

Stages of Implementation

The following implementation stages are undertaken following passage of federal legislation (assumed December 1993):

Preliminary Stage: Investment and Preparation

Duration: 18 months
Start Date: January 1, 1994
Completion: July 1, 1995

The following processes are undertaken simultaneously:

Expedited federal rule-making

Interim final rules will be promulgated. A lead agency is established to expeditiously review and respond to public comment.

Model state legislation and rules

Early in the preliminary phase, model state legislation and regulations are developed by a lead agency.

Federally-supported technical assistance for states

Planning grants are provided to states to develop their internal capacity. Technical assistance is federally supported to provide expertise to the states. Key implementation tasks are conducted federally to relieve the states of administrative burdens. In addition, the development of supporting information systems is undertaken.

Federal investment in rural and underserved areas

In order to develop capacity in rural and underserved areas, targeted investment is provided in the transition period. This investment builds capacity in underserved areas and promotes the development of community-based health plans where they do not currently exist. Rural and underserved areas are targeted because they lack sufficient primary care provision and their delivery systems are often not integrated.

Provider-workforce initiatives to train and deploy physicians and other health professionals for underserved areas are undertaken.

System reform initiatives

In order to simultaneously relieve the current crisis, national reforms (the "**other reforms**") are immediately undertaken in the following categories:

1. Health insurance reforms
2. Malpractice reforms
3. Short-term cost controls
4. Administrative simplification
5. ERISA reform to allow states to mandate employer coverage
6. Pre-emption of state anti-managed care laws
- 7.Reduction of barriers to the formation of health plans

Enactment in most states

During this period, most states are likely to pass enabling legislation using the model established above.

Following the passage of legislation, the state will submit a plan describing their operation of the purchasing cooperative which must meet the minimum federal requirements. The Department of Health and Human Services will have one month to acknowledge the states' adherence to minimum federal requirements or return the plan for amendment (the "**approval process**"). Upon the states' meeting of the federal requirements, federal funding for purchasing cooperative start-up costs are made available to the states.

States will then establish the purchasing cooperative, conduct negotiations with health plans, and conduct an enrollment of all eligible persons into the health plans or fee for service coverage offered through the purchasing cooperative ("**start-up**").

Those states not implementing in this period (**the "slow states"**) will develop internal capacity and participate in federally-supported efforts to learn from implementing states.

Stage One: Implementation in Most States

Duration: 12 months
Start Date: July 1, 1995
Completion: July 1, 1996

Coverage through the purchasing cooperatives: most states

Presumably, most states will want to meet the Federal guidelines and avoid the penalties of late reform efforts. As a result, most states will begin coverage through the purchasing cooperative on date-certain July 1, 1995.

Other states

Other states (the "**slow states**") will be taking advantage of the grace period and will be at various stages of enacting legislation, and going through the approval process and the start-up. All of the slow states will at least have begun their reform thereby avoiding back-end penalties. Some slow states may achieve universal coverage prior to the end of the grace period.

Other reforms

In addition, the investment and "other reforms" will continue.

Stage Two: Implementation of Slow States

Duration: 12 months
Start Date: July 1, 1996
Completion: July 1, 1997

Coverage through the purchasing cooperatives: slow states

The slow states will continue to be at various phases of the reform process, with most achieving universal coverage through the purchasing cooperative by July 1, 1996.

Other states

Any states, which have not submitted a plan to HHS meeting the minimum Federal requirements by the end of the grace period, July 1, 1996, (**the "late states"**) will lose tax exclusion of health benefits for its citizens.

Federal health system default

The Secretary of Health and Human Services shall have authority to establish the federal health care program that fails to establish its own system according to federal guidelines by July 1996. The nature of the substitute system shall not be specified in law in order to give the Secretary sufficient flexibility to create a workable system at the time, given constitutional constraints.

