INTRODUCTION

Making History. We are on the verge of an historic step forward for the American people. Since Franklin Roosevelt, Presidents have been trying to pass health care reform. Three years ago the issue was not on the political radar screen. All that has changed. Amidst polls showing overwhelming popular support for reform, committees in both houses of Congress have approved bills that guarantee health coverage to every American family.

Improvements in the Proposal. The legislative process has transformed our original proposal. We have listened to the ideas and apprehensions of the American people. With Congressional help, many important improvements have been incorporated into the bills now under consideration. While different committees have taken varying approaches, these bills contain a number of features that will ultimately be included in a better and more effective reform plan. Among the improvements under consideration are: cutbacks in bureaucracy and regulation; the transformation of mandatory alliances into smaller voluntary purchasing cooperatives; greater protection for small businesses; and greater choice for consumers and businesses. A stronger fail-safe budget protection device is under consideration, to ensure that the program does indeed pay for itself.

Congressional Challenge Ahead. We have made dramatic progress in our effort to guarantee lifetime health security for every American. But there remains one major stumbling block to overcome. Opponents of true reform would have us believe that our goals can be met by incremental, piecemeal reform. Having bought the land, surveyed the site, and designed the structure, they would have us build the bridge only half way across the river. That approach won't work, and will leave millions at risk.

The coming weeks will be marked by House and Senate consideration of their respective reforms. As the nation watches, they will choose either true reform -- true security for every single American -- or an unfortunate, piecemeal reform that may actually leave working families worse off.

The Administration's position is clear: universal coverage is imperative if we are to deliver on our promise to guarantee true health security to every American.

Today, we want to talk to you about why non-universal reforms just don't work.

NON-UNIVERSAL REFORMS:
What They Claim, What They Deliver

There are several non-universal reform alternatives floating around Washington. They claim to be less filling than universal coverage but taste just as great. These alternatives fall short of what they promise.

DOLE PLAN

CLAIMS: The Dole plan claims that insurance market reforms alone will enable more people to get coverage and that -- according to GOP strategist Bill Kristol -- it will "bring more people into the system and provide more security and flexibility for those already in it."

DELIVERS: The Boston Globe said that "a number of health policy analysts from all parts of the ideological spectrum" have reached a "remarkably congruent verdict: It's not likely to do much to expand access to health insurance. And it might make things worse for many who are now insured." *[Boston Globe, 7/3/94]*

A conservative health economist, Mark Pauley at the University of Pennsylvania, predicts that such measures would "probably do almost nothing, or maybe even make things worse" for the millions of people who aren't poor enough to get subsidies. *[Boston Globe, 7/3/94]*

NON-UNIVERSAL REFORM:
Hurts The Middle Class

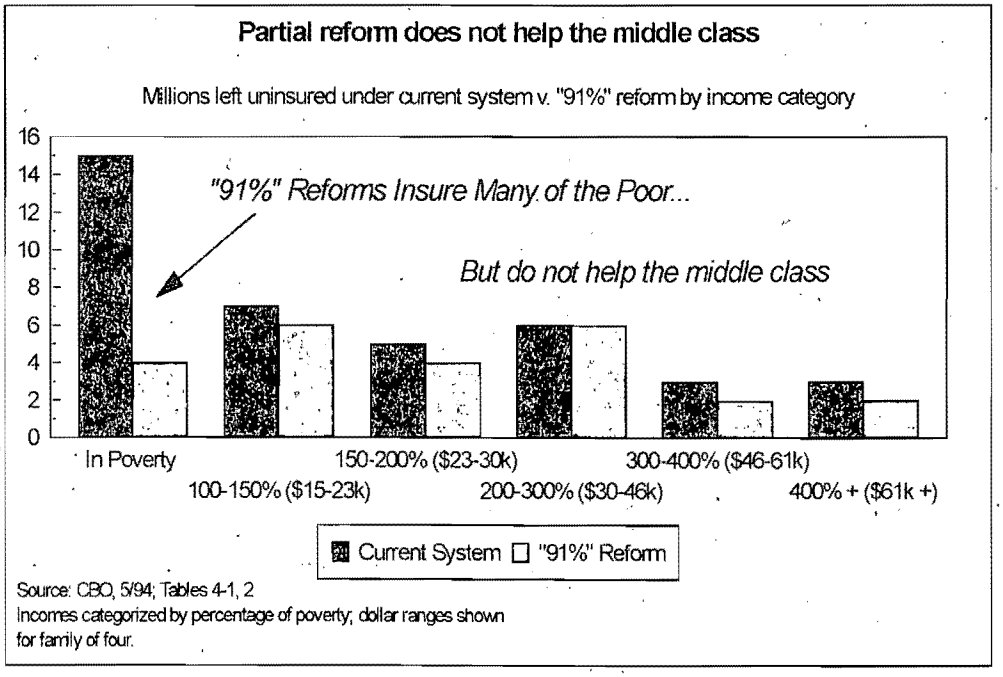
"I'll tell you why I'm fighting so hard for real health care reform...People like Jim Bryant, who told the Boston Globe he works 70 hours a week but has no health insurance for his family. He wonders if it's fair that he misses his sons' soccer games to go to his Saturday job while people who depend on welfare have health benefits. In a moment of frustration, he even suggested to his wife that they might be better off if they broke up, so that she and their sons could get the benefits that working families like theirs can't afford." -- PRESIDENT BILL CLINTON

"I guess I'm a little bitter. It is harder for working people to make ends meet, pay for their own medical, get jobs." -- JIM BRYANT, SOMERVILLE, MASSACHUSETTS.

1) Non-universal reforms cover the poor, but not the middle class.

Half-measures and quick fixes would leave every American at risk of losing their insurance. And at least 24 million Americans, most of whom work for a living, would have no coverage at all. */CBO analysis, 5/94, p. 20/*

The Congressional Budget Office also says that under a 91% proposal, "health insurance coverage would probably be more limited for middle-income people than the rich or poor." */CBO analysis, 5/94, p. 17/*



A 91% solution would help 11 of the 15 million uninsured Americans in poverty get health coverage, but would leave 16 of the 18 million middle-class Americans without insurance.

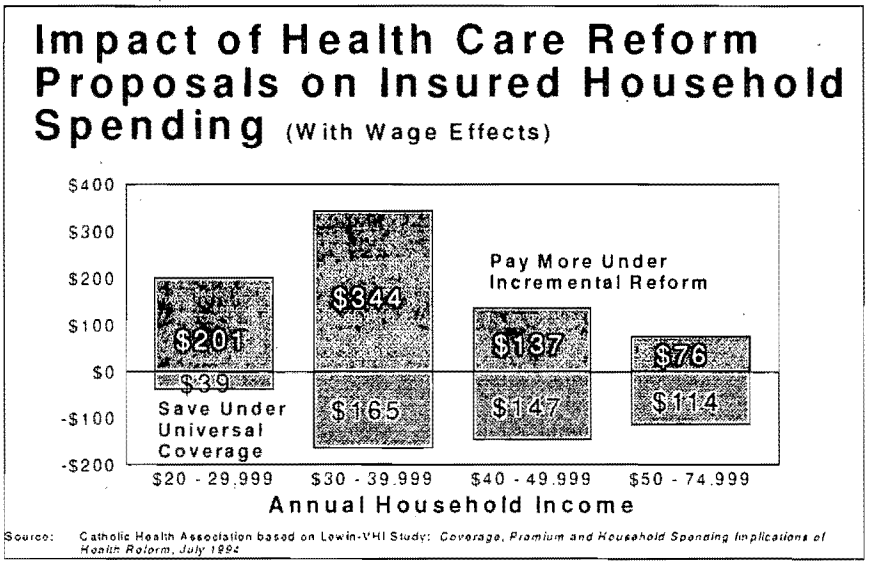
According to a new study by Families USA, over one million Americans a month will lose their insurance under a partial solution . */Families USA Special Report, 6/94, p.1/* We need universal coverage because all families -- including the middle-class -- must be protected.

While the U.S. population as a whole grew by only 1.3 million between 1988 and 1993, the number of uninsured Americans grew by 6.4 million people. Of the newly uninsured, nearly 4.8 million of them -- more than 75% -- work. *[1988 and 1993 March CPS, Bureau of the Census]*

2) Non-universal reforms increase insurance premiums.

"[W]e estimate that middle income families that currently have insurance will pay more in general for health care under partial reform than under reform that includes universal coverage." *[Lewin-VHI, July 18, 1994]*

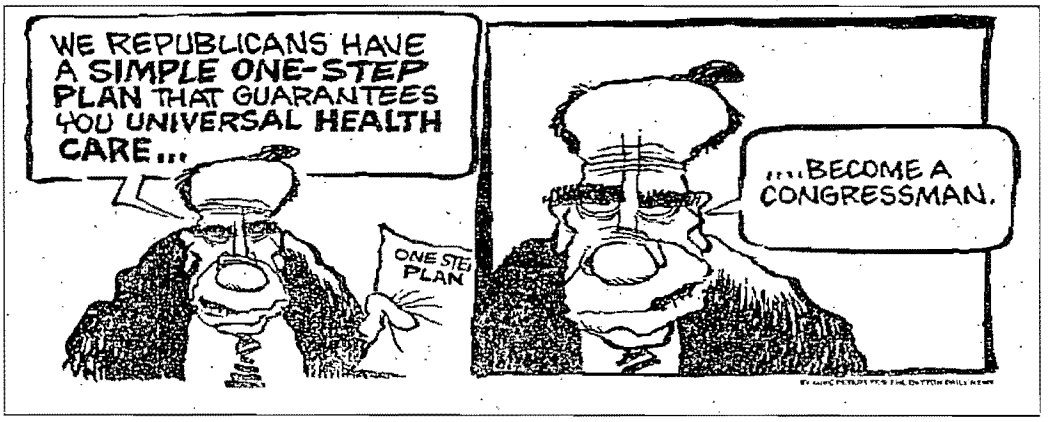
"With a portion of the population uninsured, per capita insurance costs for the insured population would be higher, compared to universal coverage." *[CBO, April 1994, p. 9]*



And The Wall Street Journal says: "The result...is the start of an upward spiral in rates" for those who still have insurance.

3) Non-universal reforms tell working Americans that their health is less important than the health of Members of Congress, federal employees, welfare families, and jailed felons.

Think of the message that non-universal reform would send to literally millions and millions of working Americans: If you are very poor, we'll guarantee your health care. If you get elected to Congress, we'll guarantee your health care. If you are employed by the federal government, we'll guarantee your health care. If you get thrown in jail, we'll guarantee your health care. If you are rich, you can guarantee your own health care. But, if you get up every day and work for a living, your health coverage is always at risk.



NON-UNIVERSAL REFORMS:
State Experience Shows It's Not Enough

"At least 37 states have enacted insurance reforms essentially identical to the [non-universal] reforms proposed in Congress. I think any insurance commissioner would say these reforms are a necessary but not sufficient way to decrease the number of uninsured. To say they're going to improve access is a bit misguided." -- PATRICIA BUTLER, HEALTH CARE CONSULTANT, BOSTON GLOBE 7/3/94

Many federal health reform proposals, such as the Dole plan, reject the goal of universal coverage and focus instead on expanding "access" through a patchwork of incremental reforms including small group market reforms, insurance reforms, low-income subsidies, community rating, medical savings accounts, voluntary alliances, tax credits and malpractice reforms. All told, more than 45 states have passed many of the reforms proposed in the Cooper and Dole bills.

