium would increase $738 and the enrollee share would increase $287 annually. The addition of another 1 million people over age 65 who do not qualify for Medicare would compound the costs even if those enrollees also paid the full premium. The average annual premium would increase an additional $670, of which the Government share for Program enrollees would be $482 and the enrollee share would be $188. The combined increase in Government cost for an additional 4 million enrollees would exceed $5 billion.

The administrative concerns we discussed in connection with the draft Federal Family Health Coverage Act would be even greater because these enrollees would have no link at all to the Federal Government as an employer.

Conclusion

For reasons of policy, cost and administration, we cannot support proposals to cover non-affiliated individuals under the Federal Employees Health Benefits Program. However, as administrators of the Program, we can help others develop programs that emulate its principles. Under the authority of the Defense Authorization Act of 1998, we are working with the Department of Defense to implement a demonstration program that will cover up to 66,000 Medicare-eligible retired military beneficiaries and their dependents in selected demonstration areas. That legislation provides specifically for separate risk pools for rating purposes. We might work in a similar way with State purchasing cooperatives to give coalitions of uninsured individuals access to the health plans offered by insurance carriers that participate in the Federal Employees Health Benefits Program.

Attachments

Attachment 1

Annual Cost of FEHBP with Uninsured in the Risk Pool

SOURCE: OPM \ RIS \ Office of Actuaries *06-May-99*

(With a Government Contribution to Uninsured)

	Self Contracts			Family Contracts			Total / Average			
	Cost	EE Prem	Count	Cost	EE Prem	Count	Cost	Govt Prem	EE Prem	Count
Current	$ 2,828	$ 792	1,752,552	$ 6,291	$ 1,761	2,366,629	$ 4,818	$ 3,469	$ 1,349	4,119,181
w/75K 55-64	$ 2,876	$ 805	1,784,462	$ 6,331	$ 1,773	2,409,719	$ 4,861	$ 3,500	$ 1,361	4,194,181
change	$ 48	$ 13	31,910	$ 40	$ 11	43,090	$ 43	$ 31	$ 12	75,000
% change	1.7%	1.7%	1.8%	0.6%	0.6%	1.8%	0.9%	0.9%	0.9%	1.8%
w/3M 55-64	$ 3,948	$ 1,105	3,028,936	$ 7,245	$ 2,029	4,090,245	$ 5,843	$ 4,207	$ 1,636	7,119,181
change	$ 1,120	$ 314	1,276,384	$ 954	$ 267	1,723,616	$ 1,025	$ 738	$ 287	3,000,000
% change	39.6%	39.6%	72.8%	15.2%	15.2%	72.8%	21.3%	21.3%	21.3%	72.8%
w/1M 65+	$ 3,441	$ 964	2,178,013	$ 7,004	$ 1,961	2,941,168	$ 5,488	$ 3,951	$ 1,537	5,119,181
	$ 613	$ 172	425,461	$ 713	$ 200	574,539	$ 670	$ 483	$ 188	1,000,000
	21.7%	21.7%	24.3%	11.3%	11.3%	24.3%	13.9%	13.9%	13.9%	24.3%

Program Costs for All Enrollees

	Total Gov't	Total Enrollee	Total Program
Current	$ 14,288,169,668	$ 5,556,510,427	$ 19,844,680,095
w/75K 55-64	$ 14,679,659,711	$ 5,708,756,554	$ 20,388,416,265
change	$ 391,490,042	$ 152,246,127	$ 543,736,170
% change	2.7%	2.7%	2.7%
w/3M 55-64	$ 29,947,806,713	$ 11,646,369,277	$ 41,594,175,990
change	$ 15,659,637,044	$ 6,089,858,851	$ 21,749,495,895
% change	109.6%	109.6%	109.6%
w/1M 65+	$ 20,227,846,450	$ 7,866,384,730	$ 28,094,231,180
change	$ 5,939,676,781	$ 2,309,874,304	$ 8,249,551,085
% change	41.6%	41.6%	41.6%
w/All ($M)	$ 35,887,483,494	$ 13,956,243,581	$ 49,843,727,075
change	$ 21,599,313,826	$ 8,399,733,154	$ 29,999,046,980
% change	151.2%	151.2%	151.2%

Attachment 2

Annual Cost of FEHBP with Uninsured in the Risk Pool

SOURCE: OPM \ RIS \ Office of Actuaries 05-May-99

(With No Government Contributions to Uninsured)

	Self Contracts			Family Contracts			Total / Average			
	Cost	EE Prem	Count	Cost	EE Prem	Count	Cost	Govt Prem	EE Prem	Count
Current	$ 2,828	$ 792	1,752,552	$ 6,291	$ 1,761	2,366,629	$ 4,818	$ 3,469	$ 1,349	4,119,181
w/300K 55-64	$ 3,008	$ 842	1,880,190	$ 6,445	$ 1,805	2,538,991	$ 4,983	$ 3,588	$ 1,395	4,419,181
change	$ 180	$ 51	127,638	$ 154	$ 43	172,362	$ 165	$ 119	$ 46	300,000
% change	6.4%	6.4%	7.3%	2.4%	2.4%	7.3%	3.4%	3.4%	3.4%	7.3%
w/3M 55-64	$ 3,948	$ 1,105	3,028,936	$ 7,245	$ 2,029	4,090,245	$ 5,843	$ 4,207	$ 1,636	7,119,181
change	$ 1,120	$ 314	1,276,384	$ 954	$ 267	1,723,616	$ 1,025	$ 738	$ 287	3,000,000
% change	39.6%	39.6%	72.8%	15.2%	15.2%	72.8%	21.3%	21.3%	21.3%	72.8%
w/1M 65+	$ 3,441	$ 964	2,178,013	$ 7,004	$ 1,961	2,941,168	$ 5,488	$ 3,951	$ 1,537	5,119,181
	$ 613	$ 172	425,461	$ 713	$ 200	574,539	$ 670	$ 483	$ 188	1,000,000
	21.7%	21.7%	24.3%	11.3%	11.3%	24.3%	13.9%	13.9%	13.9%	24.3%

Program Cost For Current Enrollees

	Total Gov't	Total Enrollee	Total Program
Current	$ 14,288,169,668	$ 5,556,510,427	$ 19,844,680,095
w/300K 55-64	$ 14,777,862,369	$ 5,746,946,477	$ 20,524,808,846
change	$ 489,692,701	$ 190,436,050	$ 680,128,751
% change	3.4%	3.4%	3.4%
w/3M 55-64	$ 17,327,897,184	$ 6,738,626,683	$ 24,066,523,867
change	$ 3,039,727,516	$ 1,182,116,256	$ 4,221,843,772
% change	21.3%	21.3%	21.3%
w/1M 65+	$ 16,276,463,123	$ 6,329,735,659	$ 22,606,198,782
change	$ 1,988,293,455	$ 773,225,232	$ 2,761,518,687
% change	13.9%	13.9%	13.9%
w/All ($M)	$ 19,316,190,639	$ 7,511,851,915	$ 26,828,042,554
change	$ 5,028,020,970	$ 1,955,341,488	$ 6,983,362,459
% change	35.2%	35.2%	35.2%

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Number of Pages 3
(Including Cover Sheet)

TO: Chris Jennings DATE: 5/18/99

Telephone Number 456-5560 Fax Number 456-5557

FROM: Ed Flynn DATE: _____

Telephone Number _____ Fax Number _____

COMMENTS:

Note for Chris Jennings:

Chris, following our conversation the other day, we prepared the attached table depicting the likely premiums that would be charged if uninsured 55-64 year olds and uninsured 65+ individuals participated in the Federal Employees Health Benefits Program as a separate risk pool.

The one thing we have not yet been able to do is predict participation at different premium price points. This is the case because our actuaries have not been able to come across any reliable information that would suggest how people in these age groups would behave and what their demographic and health characteristics might look like. If you know of anyone we should talk with who has done some work in this area, that would be helpful.

Give me a call if you want to discuss. You can reach me at (202) 606-0600.