It is unlikely any state will see the implementation of the Federal health care program, as the result of the significant incentives to gain HHS plan approval prior to July 1, 1996, including:

1. Provision of health care security to all their residents;
2. Cost control;
3. As federal taxes are levied, states must have implemented the new system to receive benefits;
4. Relief from short-term cost controls;
5. Other funds or initiatives which are tied to implementation.

Other reforms

In addition, the investment and the "other reforms" continue.

Aftermath: Workers Compensation Reform

Start Date: July 1, 1997

Global budget

Presumably, all states will have achieved universal coverage and the global budget will go into effect.

Workers compensation reforms

The leading states will enact legislation reforming workers' compensation, integrating the health care components into the comprehensive health benefits package.

(The remaining states will enact workers compensation reforms two years following the date of their coverage through the purchasing cooperative.)

Other reforms

In addition, the investment and "other reforms" will be completed, phased-out, or merged into the new system.

Other Transition Issues

Interagency Task Force

In the transition period, the White House will announce the establishment of an interagency task force and lead agencies to perform federal functions related to implementation.

The National Health Board

The interagency task force established by the White House will assume the functions of the National Health Board until it becomes operational.

Rationale and Opposing Arguments for Option I

Rationale :

1. Achieves universal access and puts cost controls in place in many states by mid-1995; complete universal access is likely to be achieved by July 1996.
2. Enables clear statement of the benefits of reform to consumers;
3. Builds on reform momentum: avoids reversal or delay;
4. Decreases administrative complexity by avoiding interim eligibility criteria and rules;
5. Incorporates all income groups simultaneously;
6. Diminishes period of uncertainty and attendant disruption in the insurance market and among providers.
7. The grace period precludes the States from blaming the Administration for denying timing flexibility.

Opposing Arguments (General Problems Accentuated by Speed):

1. Administrative overload: enrollment itself could overload purchasing cooperative/state capacities, despite the one-year grace period.

available as of July 1, 1995 in states) states as they implement reform.

The purchasing cooperatives will provide coverage for the standard benefit package. (Both the standard benefit package and the subsidy eligibility will be defined in federal law.) The states will enact workers' compensation reforms two years following the date of coverage through the purchasing cooperative. The global budget will take effect on January 1, 1999 in all states.

Stages of Implementation

The following implementation stages are undertaken following passage of federal legislation (assumed October 1993):

Preliminary Stage: Investment and Preparation

Duration: 18 months
Start Date: January 1, 1994
Completion: July 1, 1995

The following processes are undertaken simultaneously:

Expedited federal rule-making

Interim final rules will be promulgated. A lead agency is established to expeditiously review and respond to public comment.

Model state legislation and rules

Model state enabling legislation and regulations are developed by a lead agency.

Federally-supported technical assistance for states

Planning grants are provided to states to develop their internal capacity. Technical assistance is federally supported to provide expertise to the states. Key implementation tasks are conducted federally to relieve the states of administrative burdens. In addition, the development of supporting information systems is undertaken.

Federal investment in rural and underserved areas

In order to develop capacity in rural and underserved areas, targeted investment is provided in the transition period. This investment builds capacity in underserved areas and promotes the development of community-based health plans where they do not currently exist. Rural and underserved areas are targeted because they lack sufficient primary care provision and their delivery systems are often not integrated.

Provider-workforce initiatives to train and deploy physicians and other health professionals for underserved areas are undertaken.

System reform initiatives

In order to immediately relieve the current crisis, national reforms are immediately undertaken in the following categories:

1. Insurance reforms
2. Malpractice reforms
3. Short-term cost controls
4. Administrative simplification
5. ERISA reform to allow states to mandate employer coverage
6. Preemption of state anti-managed care laws
7. Reduction of barriers to the formation of health plans.

Enactment in several states

During this period, several states will pass enabling legislation using the model established above (the **"leading states"**). Those states are likely to be the ones which have already enacted reform legislation and have significant internal expertise.