However, state-level experience with non-universal reforms, implemented in recent years, has demonstrated no appreciable effect on total coverage levels or costs. Since the late 1980s, state-level health care reform activity has significantly increased, with more than 32 states passing incremental health reform measures between 1989 and 1992, and more than a dozen more acting in 1993 and 1994. *[Intergovernmental Health Policy Project, George Washington University]*

- The recent experience of one state, where community rating was implemented without universal coverage, bears out the unfortunate forecasts. A Wall Street Journal analysis noted that almost one year after this state had *"adopted stiff insurance reforms, fewer people have health coverage than under the old system."* [Wall Street Journal, 5/27/94] The reason: young people dropped coverage as rates went up, causing rates to rise further: between 20-35% for some insurers.

- In Hawaii, however, where reforms include universal employer/employee contributions, coverage approaches universal and, *"health insurance premiums are about 30 percent cheaper, while almost everything else in Hawaii is more expensive than on the mainland."* [New York Times, 5/6/94;]

Nor has the promise of better rates or cheaper benefits brought non-insuring small businesses into the system.

- Beginning in 1986, 11 states and non-profit groups began a demonstration program specifically aimed at increasing coverage by making health insurance more affordable and available to uninsured small businesses and individuals. Of the 11 demonstration projects, all used voluntary measures: 10 developed new, less expensive insurance products or subsidized existing insurance products, and one developed a health insurance information and referral service.

These demonstrations reached relatively few of the small businesses and individuals previously uninsured, leading the study to conclude that *"there is little evidence that voluntary efforts alone will close the gap on the uninsured problem."* *[testimony of W. David Helms, Ph.D., before the U.S. Senate Committee on Finance]*

States Have Already Tried Non-Universal Reforms

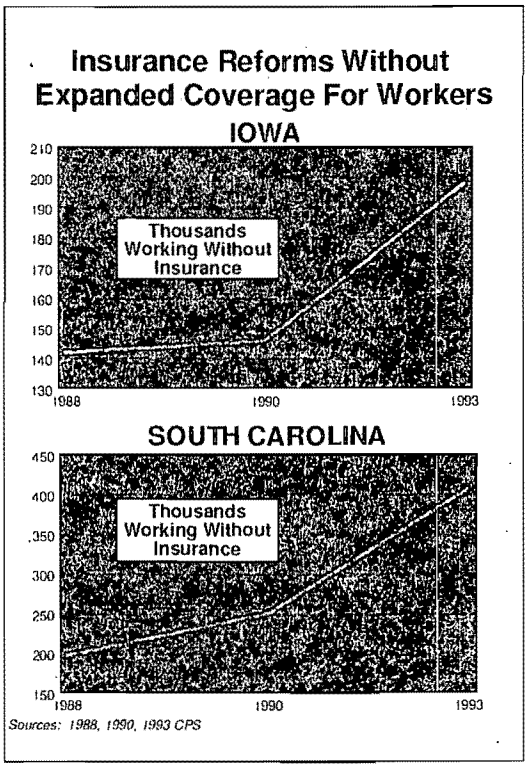
Reform Measure	Number of States
Guarantee Issue	35
Guarantee Renewal	42
Portability	37
Community Rating	19
Rating Bands	34
Voluntary Alliances	20
Tax Incentives	13
Medical Savings Accounts	7
Low-Income Subsidies/Medicaid Expansions	46

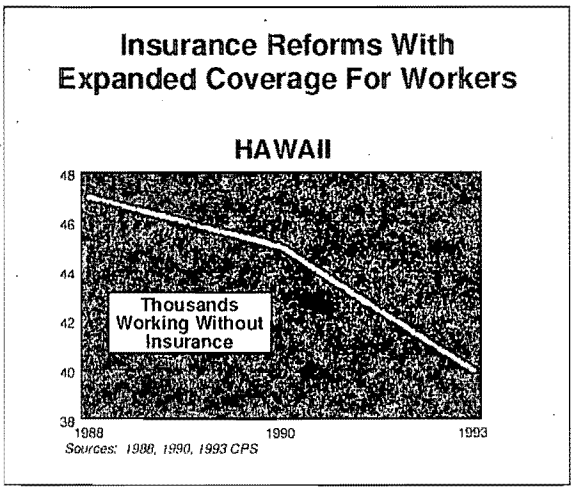
Source: Intergovernmental Health Policy Project, George Washington University, June 1994

The results of these reforms are illuminating: tens of thousands more working people left uninsured, and massive increases in insurance costs. Even in the states that successfully increased the total number of individuals covered from 1988 to 1993, half had a decrease in coverage among working people *[March CPS, 1988 and 1993, Bureau of the Census].*

A brief examination of representative states gives a taste of the differing outcomes that follow universal and non-universal reforms. Iowa's reforms resemble those suggested by the Dole plan. South Carolina's resemble the Cooper/Finance Committee plans. Hawaii is the state that has come closest to providing universal care.

1) Non-universal reforms leave more working people uncovered.





2) Non-universal reforms have hurt state budgets -- and raised working people's taxes.

Iowa and South Carolina -- states that most closely resemble the Dole and Cooper/Senate Finance plans -- enacted insurance market reforms with subsidies for poor people. Since reform, state spending on health care has continued to increase, forcing state officials to reduce funding for education and crime prevention. In these states, income taxes on working people continue to rise, even as more working people go without insurance. The message is clear: non-universal reform means that working people pay more for insurance and in taxes for the poor -- even as they lose health coverage themselves. [Sources: 1988, 1993 CPS. *State Government Finances* 1988, 1992. U. S. Bureau of Census, *State Government Tax Collection*, 1988, 1992]

NON-UNIVERSAL REFORM IS A HIDDEN TAX ON THE MIDDLE CLASS AND ON BUSINESS

"[S]o long as millions of Americans remain underinsured and uninsured, cost shifting will continue, leaving a mechanism for unwarranted price inflation in health care." -- MINNEAPOLIS STAR TRIBUNE, 6/16/94.

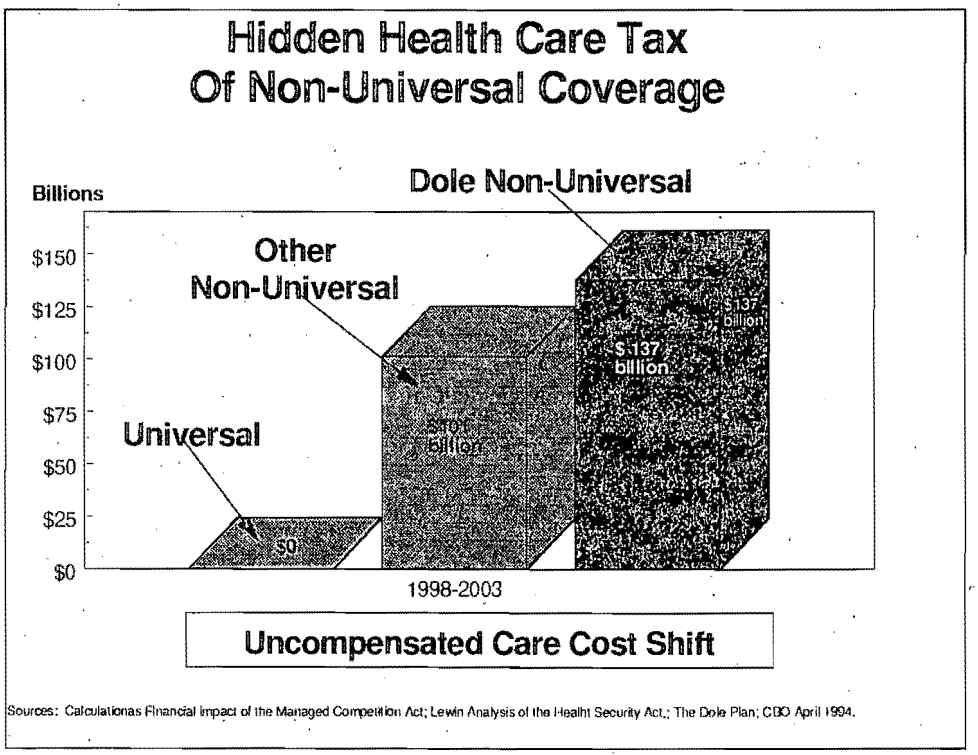
1) Non-universal reform leaves a hidden tax on working families.

People without health care coverage still get health care. But many of them don't pay for it. Their costs are shifted onto everyone who does pay an insurance premium. And their costs are higher because the uninsured often seek treatment after a problem has become a crisis, in a hospital emergency room.

A recent Department of Health and Human Services Study found that of the 90 million emergency room visits in 1992, fifty million were for ailments that could have been treated in a doctor's office -- at one-third the cost. [Source: National Hospital Ambulatory Care Survey; 1992 Emergency Department Summary; HHS, National Center for Health Statistics]