Ed Flynn
May 18, 1999

Attachment

Attachment 3

Annual Cost of FEHBP with Uninsured in Separate Risk Pools

SOURCE: OPM \ RIS \ Office of Actuaries *12-May-99*

(With No Government Contributions to Uninsured)

	Self Contracts			Family Contracts			Total / Average			
	Cost	EE Prem	Count	Cost	EE Prem	Count	Cost	Govt Prem	EE Prem	Count
Current FEHBP	$ 2,828	$ 792	1,752,552	$ 6,291	$ 1,761	2,366,629	$ 4,818	$ 3,469	$ 1,349	4,119,181
Uninsured 55-64	$ 5,486			$ 8,556			$ 7,250			
Uninsured 65+	$ 5,967			$ 9,940			$ 8,250			

Program Cost For Current Enrollees

	Total Gov't	Total Enrollee	Total Program
Current FEHBP	$ 14,288,169,668	$ 5,556,510,427	$ 19,844,680,095
Uninsured 55-64			
w/ 100K	$ -	$ 724,983,214	$ 724,983,214
w/ 250K	$ -	$ 1,812,458,036	$ 1,812,458,036
w/ 500K	$ -	$ 3,624,916,072	$ 3,624,916,072
w/ 1M	$ -	$ 7,249,832,144	$ 7,249,832,144
w/ 3M	$ -	$ 21,749,496,433	$ 21,749,496,433
Uninsured 65+			
w/ 100K	$ -	$ 824,954,999	$ 824,954,999
w/ 250K	$ -	$ 2,062,387,498	$ 2,062,387,498
w/ 500K	$ -	$ 4,124,774,997	$ 4,124,774,997
w/ 1M	$ -	$ 8,249,549,993	$ 8,249,549,993

Copied
Sperling
Jennings
Podesta

THE PRESIDENT HAS SEEN
6-1-99

THE WHITE HOUSE
WASHINGTON

May 29, 1999

15% → How much over 10 yrs
→ How much to 2020
→ If not 15%, give to Tax cuts

MEMORANDUM TO THE PRESIDENT

350
150
200

350
50
300

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Explain carrots for seniors

THE PRESIDENT HAS SEEN
6-1-99

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). It would save about $9 billion over 10 years and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

THE PRESIDENT HAS SEEN
6-1-99

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	**123.0**
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	**164.1**
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
$10,000 LIMIT*	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**141.6**
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**188.8**
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	**134.8**
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	**179.9**
Premiums		***$16***	***$20***	***$21***	***$24***	***$27***	***$34***	***$36***	***$39***	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

THE PRESIDENT HAS SEEN
6-1-99

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.

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THE PRESIDENT HAS SEEN
6-1-99

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No-ux wants - tracks to MC Myers Outrage

ILLUSTRATIVE PACKAGES. On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare Income-Related Premium ($80/100)	-25	Modernize Medicare Income-Related Premium ($80/100)	-25	Modernize Medicare Income-Related Premium ($80/100)	-25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions:**		**Additions:**	
Income-Related Premium ($60/90)	-7	Tobacco Tax	-45	Surplus	**-90**
More Provider Cuts	-7	Income-Related Premium ($60/90)	-7		
Raise Deductible to $150 and index	-10				
Subtotal:	**-24**		**-52**		
Drug Benefit:		**Drug Benefit:**		**Drug Benefit:**	
$5,000 Limit 50% Premium: $24/$48*	**+123**	$5,000 Limit 67% Premium: $16/$32*	**+164**	$5,000 Limit 67% Premium: $16/$32*	**+154**
		$10,000 Limit 50% Premium: $31/$55*	**+142**	$10,000 Limit 67% Premium: $21/$36*	**+189**
		No Dollar Limit 50% Premium: $24/$58*	**+135**	No Dollar Limit 67% Premium: $16/$39*	**+180**
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-30**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

** This amount is a necessary "cushion" pending final cost estimates. Drug estimates assume about $5 billion in savings from state maintenance of effort.

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

REVISED

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare	-14	Modernize Medicare	-14	Modernize Medicare	-14
Income-Related		Income-Related		Income-Related	
Premium ($80/100)	-25	Premium ($80/100)	-25	Premium ($80/100)	-25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions**:		**Additions**:	
Income-Related		Tobacco Tax	-45	Surplus	**-90**
Premium ($60/90)	-7	Income-Related			
More Provider Cuts	-7	Premium ($60/90)	-7		
Raise Deductible to $150 and index	-10				
Subtotal:	**-24**	**Subtotal:**	**-52**		
Drug Benefit:		**Drug Benefit**:		**Drug Benefit**:	
$5,000 Limit 50% Premium: $24/$48*	**+123**	$5,000 Limit 67% Premium: $16/$32*	**+164**	$5,000 Limit 67% Premium: $16/$32*	**+164**
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		No Dollar Limit 50% Premium: $24/$58*	**+135**	No Dollar Limit 67% Premium: $16/$39*	**+180**
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-31**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

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THE WHITE HOUSE

WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. ~~All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries~~. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). ~~It would save about $9 billion over 10 years~~ and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	123.0
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	164.1
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
*$10,000 LIMIT **	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	141.6
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	188.8
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	134.8
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
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All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

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Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
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Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions:**		**Additions:**	
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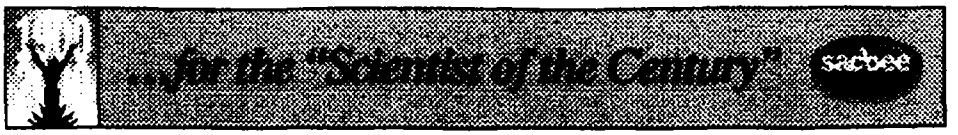

Long-term health insurance proposal put on back burner: Rescuing Medicare system is priority, GOP aides insist

By Lawrence M. O'Rourke
Bee Washington Bureau
(Published April 24, 1999)

WASHINGTON -- A proposal to help people buy long-term health insurance -- one of President Clinton's key proposals to this Congress -- has been quietly shelved by Republican leaders on Capitol Hill.

GOP aides say Congress will have to deal with preservation of the Medicare system, with the likely inclusion of prescription drug coverage, before it gets around to considering Clinton's initiative for long-term care.

With the Medicare debate unlikely to take place until 2000 -- after Clinton submits his plan later this year for Medicare preservation -- there is virtually no chance that the federal government will step in soon to help an aging society pay for long-term care in either nursing homes or the homes of family members and friends, according to Republican aides.

Appeals court to mediate Prop. 187: If compromise attempt flops, next move would be up to Davis
Lawmakers vote to limit 'club cards': Bill would let consumers keep their shopping habits private
Welfare reforms imperil Medi-Cal families, groups fear
Dan Walters: A think-small water proposal
Capitol Digest: Davis gets bill on vote counting
High court to decide if FDA can limit nicotine: Agency rules would target youth smoking
New opposition to Doolittle plan for water emerges

In his agenda for the year, on which he hoped to build his presidential legacy, Clinton urged an annual tax credit of up to $1,000 for eligible people with long-term care needs, their spouses, and certain caregivers such as adult children supporting their aging parents.

The Clinton administration estimated the cost of the program at about $6 billion over five years. But the cost to the federal treasury would climb as baby boomers reach old age and turn increasingly to nursing homes for care.

"As the elderly population grows, as there are more 85-year-olds in need of nursing home care, it would be more than Medicaid can handle," said Judith Feder, who played a key role in formulating Clinton's health policy. Feder is now dean of policy studies at Georgetown University.

About two-thirds of elderly and disabled Americans in nursing homes are on Medicaid. Most have no income and have exhausted their private savings.

A majority of Americans still mistakenly believe that Medicare pays for long-term health care, said Edward Howard, executive vice president of Alliance for Health reform, a bipartisan think tank chaired by Sens. Jay Rockefeller, D-W.Va., and Bill Frist, R-Tenn.

Given the immediate need to rescue Medicare and the growing pressure to include prescription drugs, there is little push on Capitol Hill for the Clinton long-term insurance plan.

"We're very hopeful that Congress will approve the president's proposal," said Jeanette C. Takamura, assistant secretary for aging at the Department of Health and Human Services.

But she expressed greater confidence in Congress approving the Clinton proposal for a family caregiver support program, which would cost about $625 million over five years.