Following the passage of legislation, the state will submit a plan describing their operation of the purchasing cooperative which must meet the minimum federal requirements. The Department of Health and Human Services will have one month to acknowledge the states' adherence to minimum federal requirements or return the plan for amendment (the **"approval process"**). Upon the states' meeting of the federal requirements, federal funding for purchasing cooperative start-up and federal subsidies are available to the states.

States will then establish the purchasing cooperative, conduct negotiations with health plans, and conduct an enrollment of all eligible persons into the health plans or fee for service coverage offered through the purchasing cooperative (**"start-up"**).

States not implementing in this period will develop internal capacity and participate in federally-supported efforts to learn from implementing states.

Stage One: Implementation in the "Leading States"

Duration: 12 months
Start Date: July 1, 1995
Completion: July 1, 1996

Coverage through the purchasing cooperatives: the "Leading States"

Several states will self-select to begin coverage through the purchasing cooperative on July 1, 1995 using the "date certain within states approach."

Other states

Other states (the **"second set of states"**) will enact legislation and go through the "approval process" and the "start-up" in preparation for implementation in the next stage.

Other reforms

In addition, the investment and "other reforms" will be continued.

Stage Two: Implementation in the Second Set of States

Duration: 12 months
Start Date: July 1, 1996
Completion: July 1, 1997

Coverage through the purchasing cooperatives: "second set of states"

The "second set of states " will begin coverage through the purchasing cooperative on July 1, 1996 using the "date certain within states approach."

Other states

Other states (the **"third set of states"**) will enact legislation and go through the "approval process" and the "start-up" in preparation for implementation in the next stage.

Other reforms

In addition, the investment and the "other reforms" will be continued.

Stage Three: Implementation in the Third Set of States and Reform of Workers Compensation in the Leading States

Duration: 12 months
Start Date: July 1, 1997
Completion: July 1, 1998

Coverage through purchasing cooperatives: "third set of states"

Several more states will begin coverage through the purchasing cooperative on July 1, 1997 using the "date certain within states approach."

Worker's Compensation Reform

The "leading states" will enact legislation reforming workers' compensation, integrating the health care components into the comprehensive health benefits package.

Other states

Other states (the "**fourth set of states**") will enact legislation and go through the "approval process" and the "start-up" in preparation for implementation in the next stage.

Other reforms

In addition, the investment and the "other reforms" will be continued.

Stage Four: Implementation in the "Fourth Set of States" and Reform of Workers Compensation: the "Second Set of States"

Duration: 6 months
Start Date: July 1, 1998
Completion: January 1, 1999

Coverage through purchasing cooperatives: "fourth set of states"

The "fourth set of states" will enroll coverage through the purchasing cooperatives on July 1, 1998 or January 1, 1999.

Workers compensation reforms

The "second set of states" will enact workers compensation reforms in this period.

(The remaining states will enact workers compensation reforms two years following the date of their coverage through the purchasing cooperative.)

Other reforms

In addition, the investment and "other reforms" will be completed, phased-out, or merged into the new system.

Aftermath: States not implementing by January 1, 1999

As of January 1, 1999, Federal tax credits for the purchase of health insurance will only apply to the citizens of those states which have established universal coverage through purchasing cooperatives.

The Secretary of Health and Human Services shall have authority to establish the Federal health care program in a state that declines to accept the inducements to establish its own system. The nature of the substitute system shall not be specified in law in order to give the Secretary sufficient flexibility to create a workable system at the time, given constitutional constraints.

It is unlikely any state will see the implementation of the Federal health care program as the result of the significant incentives to implement prior to 1999, including:

1. Provision of medical security to all their residents;
2. Cost control;
3. As federal taxes are levied, states must have implemented the new system to receive benefits;
4. Relief from short-term cost controls;
5. Other funds or initiatives which are tied to implementation.