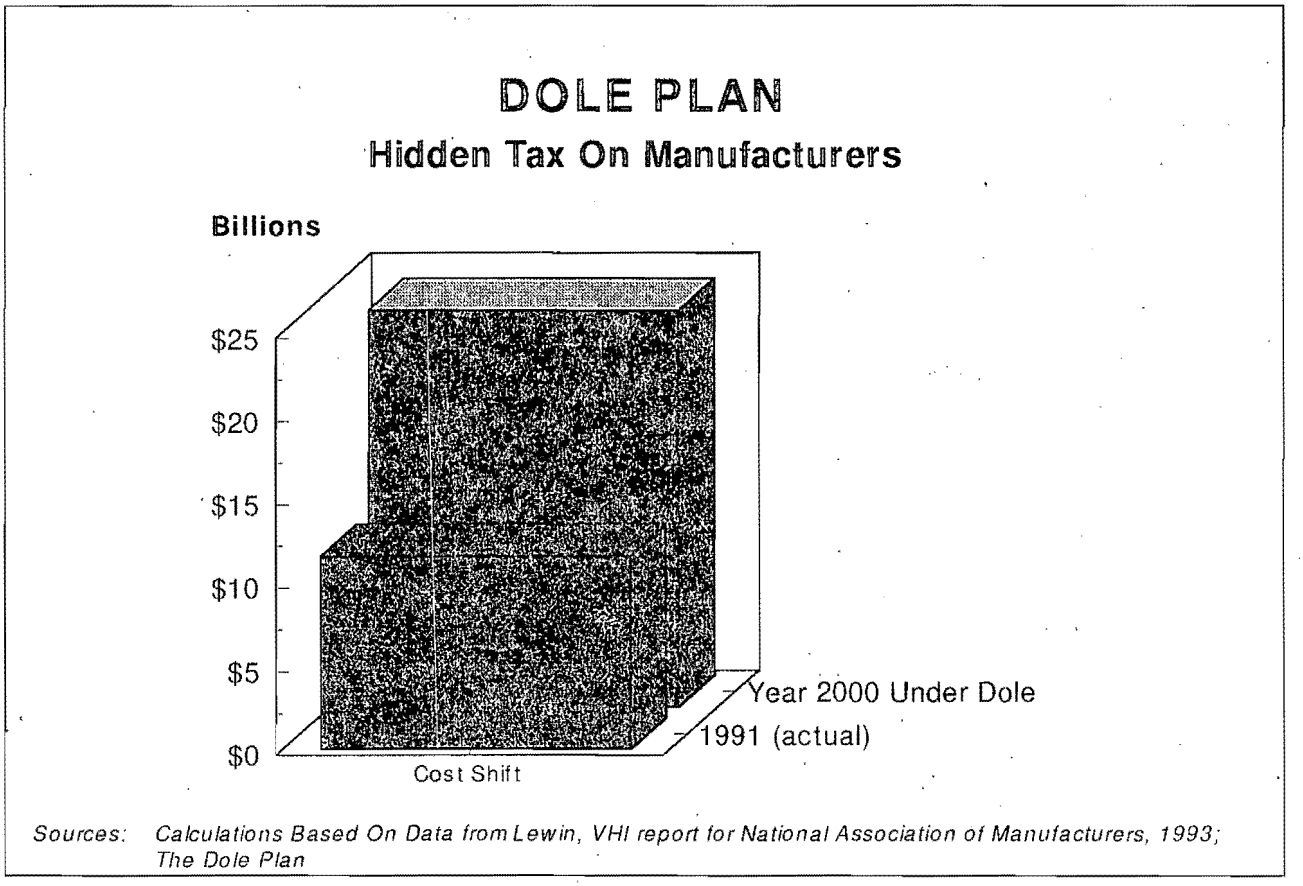
The methodology used by the Congressional Budget Office to analyze a similar plan indicates that the Dole plan would cover only 1 in 5 uninsured.

With 80% still uninsured, uncompensated care will remain at $18 billion in 1998 alone. So the Dole plan leaves $18 billion to be paid by working people who do have insurance.



2) Incremental reform is a hidden tax on businesses that provide coverage.

Another way to think of this Dole cost-shift is as a tax on businesses who provide coverage. Since most Americans get their insurance through work, businesses are forced to cut dividends, divert money from needed R&D, and cut back on hiring.



Sources: Calculations Based On Data from Lewin, VHI report for National Association of Manufacturers, 1993; The Dole Plan

The middle class gets squeezed coming and going -- either paying higher premiums themselves, or seeing jobs lost as employers cut back to cover costs shifted onto them by businesses that don't insure their employees.

INCREMENTAL REFORM FAILS OTHER KEY TESTS

1) Half-measures perpetuate "job-lock" by failing to ensure portability.

"I have great trouble seeing how you get portability without universal coverage." --U.S. SENATOR JOHN CHAFEE

- If you move to a new job and your new employer doesn't contribute, all incremental reforms give you is the right to assume the full burden by yourself -- whether or not your family can afford it. Incremental reform means millions could still lose coverage when they change jobs, be dropped if they can't afford their premium, or forced to wait six months for new coverage. That's not portability.

- Until we have *true* portability, we will never eliminate "job lock". Surveys suggest that as many as one in three working Americans are trapped in their current jobs because they fear losing the health insurance their families depend on. The CBO concluded that incremental reforms can *"reduce"* -- but not solve -- this problem. [*"Health Benefits Found to Deter Switches in Jobs,"* The New York Times, 9/26/91; CBO, 4/94, p. 28]

2) Non-universal reform cannot eliminate pre-existing condition exclusions.

"It will be nearly impossible without universal coverage . . . to outlaw the common industry practice of refusing to cover people with known medical problems, so called pre-existing conditions."
-- THE WALL STREET JOURNAL 6/15/94

- Without universal coverage, pre-existing exclusions would mean many healthy people would choose to "ride free" and go without insurance, knowing they could buy it when they get sick. This would drive up costs for all the people in the system. (Wall Street Journal, 6/15/94)

3) Incremental reforms perpetuate welfare lock and discourage work.

"At least one million adults and children are on welfare because it's the only way their families can get health care coverage" -- MOFFIT AND WOLFE, 1/90. "[an incremental approach] *would produce devastating disincentives to work . . . the creation of a near poverty trap . . . would result."* -- AARON IN NEW YORK TIMES, 2/13/94

- Even if the Dole proposal were fully funded -- which it is not -- it would only subsidize a portion of the premium for those families and individuals well below the poverty line. Welfare mothers going back to work would not only pay their own premiums, their taxes would pay for health care for those still on welfare. One expert says that the Dole plan would "make working irrational." On the other hand, an analysis of the effects of a universal proposal estimates that at least 840,000 people -- 15% of welfare rolls -- will seek jobs if the President's reform passes. *[Wolfe, University of Wisconsin, L.A. Times, 11/18/93; Boston Globe, 7/3/94]*

Shared Responsibility: The American Way

Shared responsibility is the American way -- part of the American tradition of work and reward. Nine out of ten Americans with private insurance already get it through their workplace. Real health care reform will continue this tradition, building on the existing system and expanding it to include all Americans.

And shared responsibility will lower costs for businesses that already insure their workers. Small businesses benefit most. And studies reveal that real reform will not slow the economy, and may even create jobs.

This health care reform debate is coming down to a choice between two approaches. One builds on our American system of workplace health benefits, and makes sure employers live up to their responsibilities. The other approach encourages employers to drop our health care coverage. For middle class Americans, its an obvious choice.

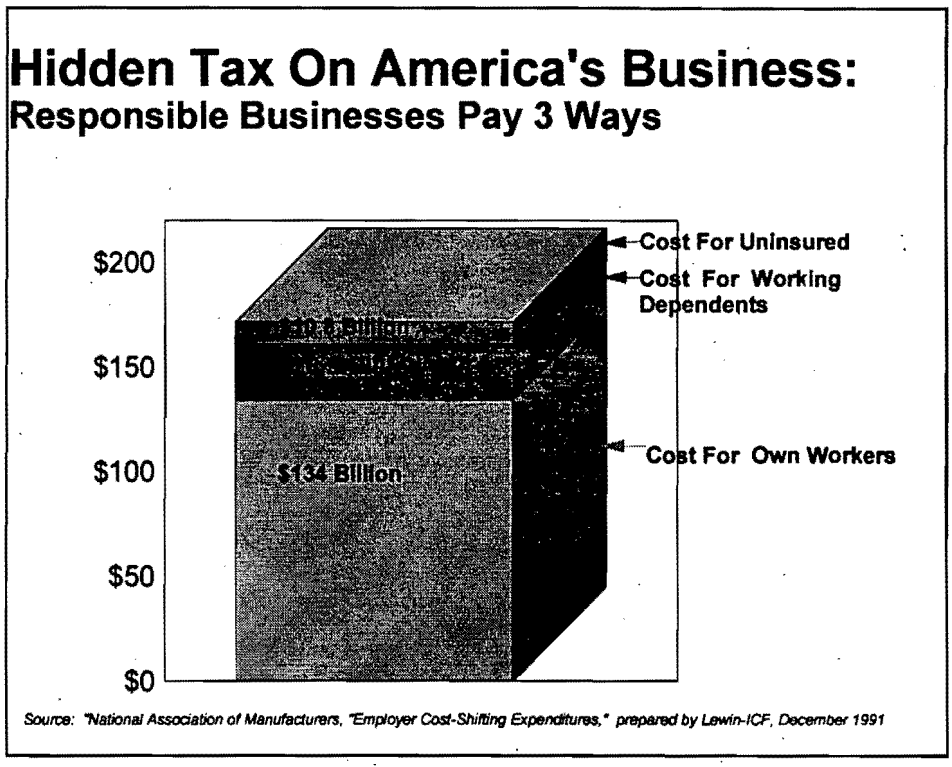
The American people overwhelmingly support Universal Coverage: 78% according to a recent *ABC News/Washington Post* Poll [June 27, 1994]. And shared responsibility is the fairest, most economical, and least disruptive way to get there.

I. WITHOUT SHARED RESPONSIBILITY, COST SHIFTING WILL PUNISH RESPONSIBLE BUSINESSES

There is often cost-shifting among firms in the same industry, "*creating a situation where some employers may actually subsidize health care provided to employees in competing firms.*" [National Association of Manufacturers, "*Employer Shifting Expenditures,*" prepared by Lewin ICF, December 1991]

The current system forces responsible employers to pay for insurance three times: First, for their employees. Second, for dependents of their employees who work, but don't get health care from their own jobs. And third, for the uninsured -- many of them working people -- who show up in America's emergency rooms, and whose unpaid costs are added to the bills of those who do have insurance. **Cost shifting is a hidden tax on responsibility and on employment.**

- In 1991, employers who took responsibility for employees and their families **paid $26.5 billion to cover dependents whose employers did not offer insurance to their workers.** [National Association of Manufacturers, "*Employer Cost-Shifting Expenditures,*" prepared by Lewin-ICF, December 1991]