The caregiver support plan would provide information and services to families caring for elderly people with long-term care needs. The support would include respite services that would allow caregivers a break from their care responsibilities. States would be required to give priority to elderly people and families living in poverty.

"Most long-term care is being provided by family members," Takamura said. About 70,000 family members would be able to get occasional breaks from their care-giving duties under the Clinton plan, Takamura said.

The U.S. private health insurance industry is "very supportive" of the Clinton proposal, said Dean A. Rosen, senior vice president of the Health insurance Association of America.

Americans are starting to buy long-term health insurance, Rosen said, estimating that about 6 million policies would be sold this year. He said the average buyer of a long-term policy is 67.

An average 40-year-old can buy a base policy for $247 a year. But it costs a 65-year-old $980 a year, and a 79-year-old $3,907 a year, Rosen said.

As baby boomers enter retirement, there will be growing public pressure for long-term insurance, Rosen said.

The private health insurance industry, he said, would like to see Congress allow purchasers to deduct the entire premiums on their tax returns. He said that employee 401(k) retirement savings plans should be adjusted to allow long-term insurance purchases.

Rosen said relatively few employers offer long-term care as part of their benefits package, and most who do offer it do not pay for it, but make it available to employees.

Russia uses U.S. devices to reduce nuke risks

Will stand firm on ABM treaty

By Martin Nesirky
REUTERS NEWS AGENCY

A1

MOSCOW — The general in charge of Russian nuclear weapons safety said yesterday that lie detectors and other U.S. monitoring devices were helping Moscow weed out officers unsuited to work with its atomic bombs.

Col.-Gen. Igor Valynkin also told a news conference that economically strapped Russia was grateful to the United States for helping to improve nuclear security and that cooperation in this area was "growing as each day passes."

But, highlighting the delicate nature of U.S.-Russian military ties at a time of a broader cooling of relations, he said Russia would not sit idly by if Washington decided to review the 1972 bilateral antiballistic missile (ABM) treaty, which prohibited national missile defense systems. The treaty is widely seen as a cornerstone of nuclear deterrence.

Last month, Defense Secretary William S. Cohen announced plans for funding of a multibillion-dollar plan to protect the American people against missile attack. He pledged that if a deployment decision is made next year, the Pentagon would proceed with a missile-defense system even if revisions to the 1972 ABM Treaty cannot be made.

"As long as it is not revised, we will stay within the framework of the treaty," he said. "If we now tamper with the treaty and revise it, then it will create instability. And we will certainly respond to a revision if it happens."

Gen. Valynkin was otherwise effusive in his praise for the help Washington has given Moscow under the Nunn-Lugar Cooperative Threat Reduction Program. It has provided more than $2 billion to Russia and other ex-Soviet states since 1991.

He said aid included special containers for transporting Russian warheads, computers for keeping tabs on atomic weapons, emergency kits and screening equipment such as polygraphs — lie detectors — for a training school north of Moscow.

"In addition to the polygraph, equipment to detect the presence of alcohol or drugs has been supplied and we have used it to test the graduates of the school," he said. "We handpick graduates and this equipment enables us to tighten control of the people who come to us to work with nuclear warheads."

Gen. Valynkin said lie detectors had not been used in the Soviet or Russian military until the United States donated them.

"We are already using them," he said, noting Mr. Cohen had watched American soldiers training Russians to use the detectors a year ago.

About 5 percent of those tested failed to make the grade, he said in separate comments reported by Interfax news agency.

Would-be nuclear officers are questioned, among other things, about possible criminal links. Gen. Valynkin said the human factor remained the biggest worry for both nuclear powers.

"The person who works with nuclear warheads knows the secrets. He has the access, he knows the security system," he said. "That's why we screen personnel who work on nuclear warheads so thoroughly."

Gen. Valynkin said military personnel under his command had been paid in December and had received two-thirds of their wages in January. August and September pay has yet to materialize, part of an enormous arrears in pay dogging not just the military.

He said there was no question of U.S. funds or equipment being misappropriated, as some critics have suggested.

"Everything provided by the Americans is under their control," the general said.

He confirmed the millennium computer-bug threat was proving a problem for the Russian military but said it would be averted.

The Washington Times

THURSDAY, FEBRUARY 4, 1999

Clinton: Medicare trumps tax cuts

By Samuel Goldreich
THE WASHINGTON TIMES

President Clinton told senior citizens yesterday that the nation faces a choice between what he called a "large and risky" GOP tax-cut plan or his proposal to use part of the budget surplus to help save Medicare from bankruptcy.

Diverting money from the surplus also will pay for Medicare coverage of drug prescriptions for the first time, he said during a speech before the American Association of Retired Persons, the nation's biggest senior citizen lobby.

Meanwhile, Democrats on a federal Medicare-reform commission released their own concerns for saving the program, saying they will not support a proposal to privatize the system unless it maintains benefit guarantees.

Mr. Clinton put a political spin on the question of what to do with the federal surplus, which is projected to add up to more than $2.5 trillion over the next 15 years. He said it would be more responsible to use 15 percent of the surplus to secure the Medicare trust fund until 2020 than to reduce income taxes, as Senate and House Republicans have proposed.

"The [GOP] plan would spend well over a trillion dollars over the next 15 years, on a tax proposal that would benefit, clearly, the wealthiest Americans," Mr. Clinton said. "It would do this before Medicare has been secured and in a way that would prevent us from . . . investing . . . in Medicare."

He dismissed the GOP proposal as the "latest in a rather long series of large and risky tax proposals" that would have eliminated the first federal surplus recorded in 30 years.

House Budget Committee Chairman John R. Kasich on Tuesday proposed using $743 billion of the surplus over the next decade to pay for a 10 percent tax cut. A spokesman for the Ohio Republican said that it's no surprise that Mr. Clinton opposes the plan, citing $108 billion in tax and fee increases included in his budget.

"Of course he's against tax cuts," said Bruce Cuthbertson, Mr. Kasich's press secretary. "He wants to spend the money."

Several members of the Medicare commission, including its co-chairman, Sen. John B. Breaux, Louisiana Democrat, have said that Mr. Clinton's plan might make their job harder by making people think that the program simply needs more money. Without radical changes, Medicare will begin going broke in 2008, when 80 million baby boomers begin retiring.

Chris Jennings, a White House health policy aide, said that while Mr. Clinton recognizes that Medicare needs to be reformed, "all the experts say that you cannot significantly extend the life of the trust fund without outside revenue."

Mr. Clinton also repeated his proposal to add prescription-drug coverage to the program, which industry experts estimate could cost as much as $30 billion annually.

A group of Medicare-commission Democrats said yesterday that drug coverage is necessary to ensure the health of the program's senior and disabled enrollees.

Rep. John D. Dingell, Michigan Democrat, and six other panel members said Medicare must not shift costs to seniors. In a letter to Mr. Breaux, they sought cost estimates for his plan to reshape Medicare along the lines of the Federal Employee Health Benefit Program, which pays workers to shop for private market insurance.

They wrote, "We need to understand whether this proposal will save money or not, and, more importantly, how it will affect seniors and people with disabilities . . . Without such information, we are concerned that further discussion of this proposal will be a poor use of our time."

Mr. Breaux has proposed driving down Medicare costs through competition by allowing private Medicare health insurers to bid to participate in the program

The Washington Times

THURSDAY, FEBRUARY 4, 1999

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The Clinton story that's too hot to handle

White House denies pressuring networks to spike the Arkansas rape story

By Bill Sammon and Paul Sperry
THE WASHINGTON TIMES

The White House tried to pressure the Fox News Channel not to broadcast a story about a woman who claims President Clinton raped her 21 years ago and then coerced her into denying it under oath, network sources said yesterday.

White House Press Secretary Joe Lockhart on Tuesday warned a Fox White House correspondent not to run the story, noting that NBC News had interviewed the woman in Arkansas and had not put the story on the air.

Fox ran the story anyway, and Internet scribe Matt Drudge yesterday published Mr. Lockhart's unheeded words of warning, which the White House did not categorically deny, but said were off the record.