Other Transition Issues

Interagency Task Force

In the transition period, the White House will announce the establishment of an interagency task force and lead agencies to perform federal functions related to implementation.

The National Health Board

The interagency task force established by the White House will assume the functions of the National Health Board until it becomes operational.

Rationale and Opposing Arguments for Option II

Phase-in by State

Rationale

(1) States can implement as they are ready. Consequently, states which are eager to implement are not held back by states which are not ready.

(2) The first set of states are likely to be most able to confront and resolve the inevitable implementation and transition problems successfully. Therefore, better solutions may be developed.

(3) Extreme implementation difficulties caused by forcing ill-prepared states to move ahead at the same rate as well-prepared states are avoided. In this sense, the first set of states act as pilot programs for the subsequent states.

(4) The federal expenditure related to the program is likely to be phased in over four years.

Opposing Arguments

(1) It is difficult to forecast how many states and which states will want to implement in any given stage. State readiness for change is evolving rapidly. Therefore, it is difficult to ensure what benefits will be achieved and what federal budgetary costs will be accrued in any given period. If a large number of states particularly some heavily populated or high subsidy states want to move quickly, it may be difficult to control federal budget exposure without appearing arbitrary or unfair.

(2) Significant differences may exist between states for as long as four years. This hinders the portability of the program for consumers, increases administrative cost to multi-state business, and may affect business decisions about the location of enterprises. Moreover, during this period there will be significant inequities in medical security for residents of different states; however inequities have long existed.

(3) Depending on the number of state implementing early, this phase-in strategy may cost more in the short term than a phase in of universal coverage for children first.

Date Certain Within States Approach

Rationale

(1) It decreases the uncertainty of the programs impact for consumers, providers, and insurers. It is possible to clearly articulate the benefits and impact of the program. Providers are better able to develop new integrated health care systems because the potential consumer market is clear. The potential collapse of certain parts of the insurance market can be more effectively addressed.

(2) A date certain approach eliminates the transitional inequities which inevitably occur if enrollment is phased-in by financing group.

(3) A phase-in creates significant administrative burdens because of the need to create and administer interim eligibility rules. This step complicates and increases the

cost of integrating the Medicaid program into the purchasing cooperative.

(4) Low income, vulnerable and underserved populations may be best served by this approach because they are enrolled at the same time as all others. This removes any welfare stigma by providing a universal means of enrollment. In addition, it removes the risk that enrollment of these populations will be delayed as long as possibly or indefinitely because they are perceived or actually are higher cost.

OPTION 3: KIDS FIRST COVERAGE

Implementation Start: January 1, 1995

Phase-in: By Population, Beginning with Children

Universal Coverage Achieved by: January 1, 2000

SUMMARY

This proposal phases in universal coverage, minimizes the financial burden of the program at the outset, and covers the most vulnerable of our citizens--children--as quickly as possible. Under this approach, health care reform is phased in by population, beginning with children. Other populations are phased in as follows:

Employer Groups: July, 1997

Individuals: January, 1998

Medicaid: January, 2000

States may be granted a grace period under certain circumstances.

This proposal is designed in two parts which will be implemented simultaneously:

- I. The quick coverage of children--"Kids First"; and,
- II. the development of structures for transitioning to the new system and the phasing in of certain population groups.

Part I, Kids First is really a precursor to the new system. It is intended to be freestanding and administratively simple, with States given broad flexibility in its design so that it can be easily folded into existing/future program structures. The Federal government, States, and the private sector will play a role in its implementation and financing.

Part II of this proposal involves the development of purchasing cooperative (PC) structures and the actual phase-in of all other population groups within the PC system.

PART I - KIDS FIRST

Stage 1 - Kids First: All employers not covering children will be mandated to do so by January 1995.

PROGRAM STRUCTURE

The Federal government, States, and the private sector will play a role in its implementation.