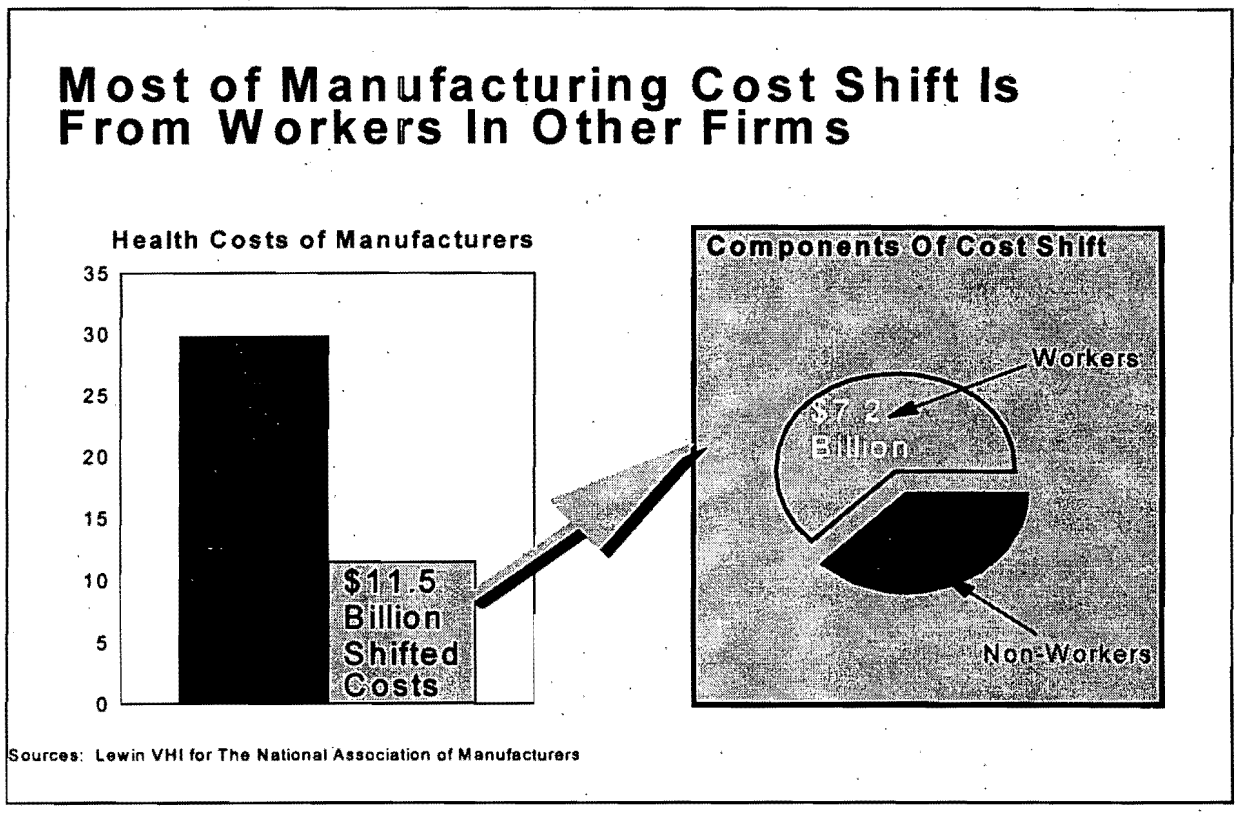


- That same year, employers who took responsibility for their employees' insurance also had an additional $10.8 billion added to their premiums to cover the uncompensated hospital costs of families without any insurance. Nearly half of this was to pay for **"workers, or dependents of workers, in firms that didn't provide coverage."** [National Association of Manufacturers, "*Employer Cost-Shifting Expenditures,*" prepared by Lewin-ICF, December 1991]

The manufacturing industry -- a critical source of high-wage jobs and export-quality American goods -- has been hard hit by cost shifting. America's manufacturers are among the nation's most responsible sector, covering almost all of their workers. They must compete against foreign manufacturers with a stable, insured, productive workforce, while carrying the extra burden of companies that do not provide coverage.

- **Bethlehem Steel has 20,000 employees but pays insurance for 160,000 people**. Although locked into a competitive battle with Canadian steel producers just across the border, Bethlehem is burdened by $65 million in additional health care costs -- almost a third of their total health care bill -- **because of cost-shifting.** [Testimony of B. Boyleston, V.P. for Human Resources, before Congressional Steel Caucus, 6/23/94]

- One study estimates that 28% -- or $11.5 billion -- of the health care costs paid by manufacturing companies are a result of cost-shifting. [National Association of Manufacturers, *"Employer Cost-Shifting Expenditures,"* prepared by Lewin-ICF, December 1991]



- **Universal coverage will eliminate the penalty on businesses that provide coverage.** *"Universal coverage would mean that those firms that now offer insurance would no longer need to pay indirectly through higher doctor and hospital bills for the care given to uninsured workers and their families. On the other hand, firms that do not now provide insurance could no longer ride free."* [CBO, 2/94]

II. AVOIDING SHARED RESPONSIBILITY MEANS MORE WORKERS WILL LOSE THEIR COVERAGE

"For those who have suggested that the best policy may be to muddle through with only small, incremental changes, our analysis suggests that the number of uninsured workers in small businesses will continue to grow. If our survey proves true, in the years ahead ***30 percent of small businesses currently providing insurance will drop their insurance coverage because of the high cost.***" [Health Affairs, Spring 1992]

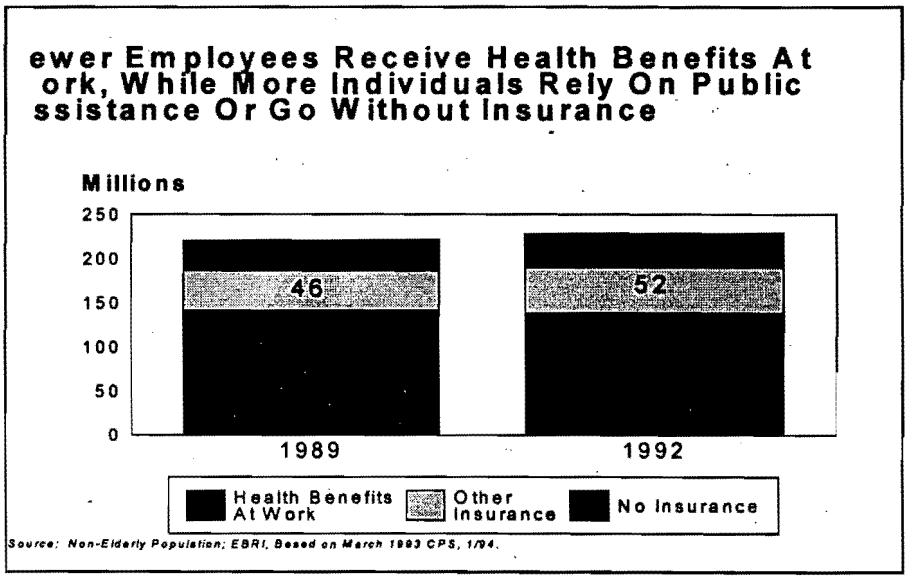
- Under one proposed plan, where benefits were not guaranteed at work, two million workers in small businesses would lose their employer's contribution. [CBO, 2/94]

- Another reform alternative would cost 1.3 million Americans their insurance every month. And 1.8 million Americans a month would lose their coverage under yet another leading alternative. [Lewin-VHI estimates for Families USA]

- If employers are allowed to dodge responsibility every worker in the United States will be at risk of having to bear the entire burden of health insurance alone -- $3900 or more each year.

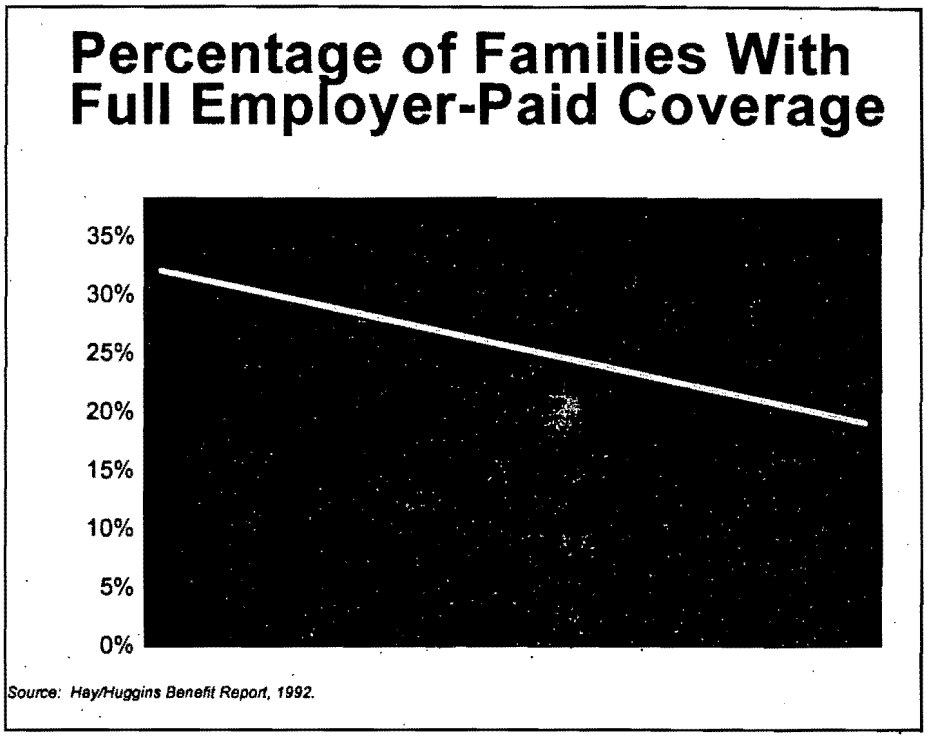
More and more, employees are being hurt as rising costs force companies that take responsibility to cut back.

- The percentage of workers whose employers sponsor health insurance plan is already falling -- from 81% in 1988 to 78% in 1992. In 1978, 23% of new companies offered health benefits to their employees. In 1992, that percentage had dropped to 15%. [Department of Labor, 5/94; University of North Carolina, 8/92]



- Nearly six in ten Americans earning between $30,000 and $50,000 a year have experienced health benefit cutbacks in their households. The percentage of families with full employer-paid coverage fell from 32% in 1988 to 19% in 1992. [New York Times/CBS News Poll 4/7/93; Hay/Huggins Benefit Report, 1992]

- Steve Burd, President and Chief Executive Officer of **Safeway** Inc. -- one of the world's largest food retailers -- said his company competes "with some very large companies that don't offer the same kind of coverage." If health reform doesn't pass with the employer mandate, Burd fears that Safeway might be forced to curtail its coverage "to level the playing field." [LA Times Friday July 22, 1994]



Some voluntary systems end up creating welfare-like incentives for irresponsible behavior.

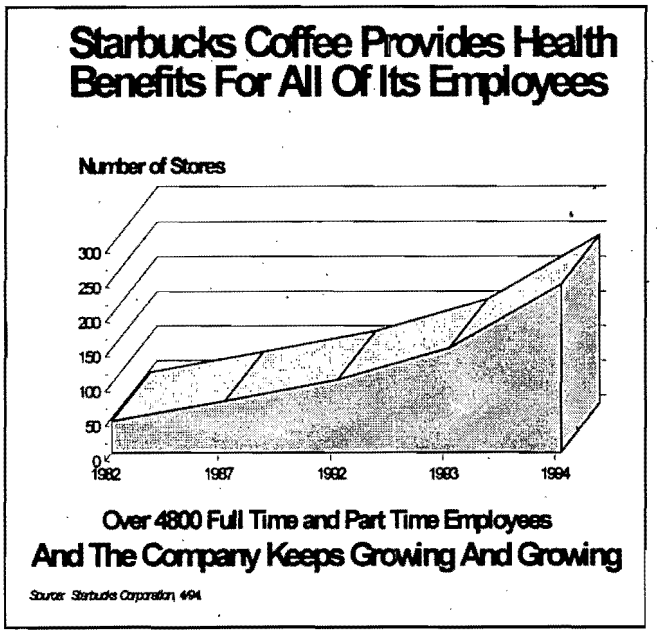
One proposed plan would cause employers that take responsibility for their workers to bear even greater costs. Employers are encouraged to shove their employees out of the system, where taxpayer-funded subsidies will help workers buy coverage.

