DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

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DATE 7-25-94

TOTAL NO. OF PAGES (INCLUDING COVER) 8

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JUL 25 1994

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NOTE TO JUDY FEDER AND JERRY KLEPNER

Mike Hash of the House Energy & Commerce Committee staff has requested information on the sources and uses of funds for graduate medical education and academic health centers for the Education & Labor and Ways & Means reported bills. Peter Budetti of the Senate Finance Committee staff has requested similar information for the Labor & Human Resources and Finance reported bills.

The attached draft tables present estimated figures for sources and uses for the respective reported bills. The key assumptions upon which the figures are based are listed for each table.

These tables were developed with the assistance of the Department's management and budget staff.

If there are any questions regarding these tables, please call Kate Rickard at 690-5824.

7/25

Brian Biles

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Education and Labor Reported Bill[1]

USES OF FUNDS[2]

	1996	1997	1998	1999	2000
Academic Health Centers	$3.8 b	$4.1 b	$4.2 b	$4.7 b	$4.8 b
Graduate Medical Education	$3.4	$3.75	$6.0	$6.0	$6.0
Graduate Nurse Education	$ .2	$ .2	$ .2	$ .2	$ .2
Medical Schools	$ .2	$ .2	$ .0	$ .0	$ .0
TOTAL	$7.6 b	$8.25 b	$10.4 b	$10.9 b	$11.0 b

Calendar year outlays in billions

SOURCES OF FUNDS

	1996	1997	1998	1999	2000
Medicare IME[3]	$2.9 b	$2.9 b	$3.0 b	$3.1 b	$3.2 b
Medicare DME[4]	1.6	1.6	1.7	1.7	1.8
1 1/2% of[5] Private Premiums	6.3	6.7	7.0	7.4	7.8
Total Sources	$10.8 b	$11.2 b	$11.7 b	$12.2 b	$12.8 b

Calendar year outlays in billions

1 Sums may not add due to rounding.

2 Amounts specified in reported bill.

3 Reported bill specifies Medicare contributions equal to IME payments at the 5.2 percent level. The figures here are based on CBO projections of Medicare IME at the 5.2 percent level assuming growth constrained to the CPI.

4 Reported bill specifies Medicare DME contributions at same level as under current law. Figures here are based on current law CBO projections assuming growth constrained to the CPI.

5 Reported bill specifies an additional source of funds from an assessment on private premiums. Figures here assume that basic benefit package will be about the same as under HSA, and that the number of people in private insurance is about the same as under HSA.

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Senate Finance Reported Bill

USES OF FUNDS[1]

	1996	1997	1998	1999	2000
Academic Health Centers	$ 6.3 b	$ 7.2 b	$ 8.2 b	$ 9.4 b	$10.6 b
Graduate Medical Education	$ 3.2	$ 3.6	$ 5.8	$ 6.0[2]	$ 6.2[2]
Graduate Nurse Education	$ .2	$ .2	$ .2	$ .2	$ .2
Medical Schools	$ .2	$ .3	$ .4	$ .5	$ .6
TOTAL	$ 9.9 b	$11.3	$14.6	$16.1	$17.6

Calendar year outlays in billions

SOURCES OF FUNDS

	1996	1997	1998	1999	2000
Medicare IME[3]	$ 4.2 b	$ 4.6 b	$ 5.0 b	$ 5.5 b	$ 6.0 b
Medicare DME[4]	1.6	1.7	1.8	1.9	2.1
1 1/2% of Private Premiums[5]	5.8	6.2	6.4	6.8	7.2
Total Sources	$11.6 b	$12.5 b	$13.2	$14.2 b	$15.3

Calendar year outlays in billions

1 Amounts specified in reported bill.

2 Reported bill specifies that in 1999 and 2000 total funds for Graduate Medical Education would be increased by the change in the national premium target. Figures here have been estimated using CBO projections of the CPI-U for those years.

3 Reported bill specifies Medicare contributions equal to those under current law at the 7.7 percent level. The figures here are based on current law CBO baseline projections.