- The **Federal government** will finance the subsidization of the program (including subsidies for individuals and employers), technical assistance to States and State program administration. Additionally, the standard benefit package will be community rated and established at the Federal level; children's coverage will be Federally mandated on States and employers.
- **States** will have the full responsibility for program implementation and administration, including the administration of subsidies, regulation, oversight etc. States will be given very broad authority to implement the mandate, and would not be expected to have the PC structure in place in order to implement Kids First. States could use their Medicaid program, set up another plan, or allow employers the option to "buy-in" to any structure the state developed, including Medicaid.
- **All insurance companies** will be required to offer the children's standard benefit package. **All employers** will be required to pay at least 80% of the bench mark premium.

PROGRAM GOALS

- Provide all children with health care coverage as quickly as possible.
- Keep the approach simple, that is, keep the administrative and program demands of enrolling children as simple as possible. Leave the resources of the State focused on developing PCs and the infrastructure for the new system, including various reforms identified in Part II.

- Provide minimum disruption to current/future program structure and coverage.

ELIGIBILITY FOR KIDS FIRST

The following children will be eligible for Kids First:

- Uninsured children in working families - Employers will be responsible for assuring the coverage of all children either through a private insurance plan or a plan offered by the State.
- Uninsured children in non-working families - States will be required to cover children in non-working families who are currently not eligible for Medicaid.
- Children covered by Medicaid - Children who receive Medicaid benefits because they are categorically eligible or medically needy will remain in Medicaid. For children who fall under any other Medicaid category, states can either enroll them in a new state plan or keep them on Medicaid.

PROGRAM FINANCING

- Several funding streams including employers, government and families will finance Kids First, and it will be administered by States.
- Although States will have the option to establish PCs and to begin phasing in Medicaid or any adult groups in advance of the phase-in dates, no additional Federal funds will be available prior to the dates specified. Additionally, as other groups are phased-in, children in Kids First will be phased into PCs in order of parental coverage, i.e., children receiving coverage through parent's employers will be phased in July 1997, children receiving coverage in State plans and/or Medicaid (non-categorically eligible children) in January 1998, and all categorically eligible children in January 2000.
- The employer mandate will mirror employer/employee premium contribution levels present at full enrollment; e.g., 80/20. (Tax incentive structures will be contingent on decisions made by the Coverage Groups.)
- Subsidies will be available for both the employee and employer portion of the premium and will be Federally financed. (See subsidy discussion.)

- States will be held to a maintenance of effort for their current children's programs; e.g., Medicaid, crippled children's programs, other child health programs, etc..

PROGRAM ADMINISTRATION

- States will have full administrative responsibility for implementation, operation and oversight of the program.
- States will be given maximum flexibility to design and develop a program that meets the needs and complements the existing/future designs of their State health care program.
- States will have the flexibility to fold children into existing Medicaid programs or to develop other plans/PCs.

States could:

- Develop a State plan for the enrollment of children. A State could opt to allow employers to "buy-in" to the State plan.
 - Use the Medicaid program, or a subset of the administrative functions used to operate the Medicaid program, e.g., the fiscal agent. Also, States could allow the employers to "buy-in" to Medicaid.
 - Contract with health plans, such as HMOs, to serve the children and allow employers to "buy-in" to the State program. Conversely, employers could be allowed to contract directly with the same plans which the State may have certified to serve children.
 - Use the purchasing cooperative or similar structure if available.
 - Require state insurance commissioners to oversee the operation of state plans and private plans to assure comprehensive coverage and access to the newly defined Kids First standard benefits package.
- States may be granted a grace period for the phase-in of children under certain circumstances, e.g., if States can demonstrate that their PC structure will be in place within

six months, they may be allowed to delay the phase-in of Kids First.

- By July 1997, States will be required to develop fully established PCs.