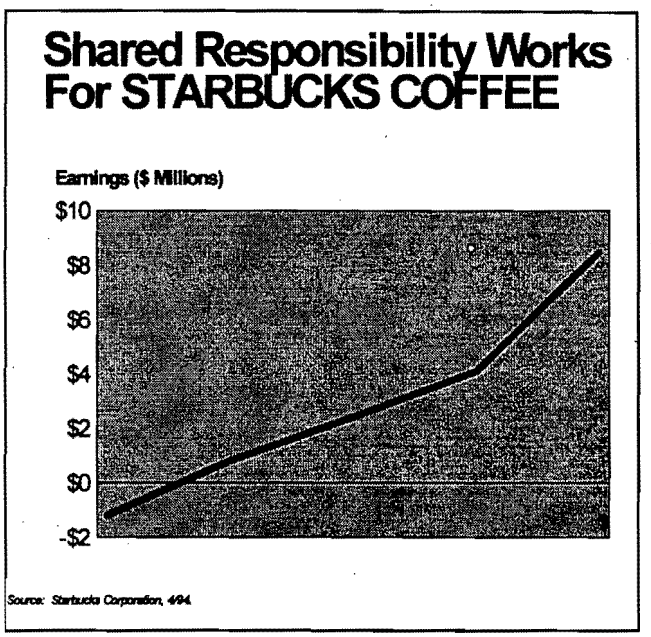
- The cost of subsidies to taxpayers could be "much higher" without benefits guaranteed at work. The study found that under these proposed schemes **companies would have "powerful incentives" to drop coverage for their employees and to shift costs to the government,** which would subsidize the premiums. [Center on Budget and Policy Priorities]

III. SHARED RESPONSIBILITY IS GOOD BUSINESS

"The simple math is it saves the company money. It costs about $1,500 per year to cover each employee, part time and full time, and the cost of attrition if we have to hire and retrain a new employee is over $3,000." [Starbucks CEO Howard Schultz]

- **Starbucks Coffee**, with 4,800 employees, was named one of the fastest growing companies in America in 1993 by Fortune Magazine. CEO Howard Schultz believes that a comprehensive employee benefits package for all workers is the key to competitiveness: *"At Starbucks Coffee Company adding benefits for part-time and full-time employees is leading to a healthier workforce and bottom line. The longer an employee stays with us, the more we save."* And Starbucks posts higher profits every year, sales have grown almost 80% over the last three years, and the stock price continues to climb.





- **PictureTel**, the technology and market leader in video conferencing, has doubled the number of its employees since 1991 to 865. They are able to provide health care benefits to all their employees and yet still grow at world class rates -- an astonishing compounded growth rate of 97% over the past five years. PictureTel is the market leader both in the U.S. and in Europe.

Shared responsibility works around the world.

"[Pizza Hut and McDonalds] are living proof that shared responsibility works for employers and employees, and as a means for a nation to achieve universal coverage," [The Health Care Reform Project, "Do As We Say, Not As We Do," July 1994]

- **Pizza Hut**, which earned a net profit last year of $372 million, does not contribute to health insurance for many of its hourly restaurant workers in the United States. The company does make a group insurance plan available, but employees are required to pay the full amount. After six months, the company will contribute to the cost of supplemental coverage, but paying for the basic plan is still the responsibility of the employee.

  By contrast in Germany, Pizza Hut is required to pay 50 percent of its employees' premiums. As of 1991, there were 64 Pizza Hut restaurants in Germany with revenues of $39 million and 2,100 employees. In Japan, Pizza Hut is required to pay 50 percent of the premiums for employees who work at least 30 hours per week -- as most do at any of the company's 65 Japanese restaurants. Pizza Hut is doing so well there that two years ago the company announced its intention to quadruple the number of Pizza Huts in Japan by 1997.

- **McDonald's** does not cover hourly or part-time workers at its restaurants in the United States. However, McDonald's does pay for coverage for its workers in Belgium, Germany, Japan, and The Netherlands. Germany is one of McDonald's six largest markets, with 27,000 employees and revenues of nearly $1 billion in 1992. Likewise, in The Netherlands, McDonald's now has 100 stores, a 17.6 percent increase over last year. In Japan, the number of McDonald's restaurants (1,048) has increased 8 percent since 1993.

IV. SHARED RESPONSIBILITY HAS A SMALL IMPACT ON BUSINESS

"In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection." [President Richard M. Nixon]

"I can assure you that there's not going to be a single job lost if the insurance plan you are proposing goes into effect." [Eric Sklar, Owner, Burrito Brothers Restaurants]

- A system of employer-employee shared responsibility makes sense because it builds on the existing system. Nine out of ten Americans with private insurance get it through employers. [EBRI, 1/94] 85% of firms with more than 25 employees offer their workers health benefits. [HIAA, "Source Book of Health Insurance Data," 1992]

- A recent survey of over 1,000 major employers, including Fortune 100 and Fortune 500 companies, found that "almost all provided medical coverage to full time salaried employees." [Daily Labor Report, 3/1/94]

- Many businesses that already provide coverage could see costs actually drop as the burden of cost-shifting is lifted. Small businesses -- who currently pay 35% more than large businesses to ensure their employees than their larger counterparts -- would benefit most dramatically. [Hay Higgins Report]

- The President's original proposal capped contributions at 7.9% of payroll, and with discounts many small businesses would have paid only 3.5%. Every congressional proposal pending contains even greater protection for our nation's smallest companies. All of the proposals would have costs far below the 90 cent per hour minimum wage increase signed into law by then-President George Bush.

- Recent studies of the minimum wage increase show negligible effects on employment. A study comparing fast food employment in New Jersey where the minimum wage increased, and Pennsylvania where wages stayed stagnant, found a greater employment increase in New Jersey. [Card and Krueger. Princeton University]

- Studies have estimated that reform with shared employer-employee responsibility will create jobs -- as many as 258,000 in the manufacturing sector, and as many as 750,000 in home health care. ["The Impact of the Clinton Health Care Plan on Jobs, Investments, Wages, Productivity and Exports," Economic Policy Institute November 1993; Reuters, from Brookings Institute study, 9/17/93]

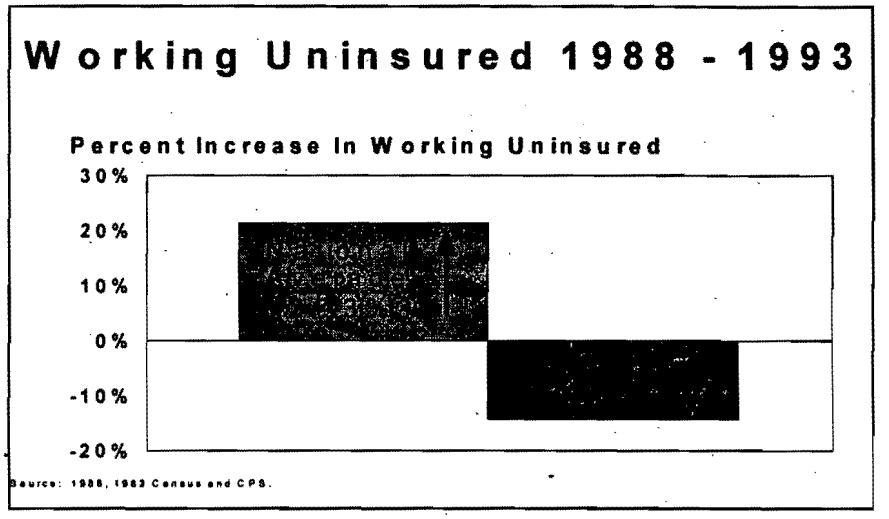
V. HAWAII: HEALTHIER BUSINESSES, HEALTHIER PEOPLE

"It is clear that the "employer mandate," . . . has succeeded in bringing Hawaii to the threshold of universal health insurance coverage. That seems to have helped restrain health care inflation, a serious problem here but less critical than on the mainland: ***health insurance premiums are about 30 percent cheaper here****, while almost everything else in Hawaii is more expensive. "*
[*"Hawaii is a Health Care Lab as Employers Buy Insurance",* New York Times, 5/6/94]

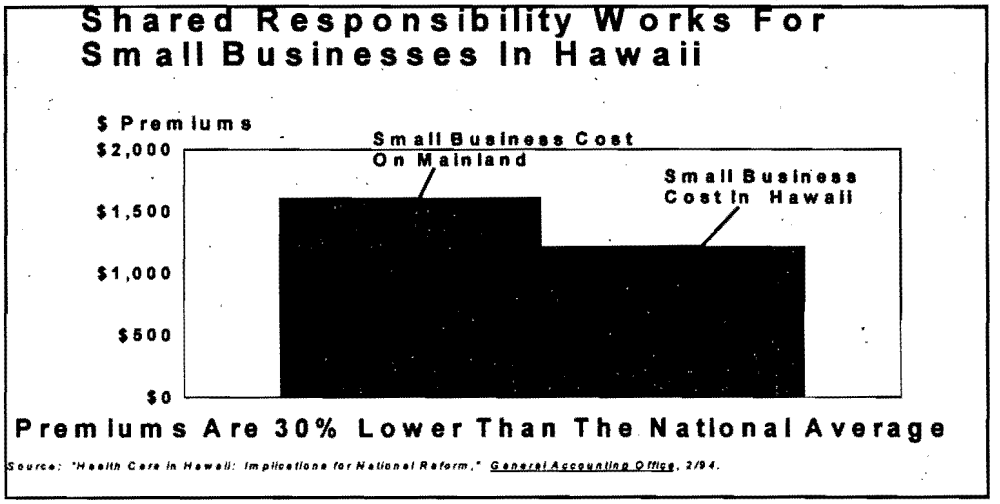
Shared responsibility is neither an untried novelty nor an exotic import unsuited to the American way of business.

Hawaii (1974), Oregon (1989) and Washington State (1993) are the only states with a current commitment to universal coverage. All have chosen employer-employee shared responsibility as the most practical way to achieve it.

- Since 1988, the number of working uninsured in America has increased by 21%. But during that same period Washington enjoyed a 19% decrease in its working uninsured, Hawaii saw a 15% dropped in working uninsured, and Oregon's shrank by 2%. [CPS and Census data, 1988, 1993]



- Hawaii, the state that's had shared responsibility the longest, has 96% coverage. Employer-paid premiums are 30% lower than they are on the mainland. [GAO, 2/94; Hawaii Department of Health, 11/92].



- Since Hawaii began asking all employers to provide insurance in 1974: the unemployment rate has dropped to one of the lowest in the nation; small business creation has remained high; and the rate of business failures is less than half the national rate. [Hawaii Department of Labor and Industrial Relations; Dun and Bradstreet, *Monthly New Business Incorporation Rate*; Journal of the American Medical Association, 5/19/93]

"Universal access is in itself a cost-containment strategy. Because virtually all of Hawaii's people have access to primary care through the employer mandate and the state programs it has made possible, utilization of high-cost services is well below the rest of the nation. This leads to low health care costs, comparatively low small business insurance rates, and a lower portion of gross domestic product spent on health care when the state is compared to the rest of the nation." [*"Hawaii 's Employer Mandate and it's Contribution to Universal Access"* JAMA, 5/19/93]

7/24/94

HEALTH CARE REFORM -- OPTION 1

- No Mandates. Under this plan, neither employers nor employees would be required to purchase health care insurance.

- Targeted Subsidies. Subsidies would be available to encourage certain low income individuals and firms to purchase insurance. These subsidies would be targeted to groups that tend not to have health insurance.