Asked yesterday about pressuring the cable news network, Mr. Lockhart said, "I'm just not going to discuss the private conversations I have, even if others can't keep them private."

Mr. Drudge quoted Mr. Lockhart as telling Fox, "You guys will regret this. Clinton haters have been putting this story out for a decade now, as far back as the '92 campaign."

According to the Drudge Report on the Internet, Mr. Lockhart went on to warn the correspondent, "If you go with the story after NBC News decided not to, there won't be any argument about whether Fox News is right wing or not."

James Kennedy, spokesman for the White House Counsel's Office, later called Fox to argue that Mr. Lockhart's phone call had been off the record, Mr. Drudge said. The network aired the story without using Mr. Lockhart's quotes.

Persons close to the network said Mr. Drudge extracted the Lockhart quotes from the network's computer system, but another person close to Mr. Drudge said this was not so, that he obtained the quotes by talking with "real live sources."

In any event, persons at the network confirmed the accuracy of the quotes to The Washington Times yesterday.

The use of the quotes irked some Fox journalists, who intended to honor the White House off-the-record request. Mr. Drudge declined comment.

Mr. Lockhart was asked by Bill Sammon of The Washington Times yesterday at his regular White House briefing whether such pressure was heavy-handed spin con-

see DOE, page A12

U.S. might commit 4,000 to Kosovo

Peace agreement could spur move

By Andrew Cain
THE WASHINGTON TIMES

The chairman of the Joint Chiefs of Staff said yesterday that the United States might send up to 4,000 ground troops to Kosovo if the warring factions reach a Balkan peace accord in the coming weeks.

European troops should make up the bulk of a NATO contingent of some 30,000 peacekeepers in Kosovo, Army Gen. Henry Shelton and Defense Secretary William S. Cohen told the Senate Armed Services Committee. Mr. Cohen said U.S. troops could be committed for up to five years.

The Contact Group on the Balkans — Britain, France, Germany, Italy, Russia and the United States — has ordered Kosovo's warring factions to reach an agreement before Feb. 20 or run the risk of NATO air strikes. Peace talks are [illegible] Castle outside Paris.

Such Republican senators as Jeff Sessions of Alabama are wary of deploying troops in Kosovo with no exit strategy. President Clinton ordered 20,000 troops into Bosnia-Herzegovina more than three years ago to enforce an uneasy peace there. Today, more than 6,000 U.S. troops remain, with no assurances from the administra-

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Clinton gets invitation to testify

But Senate Republicans not able to get him to talk again

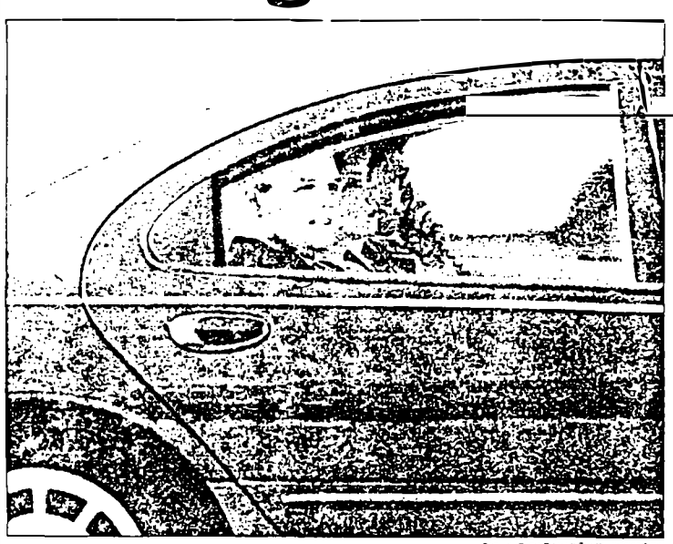


Photo by Roger Richards/The Washington Times

Busy: Clinton aide Sidney Blumenthal (on phone) leaves the Capitol after talking to House prosecutors.

By Jerry Seper
THE WASHINGTON TIMES

Senate Republicans, wrapping up three days of closed-door depositions of key impeachment witnesses, called yesterday on President Clinton to testify before the full Senate — a move immediately rejected by the White House.

"Your knowledge, intent, actions and omissions are central to the charges the House of Representatives have made against you," the senators said in a letter. "Personal answers from you should prove beneficial in our efforts to reconcile conflicting testimony."

"We are of the view that given the gravity of the conduct alleged in the articles of impeachment and the consequences for you personally, the office of the president and the country, you should give every consideration to our request," said the letter, signed by 28 Republican senators, including Majority leader Trent Lott.

White House Press Secretary Joe Lockhart said the president already "has testified" and would not do so again before the full Senate.

"The time now is to find a way to bring this to an end, not to extend it," he said. "And again, I think, whether it's finding our facts or looking to at the last minute seek to get additional testimony from the president, it says less about the constitutional issues that are here and more about the political dynamic that exists at the Capitol now."

The GOP request came as House prosecutors ended their final deposition of the week, a four-hour session with White House aide Sidney Blumenthal. He is key to accusations Mr. Clinton sought to obstruct justice in the Monica Lewinsky grand jury investigation.

Mr. Blumenthal, according to lawyers and others close to the probe, told Rep. James E. Rogan, California Republican and one of the 13 House prosecutors, that while Mr. Clinton lied to him about his relationship with Miss Lewinsky, he did so to protect his family and not to obstruct justice.

Mr. Blumenthal had little elaboration on testimony he already

see LETTER, page A11

With acquittal, White House promises to be 'gloat-free zone'

By Andrew Cain
THE WASHINGTON TIMES

President Clinton's spokesman yesterday declared the White House a "gloat-free zone," saying the president will feel a sense of relief rather than triumph if the Senate votes to acquit on the articles of impeachment.

"I now declare in a post-impeachment era, this a gloat-free zone," Clinton spokesman Joe Lockhart told reporters shortly after White House aide Sidney Blumenthal wrapped up his deposition before House managers on Capitol Hill.

"While I think there'll be some sense of relief" if Mr. Clinton is acquitted, Mr. Lockhart added, "I don't think that there'll be anything that will happen here that will give anyone any pause" on Capitol Hill.

Sen. Orrin G. Hatch, Utah Republican, repeated yesterday that Republicans cannot muster 67 votes to oust Mr. Clinton in the first presidential impeachment trial in 131 years.

Last week, The Washington Times reported that the White House planned to portray Mr. Clinton as the victim of right-wing extremists. Some Republicans are especially concerned that the White House will use its formidable public-relations machine against them to try to salvage the president's reputation.

But the White House is wary of

see ACQUIT, page A11

Democrats oppose a 'finding of fact'

Democrats strongly oppose a "finding of fact" if live witnesses, further depositions and even, using clips of depositions. Meanwhile, Republicans emerged from a closed meeting last night saying if they cannot find a "minimum of five" Democrats to support a finding of fact, they will abandon the idea. A11

Williams admits acting 'hastily' in accepting aide's resignation

Staff member will return to work with another position

By Ronald J. Hansen and Joseph J. Sedmon
THE WASHINGTON TIMES

D.C. Mayor Anthony A. Williams conceded yesterday he acted "too hastily" in accepting aide David W. Howard's resignation last week for using a word that sounded like a racial slur and said he will give the campaign veteran another job on his staff.

In a 20-minute meeting, Mr. Howard declined the mayor's offer to return to his job as chief of constituent services nine days after he quit. He agreed to accept another job as early as next week.

"The recently completed review of the incident confirmed for me that Mr. Howard did use the word 'niggardly' but did not use a racial epithet," Mr. Williams said in a written statement issued shortly after 3 p.m. "The review also showed that an employee ... did misunderstand Mr. Howard to have used a racial epithet."

The mayor said he asked Mr. Howard, who is white, to withdraw his resignation.

Mr. Williams' four-paragraph statement followed an internal probe conducted at his request by Keba Pittman Evans, his chief of staff, and delivered to him Monday evening.

Mrs. Evans' duties will be "dramatically shrunk" because her handling of the Howard incident left the mayor so uninformed and exposed politically, said a Williams adviser who spoke on condition of anonymity.