4 Reported bill specifies Medicare contributions at same level as under current law. The figures here are based on current law CBO baseline projections.

5 Reported bill specifies an additional source of funds from an assessment on private premiums. Figures here assume that the basic benefit package would be about 8.5% less expensive per capita than under HSA, and that the number of people in private insurance would be about the same as under HSA.

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Labor & Human Resources Reported Bill[1]

USES OF FUNDS[2]

	1996	1997	1998	1999	2000
Academic Health Centers	$6.28 b	$7.25 b	$8.22 b	$9.4 b	$10.6 b
Graduate Medical Education	$3.2	$3.55	$4.8	$5.8	$5.8
Graduate Nurse Education	$ .2	$ .2	$ .2	$ .2	$ .2
Medical Schools	$ .2	$ .3	$ .4	$ .5	$ .6
TOTAL	$9.9 b	$11.3 b	$13.6 b	$15.9 b	$17.2 b

Calendar year outlays in billions

SOURCES OF FUNDS

	1996	1997	1998	1999	2000
Medicare IME[3]	$2.9 b	$2.9 b	$3.0 b	$3.1 b	$3.2 b
Medicare DME[4]	1.6	1.6	1.7	1.7	1.8
1 1/2% of[5] Private Premiums	6.3	6.7	7.0	7.4	7.8
Total Sources	$10.8 b	$11.2 b	$11.7 b	$12.2 b	$12.8 b

Calendar year outlays in billions

1 Sums may not add due to rounding.

2 Amounts specified in reported bill.

3 Reported bill specifies Medicare contributions equal to IME payments at the 5.2 percent level. The figures here are based on CBO projections of Medicare IME at the 5.2 percent level assuming growth constrained to the CPI.

4 Reported bill specifies Medicare DME contributions at same level as under current law. Figures here are based on current law CBO projections assuming growth constrained to the CPI.

5 Reported bill specifies an additional source of funds from as assessment on private premiums. Figures here assume that basic benefit package will be about the same as under HSA, and that the number of people in private insurance is about the same as under HSA.

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Ways & Means Reported Bill

USES OF FUNDS[1]

	1996	1997	1998	1999	2000
Teaching Hospitals					
Medicare IME[2]	$4.2 b	$4.2 b	$6.2 b	$5.9 b	$5.5 b
1% Private[3] Premiums	0.1	0.0	0.0	.4	.4
TOTAL	4.3	4.2	6.2	6.3	5.9
Graduate Medical Education					
Medicare DME[4]	$1.6	$1.6	$2.7	$2.9	$3.1
1% Private[5] Premiums	1.3	2.0	2.1	1.9	1.9
TOTAL[6]	2.9	3.6	4.8	4.8	5.0
Grad. Nurse Ed.	$ 0	$ 0	$ 0	$ 0	$ 0
Medical Schools[7]	$ .05	$ .05	$ .05	$ .05	$ .05
TOTAL	$7.3 b	$7.8 b	$11.1 b	$11.1 b	$11.0 b

Calendar year outlays in billions

SOURCES OF FUNDS[1]

	1996	1997	1998	1999	2000
Medicare IME					
Parts A & B[8]	$4.2 b	$4.2 b	$3.8 b	$3.5 b	$3.2 b
Part C[9]	0	0	2.4	2.4	2.3
TOTAL	4.2	4.2	6.2	5.9	5.5
Medicare DME					
Parts A & B[10]	$1.6	$1.6	$1.7	$1.7	$1.8
Part C[9]	0	0	1.0	1.2	1.3
TOTAL	1.6	1.6	2.7	2.9	3.1
1% of Private[11] Premiums	1.5	2.0	2.2	2.3	2.4
Total Sources	$7.3 b	$7.8 b	$11.1 b	$11.1 b	$11.0 b

Calendar year outlays in billions

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NOTES

1. Sums may not add due to rounding.

2. Includes Medicare IME payments for Parts A, B, and C, consistent with reported bill.

3. Consistent with reported bill, payments to teaching hospitals from the 1% premiums are equal to the residual after accounting for payments for direct graduate medical education and for medical schools.