- Subsidies Capped at Premium Targets. To the extent premiums exceed the statutory premium targets outlined below, individual and business subsidies only will be available up to the value of the premium target. Assume, for example, a low income individual eligible for subsidies equal to 100 percent of his premium cost. If he chooses a health plan with a premium above the statutory target, only that portion of the premium below the target would be 100 percent subsidized. *If and when we put caps in place is yet to be determined.*

- Targeted Individual Subsidies. The following subsidies would be available to individuals:

  - Low-income families. Beginning in 1997, low income individuals and families would receive a subsidy worth a fixed percentage of the average premium. For those below 75 percent of the Federal poverty level, these subsidies would equal 100 percent of the premium. For persons with income between 75 and 200 percent of poverty, the subsidy would range on a sliding scale from 100 to 0 percent. *Consideration is being given to phasing out over 100 to 200 percent of poverty.*

    To maximize participation, individuals determined to be presumptively eligible for 100 percent subsidies automatically would be enrolled at point-of-service.

  - Cash assistance recipients. Beginning with the January 1, 1997 abolishment of Medicaid, cash assistance recipients would receive subsidies equal to 100 percent of the premium.

  - Former non-cash Medicaid eligibles. Beginning in 1997, individuals who would be medically needy or other non-cash recipients under the current Medicaid program (except pregnant women, infants and children) would receive subsidies covering 100 percent of the premium for six months, then would be treated the same as others based on income.

- Individuals leaving welfare for work. Beginning in 1997, individuals leaving welfare for work would receive subsidies equal to 100 percent of the premium for two years (not one year limit under current law).

- Low income pregnant women and children. Beginning in 1997, pregnant women and children under 19 with incomes up to 185 percent of poverty would be eligible to receive subsidies equal to 100 percent of the premium. For those with incomes between 185 percent and 240 percent of poverty, the subsidies will range on a sliding scale from 100 to 0 percent. As above, individuals determined to be presumptively eligible for 100 percent subsidies would be automatically enrolled at point-of-service.

- Temporarily unemployed, uninsured. Beginning in 1997, individuals working for six months in a job with insurance would be eligible for the low income subsidy for up to six months after losing their jobs. In calculating these persons' eligibility for such subsidies, AGI will be adjusted to exclude (1) unemployment compensation and (2) 75 percent of income earned while employed. To maximize participation, individuals would be encouraged to enroll when applying for unemployment insurance benefits (we're still checking with DoL on feasibility of this last item).

- Employer Subsidies. The following subsidies would be available to employers:

  - Employers who expand coverage to additional workers. Beginning in 1997, employers who expand coverage to all their employees in a specific class (i.e., full time, part time) would receive subsidies to make their employees' premiums more affordable. Employers would pay the lesser of 50 percent of the premium or 8 percent of each newly insured employee's wages. The employee would pay 50 percent of the premium, with workers with incomes under 200 percent of poverty eligible for the individual subsidies described above. This subsidy would be available to employers for a maximum of five years.

- Individuals up to age 25. To further maximize coverage, dependents could be covered under parents' policies until they turn 25.

- Premium Assessment. As provided for in HSA, a national per capita baseline premium target would be established and adjusted for each health care coverage area. To the extent community rated plans exceed that target, they would pay an assessment on the excess at a rate of 25 percent. As in HSA, the initial target for community rated plans would be established based on current expenditures. The per capita target for both community rated and experienced rated plans would increase at the following rates, except that the target for experienced rated plans would be measured on a three year rolling average basis:

1996:	CPI + 3.0%
1997:	CPI + 2.5%
1998 & beyond:	CPI + 2.0%

- o Risk Adjustment. Risk adjustment between community-rated health plans to account for differences in health status among enrollees.

  In addition, experienced rated plans would be required to make transfers to the community rated plan pools to adjust for the increased morbidity rates in the community rated pools due to the coverage of the nonworking population, including the former Medicaid population, retirees, and other individual purchasers. The Secretary of HHS would estimate the above average costs incurred by community rated plans that provide services to individual purchasers and that total amount of costs would be assessed on a per capita basis from all insurance plans, including those in the community rated pool and in the experience rated market. The receipts would then be redistributed to community rated plans based on the portion of above average cost individuals they enroll.

- o Insurance Market Reforms. As follows:

  - o Market segments and boundaries. Firms with fewer than 500 workers and individual purchasers (self-employed, nonworkers, Medicaid-eligibles) would be in the community rated pool. Firms with 500 or more workers, existing Taft-Hartley plans, and rural cooperatives with 500 or more members would be permitted to self-insure or purchase experience-rated coverage.

  - o Community rating requirements. Community rated plans could modify their rates based on coverage category (e.g., single, family, etc.), geography, and age (with 2:1 band for population under 65 years of age). Each health plans would be required to establish a single set of rates for the standard benefits package applicable to all individuals and groups within the community-rated segment of a community rating area. Rates for HIPCs could be discounted to reflect administrative savings.

  - o Health plan requirements. Health supplemental benefits must be priced and sold separately from the comprehensive benefits package. Plans would be subject to the following market reforms: guarantee issue, guarantee renewal, open enrollment, limit pre-ex exclusions to 6 months; and exit from market rules.

  - o Guaranty fund. States would be required to establish guaranty funds for all community-rated health plans.

  - o HIPCs. The plan includes multiple, competing, voluntary HIPCs. If a HIPC is not available in every community rating area, states would be required to establish or sponsor HIPC in unserved area. HIPCs would be responsible for entering into agreements with plans and employers; enrolling individuals in plans; collecting and distributing premium payments; coordinating out-of-coverage with other HIPCs; and providing consumer information on plans' quality and cost.

HIPCs must accept all eligible individuals and firms; provide enrollees a choice of at least 3 plans, including 1 FFS. Requirement of 3 plans could be waived by Governor in rural areas. The National Health Board would establish fiduciary standards for HIPCs. HIPCs would be permitted to negotiate discounts with plans reflecting economies of scale in administration and marketing.

Eligible employers (firms with less than 500 workers) must offer at least three plans, including a FFS to their employees. Firms could satisfy this requirement by offering a HIPC to their employees. These firms could choose from among the HIPCs in their community rating area. In order to qualify for employer premium contribution, employees would be required to purchase health insurance through the HIPC chosen by their employer. Employees could choose from the plans offered by the HIPC.

- o **Self-insured plans.** In general, self-insured plans must comply with the above responsibilities and reforms, including employer and individual premium contribution requirements, coverage of a comprehensive package of benefits, guaranteed issue and renewal, and pre-existing condition limits.

- o **Long Term Care.** This plan includes a federal entitlement capped at $48 billion over the 1995-2004 period.

- o **Medicare Drug.** This initiative gives Medicare beneficiaries three options: fee-for-service, a Drug Benefit Carriers option, and an HMO option -- all effective 1/1/98. Beneficiaries would have a $500 annual deductible; a 20 percent copay; and an annual out-of-pocket limit of $1,200 in 1998. Medicare Part B premium would be increased by 25 percent of drug benefit costs, with Medicare paying the remaining 75 percent. Drug manufacturers would sign rebate agreements with HHS in exchange for no formulary. Drugs used as part of HMOs or capitated drug plans and the working aged would not be subject to rebates. Rebates for single source and innovator multiple source drugs would be 15 percent; multiple source drug rebate would be 6 percent.

- o **Revenue Provisions.** Same as Senate Finance, except high cost premium assessment and provisions on attached list, "Modifications to Senate Finance Committee bill."

7/24/94

HEALTH CARE REFORM -- OPTION 2

- Mandates. Under this plan, an employer mandate would be triggered in the year 2000 if 95 percent coverage were not achieved under the voluntary targeted subsidy program.

- Targeted Subsidies. Subsidies would be available to encourage certain low income individuals and firms to purchase insurance. These subsidies would be targeted to groups that tend not to have health insurance.

- Subsidies Capped at Premium Targets. To the extent premiums exceed the statutory premium targets outlined below, individual and business subsidies only will be available up to the value of the premium target. Assume, for example, a low income individual eligible for subsidies equal to 100 percent of his premium cost. If he chooses a health plan with a premium above the statutory target, only that portion of the premium below the target would be 100 percent subsidized. *If and when we put caps in place is yet to be determined.*

- Targeted Individual Subsidies. The following subsidies would be available to individuals:

  - Low-income families. Beginning in 1997, low income individuals and families would receive a subsidy worth a fixed percentage of the average premium. For those below 75 percent of the Federal poverty level, these subsidies would equal 100 percent of the premium. For persons with income between 75 and 200 percent of poverty, the subsidy would range on a sliding scale from 100 to 0 percent. *Consideration is being given to phasing out over 100 to 200 percent of poverty.*

    To maximize participation, individuals determined to be presumptively eligible for 100 percent subsidies automatically would be enrolled at point-of-service.

  - Cash assistance recipients. Beginning with the January 1, 1997 abolishment of Medicaid, cash assistance recipients would receive subsidies equal to 100 percent of the premium.

  - Former non-cash Medicaid eligibles. Beginning in 1997, individuals who would be medically needy or other non-cash recipients under the current Medicaid program (except pregnant women, infants and children) would receive subsidies covering 100 percent of the premium for six months, then would be treated the same as others based on income.

- o Individuals leaving welfare for work. Beginning in 1997, individuals leaving welfare for work would receive subsidies equal to 100 percent of the premium for two years (not one year limit under current law).

- o Low income pregnant women and children. Beginning in 1997, pregnant women and children under 19 with incomes up to 185 percent of poverty would be eligible to receive subsidies equal to 100 percent of the premium. For those with incomes between 185 percent and 240 percent of poverty, the subsidies will range on a sliding scale from 100 to 0 percent. As above, individuals determined to be presumptively eligible for 100 percent subsidies would be automatically enrolled at point-of-service.

- o Temporarily unemployed, uninsured. Beginning in 1997, individuals working for six months in a job with insurance would be eligible for the low income subsidy for up to six months after losing their jobs. In calculating these persons' eligibility for such subsidies, AGI will be adjusted to exclude (1) unemployment compensation and (2) 75 percent of income earned while employed. To maximize participation, individuals would be encouraged to enroll when applying for unemployment insurance benefits (we're still checking with DoL on feasibility of this last item).

- o Employer Subsidies. The following subsidies would be available to employers in the absence of an employer mandate:

  - o Employers who expand coverage to additional workers. Beginning in 1997, employers who expand coverage to all their employees in a specific class (i.e., full time, part time) would receive subsidies to make their employees' premiums more affordable. Employers would pay the lesser of 50 percent of the premium or 8 percent of each newly insured employee's wages. The employee would pay 50 percent of the premium, with workers with incomes under 200 percent of poverty eligible for the individual subsidies described above. This subsidy would be available to employers for a maximum of five years.

- o Individuals up to age 25. To further maximize coverage, dependents could be covered under parents' policies until they turn 25.

- o Premium Assessment. As provided for in HSA, a national per capita baseline premium target would be established and adjusted for each health care coverage area. To the extent community rated plans exceed that target, they would pay an assessment on the excess at a rate of 25 percent. As in HSA, the initial target for community rated plans would be established based on current expenditures. The per capita target for both community rated and experienced rated plans would increase at the following rates, except that the target for experienced rated plans would be measured on a three year rolling average basis:

1996:	CPI + 3.0%
1997:	CPI + 2.5%
1998 & beyond:	CPI + 2.0%

- **Risk Adjustment.** Risk adjustment between community-rated health plans to account for differences in health status among enrollees.