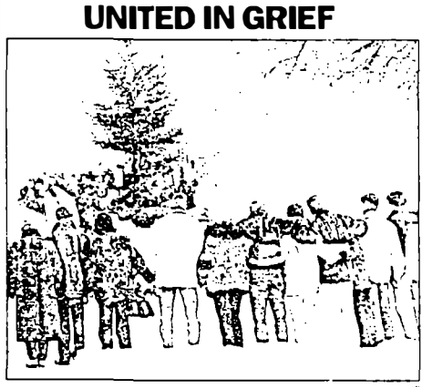
The mayor now knows he "has this problem" with Mrs. Evans, the adviser told The Washington Times.

Mrs. Evans did not return repeated phone calls yesterday.

Mr. Howard, 44, later told The Times that he, too, acted hastily in resigning after rumors swirled through the city government and neighborhoods that he used the word "nigger" in a Jan. 15 meeting with two staffers, one of whom is black.

see HOWARD, page A12

UNITED IN GRIEF



Relatives of 20 who died a year ago when a U.S. Marine jet sliced the cable of their ski lift gather on the slopes of Mount Cermis in Italy yesterday to remember them. The pilot faces a court-martial.

Russia uses U.S. devices to reduce nuke risks

Will stand firm on ABM treaty

By Martin Nesirky
ASSOCIATED PRESS

MOSCOW — The general in charge of Russian nuclear weapons safety said yesterday that the detectors and other U.S. monitoring devices were helping Moscow weed out officers unsuited to work with its atomic bombs.

Col.-Gen. Igor Valynkin also told a news conference that economically strapped Russia was grateful to the United States for helping to improve nuclear security and that cooperation in this area was "growing each day passes."

But, highlighting the delicate nature of U.S.-Russian military ties at a time of a broader cooling of relations, he said Russia would not sit idly by if Washington decided to review the 1972 bilateral anti-ballistic missile (ABM) treaty, which prohibited national missile defense systems. The treaty is widely seen as a cornerstone of nuclear deterrence.

Last month, Defense Secretary William S. Cohen announced plans for funding of a multibillion-dollar plan to protect the American people against missile attack. He pledged that if a deployment decision is made next year, the Pentagon would proceed with a missile-defense system even if it [illegible]

INSIDE

Thursday, Feb. 4, 1999
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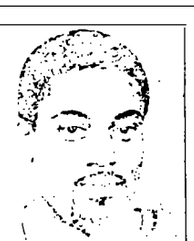

WELCOME BACK, ROD — The

Nation

MEDICARE MANEUVERS — The president says the nation must choose between tax cuts or his plan to save Medicare. A10

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Mir crew to use mirror to reflect sun

Giant device will beam light to regions around Europe

By Vladimir Isachenkov
ASSOCIATED PRESS

MOSCOW — The crew of the Mir space station set out yesterday to conduct a dazzling experiment with a space mirror that will send a beam of reflected sunlight flashing over the former Soviet Union and parts of Europe.

The Znamya, or Banner, experiment, which was scheduled to start at 5 a.m. EST today, envisages unfolding a mirror made of a thin plastic covered by a metal layer [illegible] publics before reaching Germany and the Czech Republic, said Mission Control spokesman Valery Lyndin.

The mirror, 83 feet in diameter, will send a beam of light illuminating a spot five miles in diameter in each of the designated regions, provided the sky is clear, he said.

Mir cosmonauts Gennady Padalka and Sergei Avdeyev will steer a Progress cargo ship to hold the spot of light steady for about 15 seconds in each area of the experiment. They will try to film the re- [illegible] larger models that may be used to illuminate sun-starved northern cities. In the more distant future, such devices may act as "solar sails," using solar wind to help push spaceships through space.

The folded membrane is attached to a Progress cargo ship docked to the station. At the start of the experiment, the crew will jettison the Progress, guide it to a position about 1,312 feet away from the station and send a signal to unfold the mirror.

Russia [illegible]

Price controls don't work

OPPOSING VIEW **Real problem is lack of prescription drug insurance.**

By Alan F. Holmer

Like USA TODAY, the pharmaceutical industry is working hard to find a solution that will provide all patients, especially seniors, access to medicines that are saving lives and improving quality of life.

The industry is testing more than 1,000 new medicines (more than 400 to treat the top three killers of seniors). It's in everyone's interest to find a solution that supports continued innovation for tomorrow's cures and enables more seniors to benefit from pharmaceuticals.

Unfortunately, extending government price controls to all drugs purchased by seniors is a too-good-to-be-true "answer" to a very complex problem. The proposal would not address the underlying issue: lack of prescription drug coverage for 35% of the elderly. It would not give near-poor seniors what they really need, insurance that covers prescription medicines. Instead, it would expand price controls to 42% of the market. You don't have to go back further than the '70s and long lines at gas stations to remember that price controls don't work.

Price controls have consequences beyond this generation of seniors. They would discourage biomedical innovation and investment in developing tomorrow's cures. Almost every day, the media report breakthrough medicines for cancer, arthritis, AIDS and other diseases. These breakthroughs don't just happen. They're brought about by investment in drug discovery, most of it by pharmaceutical companies. If this proposal were enacted into law, there would be fewer good-news stories because innovation would be stifled.

Instead of adopting a quick fix that would wreak havoc with a system that works well for most Americans, including the 65% of seniors who have prescription drug insurance coverage, let's focus on the real problem: 35% of seniors lack coverage. The National Bipartisan Commission on Medicare is grappling with this issue. Let's wait and see what the experts have to say. Then, let's have a serious debate on how to ensure the benefits of innovative medicines to all seniors, without hurting the research that will lead to cures for seniors and for their children and grandchildren.

Alan F. Holmer is president of the Pharmaceutical Research and Manufacturers of America.

Great expectations

Never mind the Oscar Wilde bit about how the only thing worse than being talked about is not being talked about. The only thing worse than flopping a grand entrance is flopping before you even make it to the ballroom door.

That's the fate this week of three creatures of our high-tech times. First, there's Cell Pathways Inc., one of those biotech companies where research by incredibly serious PhDs attracts incredibly unserious share prices.

Cell Pathways stock began to trade on the Nasdaq exchange in November, reaching a low of $8.12. On news of the company's efforts to make a drug that could induce cancer cells to kill themselves, the stock whizzed to $29.13 on Monday. On news of the drug's poor performance in tests, the stock closed at $7.37 Wednesday. Ouch.

It's not just investors and company staff who feel bruised. The drama of high-tech has become the stuff of water-cooler conversation because, in both medicine and computers, the drama touches daily life. The trick is to keep expectations reasonable.

On the heels of Cell Pathways comes an AIDS vaccine that uses a live, weakened version of the virus.

In 1997, one group of activists was so keen on the vaccine that its members volunteered to be test subjects, a possibly fatal risk. Fortunately, monkeys were used instead. In a trial at Harvard, all infant monkeys and four of 16 adults got the full virus to some degree.

The brighter news is that bad guys suffer setbacks, too. The meanest bug in the West, the Y2K problem, has also fallen short of expectations. The electric utility in Nova Scotia began in August setting computer clocks forward at a few big plants to test its Y2K software. Halifax households have seen the second millennium, and the lights are still on.

Advice for those who pin hopes, fears and money on a high-tech future comes wrapped in the two names of Cell Pathways' test drug. Before you bet your shirt that something will Prevatac, make sure it Exisulind.

Microsoft's Credibility Questioned

Judge Calls Key Video 'Not Reliable'

By Rajiv Chandrasekaran
Washington Post Staff Writer

Voicing doubt about Microsoft Corp.'s credibility, the federal judge conducting the software giant's antitrust trial yesterday called a key video presentation that the company prepared for its defense "not reliable" and said he found inconsistencies that the government has highlighted in it to be "very troubling."

As Microsoft lawyers watched in dismay, a Justice Department attorney yesterday rolled the tape frame-by-frame on a large projection screen for U.S. District Judge Thomas Penfield Jackson, pointing to numerous discrepancies in the presentation. Microsoft had submitted it to bolster arguments that removing Internet technologies from the company's Windows 98 software creates serious glitches.