4. Includes Medicare DME payments for Parts A, B, and C, consistent with reported bill.

5. Consistent with reported bill, payments for graduate medical education from the 1% private premiums are equal to the difference between the total payments for graduate medical education and Medicare DME payments.

6. Reported bill specifies that all payments (Medicare and non-Medicare) for graduate medical education would be based on the Medicare DME methodology. Total GME payments here are estimated by adding Medicare payments to non-Medicare payments which are assumed to be proportional to the non-Medicare share of total inpatient days.

7. Amounts specified in the reported bill.

8. Reported bill specifies Medicare contributions equal to IME payments at 7.7% in 1996 and 1997, 6.8% in 1998, 6.0% in 1999, and 5.2% in 2000 and beyond. Figures here are based on CBO projections at these levels, assuming growth constrained by the CPI.

9. Reported bill specifies Medicare contributions on behalf of Medicare Part C beneficiaries. Figures here assume there will be 58 million people in Part C in 1998, 64.7 million in 1999, and 72 million in the year 2000, and that utilization for this population will be about 40 percent of that for the population in Parts A and B.

10. Reported bill specifies Medicare DME contributions at same level as under current law. Figures here are based on CBO current law projections assuming growth constrained by the CPI.

11. Reported bill specifies an additional source of funds from an assessment on private premiums. Calendar year figures here are based on preliminary fiscal year estimates from the Joint Tax Committee.

Possible Treatment of Medicaid Non-Cash Population in an Incremental Approach

♦ 1996 -- Expand eligibility for 'Medicaid' to otherwise uninsured children and pregnant women below 185% of poverty. Full federal funding for incemental costs?

♦ 1997 -- Provide subsidies for enrollment in community rated plans for:

AFDC
Non-Cash Medicaid eligibles, with the potential exception of 'spend-down' cases (see below)

PROBLEMS AND SOLUTIONS

Pre-exisiting condition exclusions: If we want to 'do no harm', then pre-existing condition exclusions must be waived for persons enrolling in community rated plans as a result of AFDC or non-cash Medicaid eligibility. If they are not waived, then many people who would receive coverage under current rules will lose access under reform.

Guranteed Eligibility: Community rated plans and the providers in them will have an extremely difficult time providing service to enrollees unless there is a minimum period of eligibility guaranteed. Most states that contract with managed care plans for AFDC recipients guarantee at least six months of eligibility; some guarantee one year.

State-to-State Variation in Eligibility: If the low income subsidy program is fully federally funded (with a partial offset coming from Maintenance of Effort payments), then there will be strong pressure for uniform national eligibility. Current non-cash eligibility varies across states. One way of resolving this problem is to not have a fully federally funded program, but require states to share in the cost.

Medicaid eligibility through Spend-Down: A relatively small number of non-aged, non-cash Medicaid recipients are eligible through 'spend-down': that is, their income is above the threshold for Medicaid eligibility, but they incur large enough medical bills to 'spend down' to eligibility. These persons are particularly difficult to enroll in private health plans. They become eligible for Medicaid exactly at the time they are sick, and they remain eligible only if they continue to incur medical bills. If eligibility were guaranteed for a period of time (e.g., six months), and pre-existing condition exclusions were waived, then they could potentially be included in private health plans; a simpler procedure would be to retain them in a fee-for-service, self-insured program (e.g., current Medicaid or Medicare Part C). Most 'spend down' cases are the aged in nursing homes; a small number are under-65.