  In addition, experienced rated plans would be required to make transfers to the community rated plan pools to adjust for the increased morbidity rates in the community rated pools due to the coverage of the nonworking population, including the former Medicaid population, retirees, and other individual purchasers. The Secretary of HHS would estimate the above average costs incurred by community rated plans that provide services to individual purchasers and that total amount of costs would be assessed on a per capita basis from all insurance plans, including those in the community rated pool and in the experience rated market. The receipts would then be redistributed to community rated plans based on the portion of above average cost individuals they enroll.

- **Insurance Market Reforms.** As follows:

  - **Market segments and boundaries.** Firms with fewer than 500 workers and individual purchasers (self-employed, nonworkers, Medicaid-eligibles) would be in the community rated pool. Firms with 500 or more workers, existing Taft-Hartley plans, and rural cooperatives with 500 or more members would be permitted to self-insure or purchase experience-rated coverage.

  - **Community rating requirements.** Community rated plans could modify their rates based on coverage category (e.g., single, family, etc.), geography, and age (with 2:1 band for population under 65 years of age until there is a mandate). Each health plans would be required to establish a single set of rates for the standard benefits package applicable to all individuals and groups within the community-rated segment of a community rating area. Rates for HIPCs could be discounted to reflect administrative savings.

  - **Health plan requirements.** Health supplemental benefits must be priced and sold separately from the comprehensive benefits package. Plans would be subject to the following market reforms: guarantee issue, guarantee renewal, open enrollment, limit pre-ex exclusions to 6 months; and exit from market rules.

  - **Guaranty fund.** States would be required to establish guaranty funds for all community-rated health plans.

  - **HIPCs.** The plan includes multiple, competing, voluntary HIPCs. If a HIPC is not available in every community rating area, states would be required to establish or sponsor HIPC in unserved area. HIPCs would be responsible for entering into agreements with plans and employers; enrolling individuals in plans; collecting and distributing premium payments; coordinating out-of-coverage with other HIPCs; and providing consumer information on plans' quality and cost.

HIPCs must accept all eligible individuals and firms; provide enrollees a choice of at least 3 plans, including 1 FFS. Requirement of 3 plans could be waived by Governor in rural areas. The National Health Board would establish fiduciary standards for HIPCs. HIPCs would be permitted to negotiate discounts with plans reflecting economics of scale in administration and marketing.

Eligible employers (firms with less than 500 workers) must offer at least three plans, including a FFS to their employees. Firms could satisfy this requirement by offering a HIPC to their employees. These firms could choose from among the HIPCs in their community rating area. In order to qualify for employer premium contribution, employees would be required to purchase health insurance through the HIPC chosen by their employer. Employees could choose from the plans offered by the HIPC.

- o **Self-insured plans.** In general, self-insured plans must comply with the above responsibilities and reforms, including employer and individual premium contribution requirements, coverage of a comprehensive package of benefits, guaranteed issue and renewal, and pre-existing condition limits.

- o **Long Term Care.** This plan includes a federal entitlement capped at $48 billion over the 1995-2004 period.

- o **Medicare Drug.** This initiative gives Medicare beneficiaries three options: fee-for-service, a Drug Benefit Carriers option, and an HMO option – all effective 1/1/98. Beneficiaries would have a $500 annual deductible; a 20 percent copay; and an annual out-of-pocket limit of $1,200 in 1998. Medicare Part B premium would be increased by 25 percent of drug benefit costs, with Medicare paying the remaining 75 percent. Drug manufacturers would sign rebate agreements with HHS in exchange for no formulary. Drugs used as part of HMOs or capitated drug plans and the working aged would not be subject to rebates. Rebates for single source and innovator multiple source drugs would be 15 percent; multiple source drug rebate would be 6 percent.

- o **Revenue Provisions.** Same as Senate Finance, except high cost premium assessment and provisions on attached list, "Modifications to Senate Finance Committee bill."

- o **Trigger Determination.** On January 15, 1999, the Health Care Coverage Commission would determine whether the voluntary system has achieved 95 percent coverage. If the Commission determines that at least 95 percent of all Americans had health coverage, they would send recommendations to the Congress on how to insure the remaining uninsured individuals. If coverage is below 95 percent, the Commission would send to Congress on February 15, 1999 one or more legislative proposals to achieve universal coverage.

- **Employer Mandate Triggered.** If universal coverage legislation (under an expedited process) is not enacted by November 1, 1999, an employer mandate would go into effect on January 1, 2000.

- **Nature of Mandate.** Under the mandate, employers with 25 or more employees would have to pay 50 percent of their employees' premium costs, with the employee paying the remainder. Firms employing fewer than 25 workers would be exempt from the employer mandate. Individuals would be required to have health insurance.

- **Subsidies.** Subsidies would be available to reduce both employer and individual costs:

    - Employers would pay the lesser of 50 percent of the premium or 8 percent of each employee's wage.

    - Workers would pay the lesser of 50 percent of the premium or 8 percent of wages, or the most they would owe under the regular low income subsidy program available in the voluntary system. Workers with incomes under 200 percent of poverty would be subsidized for their 50 percent of premium on a sliding scale. No family would pay more than 8 percent of their AGI for their family's 50 percent share.

    - Non-workers and those in exempt firms would have the "employee" share of their premium capped at 8 percent and would also be subsidized on the "employer" share of the premium according to a separate schedule that phases out up to 200 percent of poverty.

National Health Care Commission

A National Health Care Commission would be established to monitor and make recommendations with respect to trends in health insurance coverage and costs. The Commission would consist of seven members to be appointed by the President based on their expertise and national recognition in the fields of health economics, including insurance practices, benefit design, provider organization and reimbursement, and labor markets.

The Commission would be appointed by the President within nine months of enactment and confirmed by the Senate. The President would designate one individual to serve as Chairperson of the Commission. The terms of members of the Commission shall be for six years, starting on January 1, 1996, except that of the members first appointed three shall be for a term of four years and three for a term of five years, other than the Chairperson.

The Commission may be advised by expert private as well as public entities which focus on the economic, demographic, and insurance market factors that affect the cost and availability of insurance. The Commission would conduct analyses of health care costs and health care coverage.

Beginning in 1998, the Commission would issue annual reports detailing trends in health care coverage and costs. The reports will include measurements of structure and performance of both costs and coverage broken down nationally, by state, and to the extent practical by health care coverage area.

Among other things, the Commission would report generally on:

Demographics and employment status of the uninsured and reasons why they are uninsured;

Structure of health delivery systems;

Status of insurance market reforms;

Development and operations of health insurance purchasing cooperatives;

Success of market mechanisms in expanding coverage and controlling costs among employers and among households;

Success of high cost health insurance premium tax in controlling costs;

Adequacy of subsidies for low-income individuals and employers;

Success of subsidy program in expanding coverage through employers and among households;

The Commission would also issue detailed findings on the per capita cost of

health care, including the rate of growth by type of provider, by type of payor, within States and within health care coverage areas. Such findings would also include the expected rate of growth in per capita health care costs, the causes of health care cost growth, and strategies for controlling such costs.

On January 15, 1999, the Commission would determine whether the voluntary system has achieved 95 percent coverage of all Americans. If the Commission determines ..(combine paper on mandate trigger)

On January 15, 1999, the Commission would determine whether the market reforms and assessments in this legislation have succeeded in controlling health care costs relative to the target rates of growth. Such determinations would be made on a national and State basis.

If the target rate of growth for national per capita premium growth have not been met, the Commission will consider and recommend to Congress a means of controlling health care costs to the target set in this legislation or to an alternative target if the Commission determines that would be more appropriate. Congress shall consider such Commission recommendation under the same procedures, and at the same time, as it considers the Commission recommendation for achieving universal coverage.

If Congress fails to pass such legislation, stand-by premium caps will go into effect requiring health plans to limit future per capita premium increases to the target level.

Alternative A: If at any point in the future, the Commission determines that health care costs in a State have failed to meet the per capita premium targets, standby premium caps will go into effect in that State.

Alternative B: If at any point in the future, the Commission determines that one half the insured population in the nation is enrolled in health plans subject to the high cost premium assessment, the following year standby premium caps will go into effect absent Congressional action.

Alternative C: If at any point in the future, the Commission determines that more than half of the insured population in a State is enrolled in health plans subject to the high cost plan assessment, the following year standby premium caps will go into effect in that State.

QUESTION: HOW DO YOU BREAK THIS DOWN BY STATE; TO INDIVIDUALS RESIDING IN THE STATE? TO HEALTH PLANS IN A STATE? TO PROVIDERS IN A STATE?

Alternative D: The Commission will make a determination whether the subsidy caps in the legislation are undermining the affordability of health insurance premiums to subsidized households and businesses. If the Commission determines that such subsidies are being seriously eroded, it will recommend to Congress a means of making insurance more affordable including through higher subsidies or health care cost controls, which

Congress will consider under special fast track procedures.

Options For Covering the Uninsured

GENERAL THESIS: In the interim, the goal is to target federal dollars to the uninsured. Thus, "target efficiency" (federal dollars spent per newly insured person) becomes a major criterion of alternative policy choices. The following general tools appear the most efficient.

Second issue concerns affordability. Depending on the specific policies pursued, and our ability to entice individuals and employers to expand coverage, federal costs to cover all the uninsured would range from $30 Billion (if the private/public mix of payments under the HSA were achieved) to $72 Billion (if the uninsured were covered entirely through public spending) per year when all are insured.

SPECIFIC POLICY OPTIONS

1. Covering Low Income Populations (5-7 million uninsured)

Individual-based subsidies. Those under 75% of poverty receive free care. Between 75%-150% based on sliding scale.

2. Transitional Insurance Coverage (to be determined).

Those losing their jobs who were previously insured would receive coverage Eligibility is based on prospective income over the next quarter (could have a different time period defined). Payments for the coverage would be based on the income-related scale in 1. Coverage would be through a community-rated pool (under 250).

3. Medicaid Options (6 million currently uninsured).

Provide a second year of Medicaid funding for those leaving welfare for work (current law is one year).

Provide financial incentives for states to increase participation in Medicaid (see if any way states can enroll categorically eligible that want Medicaid but not AFDC). Financial incentives would operate through changing the FMAP. For instance, a 5% increase in participation would increase the FMAP by X% Alternatively, the MOE payments could be adjusted as participation rates increase.

Speed up coverage for low-income children and pregnant women. OBRA 90 mandates that all children living in poverty are to be covered by 2002--change to 1999.

4. Nondiscrimination rules (11.6 million currently uninsured).

Use language similar to Chafee. Goal here is to provide assistance to individuals in firms that are not insured. Could use same general approach as Medicaid option; employers that increase the percentage of their total workforce insured would receive some level of support for those (uninsured) workers. Intent in the interim is not to provide employer subsidies to currently insured workers.