Although the demonstration appeared to viewers to have been performed on one computer, the government asserted that the company actually had filmed more than one machine and spliced the results together. The computers also appeared to have other software running on them that could have affected the results of the test.

At day's end, Microsoft officials said that they were unable to explain the inconsistencies but that they stood by points made in the video.

Since the trial opened in October, much of it has revolved around a single, highly technical question: Are Microsoft's Windows 98 and Internet Explorer software separate products that the company has combined illegally, or are they effectively Siamese twins, connected in their programming code so fundamentally that they cannot be separated?

The government claims they are distinct products. Windows, used on 90 percent of the world's computers, is a monopoly, it contends, and by combining Explorer with it, the company is illegally trying to force people to use Explorer and build a separate monopoly for it.

Earlier in the trial, the government called to the witness stand Edward W. Felten, a Princeton University computer science professor who had developed a program that he contended could remove key parts of Explorer from Windows 98 without damaging the operating system.

Microsoft maintains that this is impossible, that the two rely on each other for essential functions and can't be separated without severe damage. The tape, Microsoft told the court, documents that in computers in which Felten's program has been used to remove Internet technology, Windows slows down and can't perform certain functions at all.

When yesterday's dramatic analysis had ended, Microsoft's lawyers immediately sought special dispensation from Jackson to conduct another demonstration and create a new videotape.

Jackson, who had placed his head in his hands during the government's deconstruction of the videotape, granted the request. A new series of tests and a new tape were scheduled to be made last night in the presence of government lawyers and technical experts.

"It certainly casts doubt on the reliability of the presentation," Jackson said from the bench, referring to the inconsistencies raised by the government.

The controversy over the demonstration began on Tuesday when the lead trial attorney for the Justice Department, David Boies, asked Microsoft Senior Vice President James E. Allchin about a slight change in the text in the corner of a computer screen during a part of the demonstration. Boies claimed that the text being displayed indicated that a version of Windows altered by Felten's program was not running on the machine, despite Microsoft's representation that it was.

A clearly shaken Allchin responded that the "wrong system" must have been filmed.

But later on Tuesday—and again on the witness stand yesterday—Allchin reversed himself and maintained that the Felten-altered program indeed was running and that another program, which had been installed but then removed from the computer in question, had simply altered the text. The substance of the demonstration, Allchin maintained, was unaffected.

On the witness stand yesterday morning, Allchin, prompted by a Microsoft lawyer, said that the change in the text simply was the result of software for the Prodigy Internet access service having been loaded—and then deleted—from the test machine.

But yesterday afternoon, when Boies once again had the opportunity to question Allchin, he took issue with that explanation. With an understated announcement that he wanted to asked the witness "a few questions about the videotape," the government attorney launched into one of the most gripping lines of questioning heard to date at the trial.

Boies initially played a portion of the tape in which the narrator says that Microsoft has not "made any other changes to this computer or Windows 98 except to run Dr. Felten's program."

"Is that an accurate statement?" Boies asked Allchin.

The witness said it was true with regard to a machine in a Microsoft laboratory on which engineers conducted tests of Felten's program. But he acknowledged that "several machines" were used in the filming of the entire two-hour demonstration, which was conducted by people working for Allchin.

Focusing on the machine used for the test at issue—whether a Windows user would have problems trying to use an online service that automatically adds new features to the operating system—Boies asked Allchin: "Has it been one single machine?"

"I cannot tell from looking at this," the witness responded.

"Can you tell whether there were any programs added to or taken away from this machine?" pressed Boies.

"I would have to really study the video," Allchin said. "I don't know."

Boies then rolled the tape, pausing to show how at one point eight programs were displayed on the Windows electronic desktop, and at another point there were nine. Then Boies pointed to an instance in which the automatic update feature appears to start quickly; in another section of the tape, Microsoft had cited sluggishness in the feature as a serious flaw in the Felten program.

When the update feature was operating properly, the text in the corner of the screen appeared to be consistent with the presence of Felten's program.

"There were no delays in getting the Windows update to come up here," Boies said. "It popped right up."

A sheepish Allchin replied in the affirmative, but he maintained that delays shown in the other section of the tape were accurate. "I still stand by my testimony that this program exhibits these failures," he said.

The exchange prompted an incredulous interjection from the judge, who initially said: "It's very troubling, Mr. Allchin. I'd feel much better if you had made the tests yourself."

"I had made the tests," the witness insisted.

"But that's not what I'm seeing here," Jackson shot back.

Eventually Allchin beseeched the judge for the chance to redo the presentation, telling Jackson: "It certainly has not turned out to be a good demonstration."

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THURSDAY, FEBRUARY 4, 1999

Clinton Blasts GOP Tax-Cut Plans

Proposals Would Take Funds From Medicare, Retiree Group Told

By George Hager
and Judith Havemann
Washington Post Staff Writers

President Clinton yesterday attacked Republican tax-cut plans, using some of his strongest language to date to paint the proposals as a boon to the wealthy and to warn that the GOP would pay for those tax cuts by reducing spending on the nation's health care plan for the elderly.

Without naming him specifically, Clinton blasted a plan released Tuesday by House Budget Committee Chairman John R. Kasich (R-Ohio) that calls for a 10 percent across-the-board tax cut. The proposal, one of several plans to be offered by congressional Republicans this year, "would benefit, clearly, the wealthiest Americans, who have, I might add, done quite well as the stock market has virtually tripled," Clinton told a meeting of the American Association of Retired Persons here.

"It would do this before Medicare has been secured and in a way that would prevent us from spending" a piece of the surplus on bolstering the program, Clinton added, calling the Kasich plan "the latest in a rather long series of large and risky tax proposals."

While senior administration officials and congressional Democrats have attacked GOP tax-cut plans as tilted toward the wealthy, yesterday's speech sharpened the partisan divisions on the subject by flavoring the debate with the tough, class-warfare-style rhetoric Democrats used to derail GOP budget and tax-cut plans in 1995-96.

In his State of the Union address last month and in the budget he released Monday, Clinton proposed that the burgeoning non-Social Security budget surplus over the next 15 years be divided among Medicare, new 401(k)-style retirement accounts and spending on defense and domestic programs. Republicans have called for using the same money for tax cuts, chiefly the big, across-the-board cuts Kasich and others have backed.

BY LUCIAN PERKINS—THE WASHINGTON POST

Sen. John Breaux's Medicare plan doesn't meet all Clinton criteria.

"What you have here is two completely different, fundamental points of view," said Bruce Cuthbertson, a spokesman for Kasich. "The president believes the surplus is the government's money . . . we believe the [non-Social Security] surplus is the people's money, and the people ought to be allowed to keep it."

In the same speech to the AARP's National Legislative Council, Clinton laid down markers for the ensuing debate on overhauling Medicare, sending a signal to the 17-member bipartisan commission at work on a reform plan about what he will and will not accept.

Clinton reiterated his proposal to devote some of the surplus to Medicare. He also called for a "modern, competitive" Medicare system, pointedly leaving open the door to a proposal by Sen. John Breaux (D-La.) that would restructure Medicare to add a component under which beneficiaries would get a set dollar amount for premiums and health care plans would compete for their business.

But in an apparent critique of the Breaux proposal, Clinton insisted that any new plan offer "a defined set of benefits" without imposing "excessive new costs" on low-income beneficiaries. Critics have said Breaux's plan fails to specify a core program for health plans to bid on.

Clinton also called for adding a prescription drug benefit to Medicare, financing it with savings from unspecified reforms to the program.

Martin Corry, AARP director of federal affairs, said Clinton's proposal "advances the debate" but did not amount to a "bold breakthrough."

Breaux praised the president for "focusing in on Medicare" and said his proposals are "not inconsistent" with those before the commission.

Breaux was assailed yesterday by seven of the eight Democrats on the commission for "insufficient consultation and information" and was queried in detail about how his plan would work. The group, led by Rep. John D. Dingell (D-Mich.), suggested that without further information there was little need for next week's scheduled meeting of the commission, which is to present its final report in less than a month.