Rationale

- This approach gives States maximum flexibility to design their programs to meet State needs. It allows States which are ready for full PC implementation to proceed, while not penalizing States needing additional time and resources to develop PCs.
- Requiring States to upgrade health benefits offered by private plans to the standard benefit package level will assure that family coverage, currently provided by the employers, will more likely be kept together before the employer the mandate. This will help facilitate an easier phase-in to PCs.
- Studies have shown that when family plans are split, parents tend to opt for plans that will assure continuous coverage for their children. Given this, it is assumed that market forces will keep down the cost of health plans. That is, plans will have incentives to lower prices, with the assumption that they will attract parents, who tend to be young and healthy, later.

Considerations

- Despite the stated goal of simplicity, the program would still require substantial effort on the part of States with the possibility of limited returns, i.e., any structures developed, which are not consistent with the PC structure, will not have a long term pay off and may be very costly to develop.
- States have indicated that many of the administrative structures necessary for full implementation of health care reform will be required in the development of Kids First. They

believe that this will be administratively burdensome and costly.

- Some States have shown a preference for a phase-in approach not predicated on the enrollment of population groups.
- We are exploring administratively simple alternatives to monitor plan operation, to provide oversight of plan financing and to define data and systems requirements for program implementation.

BENEFIT COVERAGE1. Standardized Benefit Package

- In January 1995, all children 0-18 years of age will be covered by a standardized benefit package as defined by the Benefits Workgroup.
- Employers currently covering children will be required to bring their coverage package for children up to the standard benefit package.

Rationale

- Many plans currently covering low-income families are very minimal, often offering little more than catastrophic coverage. Requiring plans to upgrade their coverage to the standard benefit package would improve coverage for children--plans will be required to do so under the employer mandate, anyway. Additionally, insurers may be very willing to offer the children's standard benefit package, with the goal of attracting adults to select them during Part II of this phase-in approach.

Considerations

- Kids First requires that employers already covering children bring their plans up to levels specified in the children's standard benefit package. Under this approach, employers may drop adult coverage if they are required to provide a richer children's benefit--family coverage may be adversely affected.
- Mechanisms to monitor these changes in employer benefit packages need to be explored.
- Data requirements for the development of community rating of children's benefit packages need to be explored.
- It may be difficult for employers to renegotiate contracts with insurers to bring their children's benefit package up to the mandated standard benefit package.

- Federal law will require that any entity offering insurance to offer the standard benefits package.
- The standard benefit package will be community rated.
- Medicaid services not covered in the standard benefit package; (e.g., long-term care, transportation, etc.) will not be included in Kids First--even if the State elects to use Medicaid as the vehicle to cover currently uninsured children.

Rationale

- The standard benefit package is likely to be rich enough to provide services comparable to those in the EPSDT Program (e.g., immunization, well-child visits, screening, other preventative services, etc.).
 - States have generally elected not to include long-term care services in their State-funded uninsured children's programs (e.g., Minnesota Care). These decisions were made to curb costs and with the expectation that children will not use many long-term care services anyway.
2. Supplemental Coverage and Long-Term Care - These benefits have been addressed by the Benefits and the Long Term Care Groups and are not available in Kids First. However, the phase-in of these services will begin in 1997 when the full employer mandate is implemented.

Rationale

- The decision to exclude supplemental coverage and long-term care benefits from Kids First was made on the basis of administrative simplicity and cost.

Considerations

- If States elect to use the standard benefit package to cover children, traditionally eligible for Medicaid by poverty-level groups, these children may receive a less rich benefit package than they would have received under Medicaid.

3. Mental Health - Addressed by Mental Health Group.**SUBSIDIES**

- Subsidies will be federally financed.
- Low-income working families and employers will be eligible for subsidies to cover premium costs.
- Deductibles would be waived, however, coinsurance would be allowed.
- Subsidies will be determined using a Federal formula on a national basis and States will use either the current welfare system or a new agency to determine individual and employer eligibility.
- Total family out-of-pocket expenditures for coverage under Kids First would be capped at 2 percent of total family income.
- Subsidies for individuals will be determined on the basis of family income (asset and resource tests currently used in Medicaid will not be applied).