5. Specially marketed program for those employers not currently offering insurance (7-8 million in firms under 25).

Target product for employers that have not offered insurance over the past 18 months (basis of eligibility)--the national demonstrations (see below) used 6 to 12 months as their guide. Product would be HSA-8% (same as the ultimate mandated package) with 50% employer contribution. Worker share would be subsidized.

We have substantial experience with these projects from several state demonstrations; most were relatively unsuccessful in expanding enrollment. Some, however, particularly in Florida were--the Florida demo was able to enroll nearly 20% of previously uninsured firms between the size of 2 and 19. Average group size was small--under 5. (Side note: in the Florida experience the toughest sell was the owner; 85% of those owning small firms were insured! The Florida strategy was to sell the policy as 50/50 in a broader pool--saved the owner money and seemed fair).

Financing.

1. 2% of payroll assessed on those workers currently uninsured (free rider assessment). A per capita assessment would be levied using firms average payroll as base.

2. Tobacco Tax.

3. Risk adjustment assessment on firms outside the community rate.

4. Bradley tax revenue.

Trigger

See attached page. Would generally require 50/50% with individual-based subsidies.

Modelling specs for MBB2

Benefit package/premiums	5% below CBO's HSA, plus adverse selection "tax" of: 1996-98 8% 1999 (year 4) 6% 2000 (year 5) 5% 2001 (year 6) 0%
Premium caps	same as HSA, in principle, but will be impossible to get same effectiveness without universal coverage, since more $ will be outside premiums for a while. Will supply percents and growth rates through time separately.
Before universal coverage (year 5), age rating	maximum ratio 2:1. Use AHCPR breaks devised for L&HR/Finance.
6 month pre-existing condition waiting period if previously uninsured, until universal coverage	reduces adverse selection, but insignificantly (ignore).
Uncompensated care pool for interim period	Financed through community rate, should have no net effect on premium vs. CBO's HSA if premium caps in place and net average provider prices can be assumed to adjust appropriately each year as well, EXCEPT for utilization increase due to claims-based reimbursement for high risk cases. Need to add x% to premium for this.
General Individual Mandate after 5 years (nonworkers, part-timers, self-employed)	Bulk of uninsured will get coverage in year 6.
Medicaid cash	capitated as in HSA from year 1 in all states
Medicaid non-cash	capitated until individual mandate, covered from year 1 in all states

Firms with 100+	employer mandate triggered if 85% of families in these firms who are currently uninsured are not covered after three years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 25-99	employer mandate triggered if 80% of families in these firms who are currently uninsured are not covered after four years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 1-24	employer mandate triggered if 75% of families in these firms who are currently uninsured are not covered after five years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firm subsidy schedule for firms that do offer:	2.8-12% individual wage caps, depending on firm size and average wage of firm;
Payroll assessments:	firms with ≤ 10 that don't offer pay 1% of payroll; firms with ≥ 11 that don't offer pay 2% of payroll. firms with ≥ 1000 pay ??? (hard to levy with no mandate)

Household subsidies:	HSA on 20% share; HSA schedule for non-full time workers for 80% share, counting wage and self-employed income; MAYBE: overlay 4-6% income protection for workers in exempt firms;

I. Financial highlights

- o Premium higher during interim transition to universal coverage, because:
  - Medicaid larger percentage of community rating pool
  - adverse selection until mandates complete
- o Number of premium subsidy recipients is smaller during interim transition to universal coverage, until mandates complete universal coverage.
- o Medicaid savings phased-in quicker, but given higher premiums, may require higher payments per capita than in HSA.
- o Number of uninsured determined by:

II. Risks

- o Medicaid "in" before universal coverage may increase pressure for self-insurance to avoid higher community rate.
- o May be impossible to sustain 1000+ assessment until year 4. Most financing packages need this money.
- o Uninsured problems could increase during interim.

Description of phased-benefit plan

1. Mandate plan 15-30% cheaper than SBP (5% below HSA) during 5 year transition. In year 6, SBP mandated for all.

2. Require MOE≥SBP for firms offering today. Per worker obligation is based on SBP, and firms with lower plan simply pay fraction of other firm's obligations.

3. Have full individual and employer mandates with HSA schedule. Nonworkers have choice between catastrophic and SBP plan. Those currently uninsured with low expected expenses will choose catastrophic plan. This plus 1. will drive SBP premium up a bit (must be re-estimated or imposed a priori).

4. Firm subsidies are 2.8-12% individual wage caps (Scenario A).

5. Individual subsidies are HSA.

6. Firms 1000+ pay 1% of payroll.

6/1/94

Modelling specs for MBB2

Benefit package/premiums	5% below CBO's HSA, plus adverse selection "tax" of: 1996-98 8% 1999 (year 4) 6% 2000 (year 5) 5% 2001 (year 6) 0%
Premium caps	same as HSA, in principle, but will be impossible to get same effectiveness without universal coverage, since more $ will be outside premiums for a while. Will supply percents and growth rates through time separately.
Before universal coverage (year 5), age rating	maximum ratio 2:1. Use AHCPR breaks devised for L&HR/Finance.
6 month pre-existing condition waiting period if previously uninsured, until universal coverage	reduces adverse selection, but insignificantly (ignore).
Uncompensated care pool for interim period	Financed through community rate, should have no net effect on premium vs. CBO's HSA if premium caps in place and net average provider prices can be assumed to adjust appropriately each year as well, EXCEPT for utilization increase due to claims-based reimbursement for high risk cases. Need to add x% to premium for this.
General Individual Mandate after 5 years (nonworkers, part-timers, self-employed)	Bulk of uninsured will get coverage in year 6.
Medicaid cash	capitated as in HSA from year 1 in all states
Medicaid non-cash	capitated until individual mandate, covered from year 1 in all states

Have some obligation for 89% share

Firms with 100+	employer mandate triggered if 85% of families in these firms who are currently uninsured are not covered after three years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 25-99	employer mandate triggered if 80% of families in these firms who are currently uninsured are not covered after four years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firms with 1-24	employer mandate triggered if 75% of families in these firms who are currently uninsured are not covered after five years, individual mandate for these families triggered at the same time. In interim, all who purchase coverage get regular subsidies. Assume that if a firm covers, it pays at least 80%-type obligation (moe assumptions apply).
Firm subsidy schedule for firms that do offer:	2.8-12% individual wage caps, depending on firm size and average wage of firm;
Payroll assessments:	firms with ≤ 10 that don't offer pay 1% of payroll; firms with ≥ 11 that don't offer pay 2% of payroll. firms with ≥ 1000 pay ??? (hard to levy with no mandate)

Household subsidies:	HSA on 20% share; HSA schedule for non-full time workers for 80% share, counting wage and self-employed income; MAYBE: overlay 4-6% income protection for workers in exempt firms;

I. Financial highlights

- o Premium higher during interim transition to universal coverage, because:
  - Medicaid larger percentage of community rating pool
  - adverse selection until mandates complete
- o Number of premium subsidy recipients is smaller during interim transition to universal coverage, until mandates complete universal coverage.
- o Medicaid savings phased-in quicker, but given higher premiums, may require higher payments per capita than in HSA.
- o Number of uninsured determined by:

II. Risks

- o Medicaid "in" before universal coverage may increase pressure for self-insurance to avoid higher community rate.
- o May be impossible to sustain 1000+ assessment until year 4. Most financing packages need this money.
- o Uninsured problems could increase during interim.

Remarks Jerry Markel

United States Office of Personnel Management

FAX TRANSMITTAL SHEET

Office of Congressional Relations
Date:

Number of Pages (including this one)

Please Deliver To:

Name: Chris Jennings	
Office:	Room:
Telephone: 456-7431	

From:

Name: Jerry Markel / Cynthia Brock-Smith	
Office:	Room:
Telephone: 606-1300	

Remarks

WARNING: Most Fax machines produce copies on thermal paper. The image produced is highly unstable and will deteriorate significantly in a few years. It should be copied on a plain paper copier prior to filing.

From: Jenny Marion
To: Ira Forman
Date: May 27, 1994
Subject: Minimum Benefits in the FEHBP

Andy Bush who works for the minority Ways & Means Committee asked for a list of minimum benefits that are offered in the FEHBP. Insurance Programs is preparing a comprehensive list to be faxxed today.

From: Jenny Marion
To: Ira Forman
Date: May 27, 1994
Subject; Request for data on number of federal enrollees in Fee For Service Plans by state

Celinda Franco from CRS called the Office of Actuaries to ask for a copy of data on the number of federal enrollees who are in fee for service plans by state. We were able to give her the numbers by plan.

From: Nancy KICHAK (NHKICHAK)
To: CJSMITH
Date: Wednesday, May 25, 1994 8:31 am
Subject: Request from Senator Kennedy's Ofice

Suzanne Calzoncit has requested the actuarial value of Blue Cross High Option. They are thinking of plan ammendments that define the benefit package in terms of acturial value.

ACTUARIAL VALUES OF 1993 FEHBP PLANS

SOURCE: OPM\RIG\Office of Actuaries *25-May-94*

Plan Name	Annual Value of Self Options
Blue Cross / Blue Shield High	$2,048
Blue Cross / Blue Shield High PPO	$2,354
Blue Cross / Blue Shield Standard	$1,924
Blue Cross / Blue Shield Standard PPO	$2,336
B.A.C.E.	$2,037
FEHBP Program Weighted Average	$2,227

Actuarial Value of Reform Proposal As Compared to FEHB for 1993

Proposal	- High Cost Sharing	1.000
	- Low Cost Sharing	1.232
BC/BS Standard	- Non-PPO	1.020
	- PPO	1.238
Mail Handlers		1.070
APWU		1.040
GEHA		1.060
NALC		1.073
Kaiser N. California		1.250
Kaiser S. California		1.240
U.S. HealthCare Pennsylvania		1.283
HIP of New York		1.336

From: Nancy KICHAK (NHKICHAK)
To: CJSMITH
Date: Friday, May 27, 1994 8:58 am
Subject: Request from Senator Chaffee's Office

Senator Chaffee's office wants actuarial values of BC Standard and largest HMO. I am sending him the standard table. He also wants actuarial value without retiree costs. Since actuarial values are based on a standard inclusive group, he really wants an idea of premium. We will look to see what we have.

Possible Mitchell-Breaux-Boren-Like Compromise

- An 80% employer requirement on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is triggered.

- Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

- Firms not covering their workers pay, a payroll assessment of 1% if firms has 1-10 workers and 2% if 11-20 workers.

- Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment

- Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

- Premiums benefits package are 5% below the CBO scoring of the HSA.

Mitchell–Breaux–Boren–Like Compromise

Government Subsidies:	
1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies:	
5 Years ($m)	373,982
employer	130,912
household	243,069
Government Subsidies:	
10 Years ($m)	1,009,331
employer	419,118
household	590,213
Select Revenue Estimates:*	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates:*	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit *	
(5 Years)	(2,398)
Net Effect on Deficit *	
(10 Years)	(43,149)
Net Effect on Deficit, Adjusted by 50% (10 Years)***	(21,574)

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** **Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.**

**** 1 Year subsidy estimates assume a fully phased–in carve–out year.