The Washington Post
Thursday, February 4, 1999

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Author remembers mother as central figure

By Paula DiPerna

Fifteen years ago, I traveled on a snowy night to Woburn, Mass., to write for a major newsmagazine about a mysterious grouping of leukemia cases among children. I was to meet Anne Anderson at a meeting of a local group, For A Cleaner Environment (FACE), which she had co-founded with her minister, Rev. Bruce C. Young.

Since 1972, Anderson had tried to convince officials that the number of leukemia cases in her neighborhood was unusual and that there might be a link to foul neighborhood water. Eventually, Young, too, became suspicious, though neither knew at first that the water was heavily contaminated with toxic chemicals.

Using common sense, intelligence and the sheer force of personal conviction born of love for her son, Jimmy, who was sick at the time with leukemia, Anderson persevered with Young's help.

They summoned other parents, elicited major involvement from the Centers for Disease Control, prodded Congress to address toxic-waste dumps through the Superfund legislation, and provoked Massachusetts into improving its system of tracking cancer cases. (Ironically, had it not been Jimmy's mother keeping track of leukemia cases, Jimmy's own case would never have been counted, so faulty was the tracking system in place at the time.)

Woburn stimulated waves of important new epidemiological research, strengthened enforcement of cleanup laws and, in the process, created a new model for community involvement in how to address public health problems possibly derived from environmental contamination. Woburn became a touchstone for the nation, a triumph of ordinary people over extraordinary events.

It is a complicated story, with many twists and turns. Yet the history of so important an ordeal should not be rewritten for the sake of entertainment, nor entertainment left to stand as history, which is what has happened in the film *A Civil Action* and the accompanying media barrage.

Not only has the film oversimplified the factual issues, it also has reduced what happened to a cynical cliché of lawyerly greed, corporate villainy and cantankerous judges — all-male egos at stake. It has turned a woman's story into a man's. And perhaps most unfortunate, the film has depicted the parents as forlorn victims with no choice but to put themselves in the hands of a legal system that supposedly never could render justice.

Yet far from being a bystander, Anderson was actively trying to expose the problem long before the attorney who inherited the case ever drove his Porsche into town.

Because Woburn, sadly, is far from alone, true history is important. All around the country, mysterious cancer clusters continue to crop up, some with a causative factor, some coincidence alone. Almost all have at their center a key lone figure, almost always a mother, fighting for redress, collecting information and bringing it to the authorities.

Indeed, it is a further twist of reality that state and local water officials appear to have gotten off scot-free in the Woburn retelling, though public wells in Woburn had been contaminated for years.

Moreover, according to the National Cancer Institute, cancer among children is rising roughly 1% a year. Environmental factors are partly suspected, and the federal government has increased its research in the area.

Although the courts are not the ideal forum for the resolution of pollution cases, they are for the moment the only forum. Good lawyers do know how to wrest resolution from the courts in cases as complex as Woburn. They also know how to get to the real truth, a truth that can be more thoughtful than a simple sum of the facts.

Fifteen years ago, Anderson asked that we postpone our first meeting just a day. Unwittingly, I had failed to note that evening was the third anniversary of the death of her son.

The events in Woburn changed the face of environmental epidemiology in the country. Change stemmed not from the rescue of a lawyer with dollar signs in his eyes, nor the deep pockets of corporations accused of polluting the water, but from the deep heart and civic outrage of a woman, a mother, and what she and those she galvanized in her community were moved to achieve.

Paula DiPerna is an environmental policy writer and analyst and author of Cluster Mystery: Epidemic and the Children of Woburn, Mass.

Today's debate: Prescription drugs

Slashing drug prices for elderly not as difficult as firms claim

OUR VIEW **Let Medicare recipients, like HMOs, buy at discount rates.**

Here's hard news from the old-age front: As many as one in eight Medicare beneficiaries say they're forced to choose monthly between medications and other household expenses such as food. In a time of expanding drug usage, a senior's out-of-pocket expenses easily can surpass $100, $200, even $300 a month.

The problem stems from the failure of traditional Medicare to cover prescriptions. This leaves almost 13 million older Americans with no drug coverage at all. Even seniors who buy independent coverage face huge costs. Only three of the 10 federally approved Medigap plans include a drug benefit, and in two of those, it amounts to only $500 a year.

The combination of poor coverage and inescapable need has made the elderly a profitable target for drug makers. According to a report by congressional investigators, retail prices charged for the five best-selling drugs for seniors are on average twice the prices given to favored customers such as HMOs, which negotiate volume discounts.

No wonder the industry expects another year of 20% earnings growth. And no wonder it vehemently opposes a fresh proposal to protect older Americans from high drug costs. The idea is to let Medicare recipients purchase prescription drugs at the discounted rates negotiated by large federal agencies. Those discounts often exceed 50%.

The idea's simplicity is hugely appealing. It gives seniors access to affordable drugs at no significant cost to taxpayers.

The industry says doing so will drive up prices for everyone and force the industry to cut back on innovation. And after spending nearly $75 million in 1997 on Washington lobbying, plus $9.7 million in political contributions during the last election cycle, you can be sure Congress will take that threat seriously.

Prices might indeed go up some. Congress' General Accounting Office concluded last year that a similar but smaller plan to include state governments in the federal purchasing plan could raise prices. But by how much was "uncertain," ultimately depending on the skill of negotiators. Likewise, innovation might suffer. But the Food and Drug Administration is approving new drugs at record rates, and to the degree that drug companies need new drug patents for income, it seems unlikely the flow of new therapies would be inhibited for long

The nation's elderly need their medications, and they need them at affordable prices. But if it comes to matters of self-interest, every taxpayer in the country might benefit. Healthier seniors mean fewer surgeries, shorter hospital stays and less long-term care, all of which are more expensive than drugs and which are now covered by federal health benefits.

Other proposals to add a traditional drug benefit to Medicare contain huge direct costs to taxpayers — $15 billion or more a year by even conservative estimates. So if the alternative offers some protection for seniors without costing taxpayers more than start-up costs, why not explore it? Because billion-dollar drug companies say they can't live with it? Millions of ailing elderly can't do otherwise.

High cost of getting old

Investigators for a congressional subcommittee compared the retail price of five drugs commonly prescribed for elderly patients against the prices the drug makers charged favored customers. Their findings:

Drug	Treatment	Price to favored customers	Retail price
Zocor	High cholesterol	$42.95	$104.80
Prilosec	Ulcers	$56.38	$111.94
Norvasc	High blood pressure	$58.83	$113.77
Procardia XL	Heart problems	$67.35	$126.86
Zoloft	Depression	$123.88	$213.72

Source: Committee on Government Reform and Oversight, minority staff report

By Quin Tran, USA TODAY

ROBERT MORTON

Midnight in Tehran

Very late on Saturday night, Nov. 21, several dark figures approached the home just north of central Tehran and were admitted by prominent Iranian opposition leader Daruosh Forohar. During the remaining hours of darkness, the visitors apparently tortured their host and his wife Parvaneh before brutally killing them. The next day their bodies were discovered by other visitors who had an appointment. Mr. Forohar, the leader of the Iran Nation Party, had 14 stab wounds, five of which were in the heart. This was just the beginning.

During the next two months, a series of prominent dissidents and writers in Iran have paid for their courage with their lives — Majid Sharif, Mohammed Mokhtari, Mohammad Pouyandeh, Mr. And Mrs. Javad Emami and Mrs. Fatemeh Eslami.

Trouble seems to flair up in Iran — strategically located north of the Persian Gulf, west of Pakistan and Afghanistan, south of Russia, and east of Iraq — whenever a Southern Democratic governor with left-wing foreign policy advisers resides in the White House. It was during the Carter administration that Tehran and Washington severed ties after Iranian militants seized the U.S. Embassy in November 1980, and took hostages, including 52 Americans.

The first response made by the radical clerics to the high-profile murders bears an eerie resemblance to the multifaceted reaction by our current Southern governor in chief when he was caught in a web of his own design. That is, they lied, claiming a foreign crime network (hint: the great Satan) was responsible for stilling those brave voices.

This did not go down well with the long-suffering Iranian people, who were hearing reports from BBC, VOA and the reliable exile press, including the authoritative Paris monthly Mihan and L.A.'s Radio Sedaye Iran, that the assassinations were an inside job. Furthermore, they all knew that such executions could never be carried out without a fatwah, or blessing, from the ayatollahs presiding over Iran's hellish theocracy.