[IMPLICATIONS OF THIS APPROACH AND ADDITIONAL OPTIONS ARE BEING EXPLORED.]

Rationale

- Several approaches were considered regarding employer and individual subsidies. However, not offering subsidies to employers could have a negative economic impact on States and small employers.
- Not offering subsidies to individuals could adversely affect low-income families covered by Kids First.
- Offering employers subsidies may prevent them from attempting to offset the cost of offering children's coverage by laying-off low-wage workers, not hiring additional employees or not hiring employees with children, etc.

- We continue to explore employer and individual subsidy approaches which would be administratively simple and encourage economic development.

Considerations

- Arguments against the provision of employer subsidies in Kids First include the concern that employers not covering children will be preferentially treated over those who already do.
- Subsidy programs are difficult to administer. States have indicated that regardless of how much flexibility they are given to implement a subsidy program, it will be administratively difficult under the short time-lines. Concerns are also raised that changes will need to be made once the subsequent stages of this phase-in are implemented.

MEDICAID INTERFACE WITH KIDS FIRST

- Until the Medicaid program is phased in completely, legislation will be developed to provide States with additional flexibility to administer the Medicaid program so that it may complement Kids First and the smooth transition to the PC and managed competition structure.
 1. Services (Long-Term Care, etc.)
 - To the extent that an employer mandate enrolls otherwise Medicaid-eligible children into private plans or these children are enrolled in a State Kids First, these children would likely lose the comprehensive benefits they now receive under Medicaid; e.g., early and periodic screening, diagnosis, and treatment. Requiring employers to cover these services may be prohibitively expensive.
 2. Groups (Spend-Down, Institutionalized Kids, Medicare/Medicaid Dual Eligible)
 - Enrolling Medicaid-eligible children into the new system first or through employer-provided coverage

could negatively impact the Medicaid eligibility of their parents because, presumably, their children would not be counted as part of the standard filing unit.

- To alleviate these types of eligibility issues, States should be given the flexibility to develop new eligibility policies that would facilitate the implementation of Kids First and the subsequent development of the PC managed competition structure.
3. State Maintenance of Effort
- The Kids First option could allow States to fold Medicaid children into a State children's program. If so, then the State's contribution into the PC system, if based on Medicaid spending during or after this transfer had taken place, would reduce the State's maintenance of effort payments. Adjusting for this lowered Medicaid enrollment in the maintenance of effort calculation could be administratively complex.
 - Conversely, if low-income children are enrolled first into Medicaid, as an easy way to provide them subsidized care in the short-term, this could also complicate the maintenance of effort standard by inflating State Medicaid spending. The extent of this difficulty depends on the base year for determining maintenance of effort.

PART II - PHASE IN OF OTHER POPULATION GROUPS

Stage One: Investment and Preparation

Duration: 2 years and 7 months (43 months)
Start Date: January 1, 1994
Completion: July 1, 1996

The following processes are undertaken simultaneously.

Preliminary Staff Working Paper for Illustrative Purposes Only

Federal Rule-Making

- Interim final rules will be promulgated.
- A lead agency is established or designated to review and respond to public comment.

Model State Legislation and Rules

- The lead agency will develop models of enabling legislation and regulation for States.

Federally-Supported Technical Assistance for States

- Planning grants are provided to States to develop their internal capacity.
- Technical assistance is Federally supported to provide expertise to the States.
- Key implementation tasks are conducted Federally to relieve the States of administrative burdens.
- The development of supporting information systems is undertaken.

Federal Investment in Rural and Underserved Areas

To develop capacity in rural and underserved areas, targeted investments will be made during the transitional period.

- Investment funds are provided to build capacity and promote the development of community-based health plans where they do not currently exist.
- Provider-workforce initiatives are undertaken to train physicians for underserved areas.