Complicating things further was the prominent role played by "moderate" President Mohammed Khatami, elected in August 1997, and presumably locked in a power struggle with the Ayatollah Khomeini's successor, supreme leader Ayatollah Ali Khamenei, over liberal reforms he advocates.

This good cop-bad cop setup has served to encourage, not neutralize, protests and demonstrations. The regime quickly found itself in the position of having to explain the unexplainable. On Dec. 14, judicial spokesman Nasiri Savaduhi announced that the perpetrators — no longer foreigners but Iranians — would be brought to justice. Specifically he charged the People's Mojahedin with the killings.

The People's Mojahedin, the nation's only armed opposition group, promptly denied responsibility, saying the Khamenei regime was to blame. Mr. Foruhar's Iran Nation Party accused hard-liners in the intelligence services of planning and executing the killings.

Under pressure, judiciary chief Ayatollah Mohammed Yazdi on Jan. 2 announced that several arrests had been made and promised that results of his investigation would be made public soon. Then President Khatami announced he had appointed a three-man investigative team to examine the role of the intelligence services in the killings.

In a stunning development on Jan. 5, the Intelligence Ministry announced that the regime's own intelligence agents — not the great Satan — had participated in the assassinations. The statement said: "These crimes are not only an act of betrayal against the intelligence ministry, but have also greatly damaged the prestige of the sacred Islamic regime."

After the foreign press saw in this news a decisive victory for Mr. Khatami and the forces of moderation, on Jan. 18 the story took yet another turn. Mr. Khatami's three-man investigation produced its work, which exonerated the intelligence services and concluded the killings were the work of unimportant other "elements," who had been in prison and are now awaiting trial.

"Khamenei and the radicals, with the consent of Khatami, tried to whitewash these crimes," said Assad Homayoun of the International Strategic Studies Association. He called the report "yet another concession Khatami has made to the supreme leader." Mr. Homayoun, the minister in charge of the Iranian Embassy in Washington, D.C. when the Ayatollah Khomeini seized control of the government in 1980, writes and is frequently interviewed about Iran as an advocate of freedom and human rights for the Iranian people.

How has the U.S. government responded to this disaster? Well there hasn't been any real response other than disapproving comments at the State Department's daily press briefing.

In a speech at the Asia Society in New York this month, Jimmy Carter's Secretary of State Cyrus Vance called on President Clinton and the Ayatollah Khamenei to improve bilateral relations. He had nothing to say about the vicious acts of repression that according to exile sources have claimed the lives of as many as 600 leading voices of dissent in Iran in the past few years.

President Clinton devoted very little of his State of the Union address to foreign affairs and none of it to international terrorism and the proliferation of strategic weapons. On the other hand, the administration is responding positively to Mr. Khamenei's surprise request last week for $500 million in U.S. grain and sugar. What prompted that action by Tehran? Call it pragmatism.

"The regime is in trouble politically and financially and so wants to experiment with rapprochement with the United States," Mr. Homayoun says

In fact, the government in Tehran has been conducting itself like a totalitarian dictatorship that is either in the throes of dissolution or on the verge of reckless aggression.

It has spent the past several years rapidly beefing up its strategic weapons with the help of China and Russia as documented by this newspaper's intrepid reporter Bill Gertz. The Israelis have become so nervous about intelligence estimates that the 1,200-mile-range Shabab-4 missile will be ready by 2002 that Foreign Minister Ariel Sharon flew to Moscow last week to attempt to address the issue in a way the Americans have not.

Last year President Khatami was used to extend an olive branch to the West when he called for cultural exchanges with the United States. With their death squad's excesses backfiring politically, the ayatollahs may have decided this was no time to poison the well with the Americans yet again. Jimmy Carter might be inclined to turn the other cheek for his enemies, but Bill Clinton has shown no qualms about sacrificing anyone, including ayatollahs, if such action could change the subject now dominating discussion in the U.S. Senate.

What an ironic idea: An American president so unpredictable that he strikes terror even in the inner sanctum of state-sponsored terrorism.

Meanwhile the Iranian people await a new dawn to end the long dark night of their despair.

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ROBERT MOFFIT

Medical reforms based on experience

Medicare is in trouble. Long-term projections of spending show that the Medicare Part A Trust Fund will go bankrupt, and total Medicare spending is estimated by the Medicare Commission to consume upward of 30 percent of the federal budget by 2025.

The Medicare reform plan emerging as the top choice of the bipartisan commission studying the future of Medicare, chaired by Sen. John Breaux. Louisiana Democrat, and Rep. Bill Thomas, California Republican, should look familiar to many members of Congress. It is modeled after the Federal Employees Health Benefits Program (FEHBP), which provides medical coverage to Congress, the Cabinet, other government workers, and some 1.6 million federal retirees and their spouses.

Under the program — which is nearly 6 years older than Medicare — beneficiaries can choose from a broad range of health plans offering a variety of benefits. Nationwide, there are nearly 400 plans from which tochoose.

Unlike Medicare, there is no huge bureaucracy controlling every aspect of health care financing and delivery; there are no price controls or central planning. Consumer choice and competition prevail. Each year, federal workers and retirees can either hire or fire their insurance plan.

Each private plan is required to offer a core set of benefits, including hospitalization and catastrophic coverage. The U.S. Office of Personnel Management (OPM) ensures that private plans competing for business in the program meet fiscal solvency requirements, clearly state the services they will provide at what cost, and do not falsely advertise. Plan premiums and benefits are subject to annual negotiation.

Under the FEHBP formula, the government pays a fixed dollar amount, which may not exceed 75 percent of the premium cost of a private plan.

The key feature of FEHBP is patient choice. Each participant has at least 12-24 private plans to choose from, and knows that his employer, the government, will pay up to 75 percent of the cost of the plan.

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A small office at OPM administers the entire program for nearly 9 million participants and protects them from false advertising, fraud and fiscal insolvency. The FEHBP program is governed by 30 pages of statute and 93 pages of regulation in the Federal Register (as opposed to a total of 111,000 pages of rules, regulations and related paperwork for Medicare).

In controlling costs, the FEHBP has outperformed both Medicare and private employer-based health insurance, even though the benefits offered by competing private plans have increased and become more varied in recent years. And it does so even though the program has a higher percentage of retirees than in private employer-based plans.

If Congress chooses to use FEHBP as the model for Medicare reform, retired Americans will have much more freedom in choosing health plans, doctors and hospitals — without bureaucratic interference. Retirees will be able to choose a plan tailored to their personal needs. They can join a plan where they will be free to make crucial decisions about treatments and procedures in consultation with doctors of their choice — rather than fighting with government "experts" over these matters.

The prospect of a FEHBP-type system — let's call it the Retiree Choice Health Program (RCHP) — should be reassuring for future retirees. They know Congress designed this solid health care system for themselves and their families based on free market principles of consumer choice and competition — a system with far less bureaucracy and regulation than exists in other government health programs, especially Medicare.

Without timely changes, Medicare faces fiscal insolvency. Then, retirees will either receive fewer benefits, or taxpayers will face substantially higher taxes.

As members of Congress seek a cure, they should look closely at the best features of their own successful system — the FEHBP. The Retiree Choice Health Program, like the FEHBP, would allow the next wave of retirees to have the same kind of system of consumer choice and competition as today's members of Congress, simply by channeling the Medicare allotment to a private plan of the retiree's choice. It would also allow those who want to remain in traditional Medicare to do so.

Congress should ensure that private plans in the new RCHP are genuine private options, not simply private in name.

Comparing traditional Medicare to the FEHBP program teaches a profound lesson. A system largely based on free market principles of consumer choice and competition does not have to be micromanaged. If the RCHP is broadly patterned after the FEHBP, there will be no need for the huge regulatory machine that characterizes Medicare — or anything like it.

Seniors would have far more freedom and control over their healthcare dollars and decisions than they have today.

Robert Moffit is deputy director of domestic policy studies for the Heritage Foundation. This article was excerpted from a study he prepared for the United Seniors Association.

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