System Reform Initiative

In order to relieve the current health care crisis, national reforms are immediately undertaken in the following categories:

1. Insurance reforms
2. Malpractice reforms
3. Short-term cost controls

4. Administrative simplification
5. Preemption of State anti-managed care laws
6. ERISA Reform to allow states to mandate employer coverage

State Requirements

During this period, States will pass enabling legislation using the Federally established model. Following the passage, States will submit a plan describing the operation of purchasing cooperatives which meet "minimum Federal requirements." The Department of Health and Human Services (HHS), or another designated Federal entity, will have one month to acknowledge the States' adherence to minimum Federal requirements or return the plan for amendment.

Stage Two: Last Minute Things

Duration: One Year
Start Date: July 1996
Completion Date: July 1997

Establishment of Purchasing Cooperatives (PCs)

With Federal "approval," States will establish purchasing cooperatives, conduct negotiations with health plans, and begin enrolling all eligible persons into health plans or fee-for-service plans offered through purchasing cooperatives.

Federal funding to establish PCs will become available on July 1996 to States, contingent upon Federal approval of their plans. (As a stronger incentive, we could opt to provide Federal funding for PCs before July 1996.)

Other Reforms

In addition, the investment and "other reforms" will be continued.

Stage Three: Employer Mandate

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in the employer mandate.

Completion Date: July 1, 1997

Coverage Through the PCs

On July 1, 1997, all employers will be required to purchase health plans for their employees through PCs.

Children receiving coverage through parent's employers will be phased in with their parents.

Federal subsidies to eligible individuals and firms will become available through mechanisms determined by the States.

Stage Four: Individual Mandate

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in the individual mandate.

Completion Date: January 1, 1998

Coverage Through the Purchasing Cooperatives

By January 1, 1998, States will assure coverage of self-insured and unemployed individuals through the PCs.

Children receiving coverage through a State plan and/or Medicaid (non-categorically eligible) will be phased in with their parents.

We are exploring the option of bringing in early retirees with benefits at this time.

Federal subsidies will become available on date-certain to qualifying self-insured unemployed individuals.

Other Reforms

Workmen's Compensation Reform will be required by January 1, 1998.

Stage Five: Medicaid

Duration: States will have the time between the passage of Federal legislation and date-certain to phase in individuals receiving acute Medicaid benefits.

Completion Date: January 1, 2000

Coverage Through the PCs

- By January 1, 2000 States will assure coverage to individuals (under 65) receiving Medicaid benefits through PCs for acute care services. Non acute-care services will be left in tact with Medicaid as a residual program.
- Children receiving coverage through Medicaid (categorically eligible) will be phased in for acute care services.

Aftermath: States Failure to Implement Mandates

As of January 1, 2000 Federal tax credits for the purchase of health insurance will only apply in those States which have established universal coverage through PCs.

The National Health Board (NHB) will be required to monitor the State implementation of each mandates and will be given the authority to grant grace periods based on States' efforts toward implementation.

If States fail to comply with various mandates and have not demonstrated sufficient efforts toward implementation, then the Secretary of HHS or the NHB will have the authority to establish a Federal health care program in that State. The nature of the substitute system will not be specified in legislation to give the Secretary or NHB sufficient flexibility to create a workable system at the time within the constitutional constraints.

It is believed that such Federal programs will not become necessary for the following reasons:

1. Provision of medical security to all State residents;
2. cost control;

3. States must implement the new system to receive financial assistance which will result in the removal of great financial burden for states;
4. relief from short-term cost controls; and
5. other funds or initiatives are tied to implementation.

Other Transitional Issues

Interagency Task Force

In the transition period, the White House will announce the establishment of an interagency task force and lead agencies to perform Federal functions related to implementation.

The National Health Board (NHB)

The interagency task force established by the White House will assume the functions of the NHB until it becomes operational.