OPTION D - HCFA Revised

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

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PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PART A - Savings/Receipts													
Hospital Update at MB-1.0 (1997-2000)	0	0	-277	-1,005	-1,918	-2,986	-3,318	-3,798	-4,158	-4,554	-3,200	-6,186	-22,014
DO NOT Reduce Indirect Med. Educ. Payments	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
Part A Interactions	0	0	26	134	228	336	408	449	495	573	388	724	2,649
Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
PART A - Costs													
Medicare Dependent Hospitals (ends FY99)	40	50	50	50	10	0	0	0	0	0	200	200	200
Rural Transition Grants (authorization; non-add)	30	30	30	30	30	0	0	0	0	0	150	150	150
Part A Sub-total	20	-2,629	-3,450	-5,007	-6,443	-8,027	-8,584	-9,443	-10,097	-10,790	-17,509	-25,536	-64,450
PART B - Savings/Receipts													
Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
Cut 1995 Physician Update (-3%; PC exempt)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
Eliminate Formula Driven Overpayment	-480	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-6,931	-10,112	-35,959
Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
Lab Coinsurance (MD+OPD)*	-411	-687	-761	-866	-970	-1,086	-1,219	-1,358	-1,545	-1,744	-3,695	-4,781	-10,647
Prohibit Certain Physician Self-Referrals	0	0	0	0	0	0	0	0	0	0	0	0	0
Resource-Based Practice Expenses for Physicians	0	0	0	0	0	0	0	0	0	0	0	0	0
Extend Part B Premium at 25% of Costs (net)	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
PART B - Costs													
Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
Payments to Eye/Ear Specialty Hospitals	2	3	3	0	0	0	0	0	0	0	8	8	8
Payments for MD Assistants/Nurse Practitioners	0	0	100	170	210	250	310	380	470	580	480	730	2,470
Part B Sub-total	-1,219	-1,853	-3,248	-3,146	-5,717	-9,282	-13,300	-18,090	-23,968	-29,964	-15,183	-24,465	-109,787
PARTS A and B - Savings													
10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
Home Health Copay - no 30 day window	-52	-578	-688	-775	-837	-908	-985	-1,068	-1,159	-1,257	-2,930	-3,838	-8,307
Extend OBRA93 Medicare Secondary Payer	0	0	0	0	-1,219	-1,788	-1,906	-2,131	-2,163	-2,303	-1,219	-3,007	-11,510
HMO Payment Improvements	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
PARTS A and B - Costs													
Repeal Medicare/Medicaid Data Bank	57	154	347	388	—	—	—	—	—	—	946	946	946
Parts A and B Sub-total	-129	-1,770	-2,283	-2,828	-4,829	-5,703	-6,130	-6,711	-7,135	-7,717	-11,839	-17,542	-45,235
HCFA Proposed Additions (7/21/94):													
Lower MSP threshold from 100 to 20 employees	0	0	0	-176	-236	-303	-342	-266	-392	-420	-412	-715	-2,135
Extend ESRD Secondary Payer to 24 Months	0	-84	-119	-127	-140	-154	-169	-186	-205	-225	-470	-624	-1,409
Cut 1995 Phys Fee Update add'l -1%; incl. PC	-100	-225	-240	-250	-240	-250	-250	-250	-255	-255	-1,055	-1,305	-2,315
Increase DSH Phase-down from 20% to 33%	0	-74	-246	-669	-730	-795	-867	-946	-1,038	-1,125	-1,719	-2,514	-6,490
HI Interaction	0	2	7	20	22	24	26	28	31	34	51	75	194
Correct MVPS Upward Bias (eff. FY95 MVPS)	0	0	-20	-210	-910	-1,880	-2,770	-3,600	-4,490	-5,480	-1,140	-3,020	-19,360
MEDICARE TOTAL, including HCFA Additions	-1,428	-6,633	-9,599	-12,393	-19,223	-26,370	-32,386	-39,464	-47,549	-55,942	-49,276	-75,646	-250,987
Possible Additions to Reach Savings Targets													
Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
Coinsurance for Independent Lab Services*	-273	-458	-527	-578	-646	-724	-812	-926	-1,030	-1,162	-2,482	-3,206	-7,136
MEDICARE TOTAL, including all Additions	-1,701	-7,091	-10,126	-13,495	-20,673	-27,857	-34,018	-41,327	-49,550	-58,056	-53,086	-80,943	-263,894

*These proposals could be combined into one lab coinsurance proposal, as in the HSA and SFC Chairman's Mark.

DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
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Number of pages to follow: Date: July 21, 1994

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Addressee's Confirmation Number: 456-5585

From: Eric J. Toder
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-0646

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Attached are the estimates you requested. Please call if you have questions.

UNCLASSIFIED

TOBACCO REVENUE ESTIMATES

Proposal	07/21/94 05:42 PM	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-99	2000-04	1995-2004
									Fiscal years ($ billions)					
1	45-cent per pack increase in cigarette tax (eff. 1/1/95)													
a	equivalent increase in other tobacco taxes	5.3	7.2	7.2	7.1	7.1	7.0	7.0	6.9	6.9	6.8	33.9	34.7	68.6
b	proportionate increase in other tobacco taxes	4.9	6.8	6.7	6.7	6.6	6.6	6.5	6.5	6.4	6.4	31.7	32.4	64.1
c	1/2 equivalent increase in other tobacco taxes	5.1	7.0	6.9	6.9	6.8	6.8	6.7	6.7	6.6	6.6	32.7	33.4	66.1
2	45-cent per pack increase in cigarette tax (eff. 1/1/95, W&M phase-in)													
a	equivalent increase in other tobacco taxes	1.9	2.6	3.8	5.3	6.7	7.0	7.0	6.9	6.9	6.8	20.2	34.7	54.9
b	proportionate increase in other tobacco taxes	1.8	2.4	3.5	4.9	6.2	6.6	6.5	6.5	6.4	6.4	18.8	32.4	51.3
c	1/2 equivalent increase in other tobacco taxes	1.8	2.5	3.6	5.1	6.4	6.8	6.7	6.7	6.6	6.6	19.4	33.4	52.8
3	45-cent per pack increase in cigarette tax (eff. 1/1/95) 75-cent per pack increase in cigarette tax (eff. 1/1/2000)													
a	equivalent increase in other tobacco taxes	5.3	7.2	7.2	7.1	7.1	9.7	10.8	10.7	10.6	10.5	33.9	52.3	86.2
b	proportionate increase in other tobacco taxes	4.9	6.8	6.7	6.7	6.6	9.2	10.2	10.1	10.0	9.9	31.7	49.5	81.2
c	1/2 equivalent increase in other tobacco taxes	5.1	7.0	6.9	6.9	6.8	9.4	10.4	10.4	10.3	10.2	32.7	50.7	83.3

TOBACCO REVENUE ESTIMATES

	Per-pound equivalent increase in all tobacco taxes		Proportional increase in all tobacco taxes		1/2 per-pound equivalent increase in all tobacco taxes	
	($ billions)		($ billions)		($ billions)	
	5-yr. estimate	10-Yr. estimate	5-yr. estimate	10-Yr. estimate	5-yr. estimate	10-Yr. estimate
45-cent per pack increase (eff. 1/1/95)						
Cigarettes	31.1	62.9	31.1	62.9	31.1	62.8
Smokeless	2.1	4.2	0.2	0.3	1.2	2.4
Other	0.7	1.5	0.5	0.9	0.4	0.8
TOTAL:	33.9	68.6	31.7	64.1	32.7	66.1
45-cent per pack increase (eff. 1/1/95, W&M phase-in)						
Cigarettes	18.5	50.3	18.5	50.3	18.5	50.2
Smokeless	1.3	3.4	0.1	0.3	0.7	1.9
Other	0.4	1.2	0.3	0.8	0.2	0.7
TOTAL:	20.2	54.9	18.8	51.3	19.4	52.8
45-cent per pack increase (eff. 1/1/95) 75-cent per pack increase (eff. 1/1/2000)						
Cigarettes	31.1	79.4	31.1	79.2	31.1	79.3
Smokeless	2.1	4.9	0.2	0.8	1.2	3.0
Other	0.7	1.8	0.5	1.2	0.4	1.0
TOTAL:	33.9	86.2	31.7	81.2	32.7	83.3

FUNDING SOURCE	1995	1996	1995-1996	1997
Tobacco	1.8	2.4	4.2	3.5
Medicare revenue provisions	0	1.9	1.9	3.1
Medicare savings	1.4-1.7	6.6-7.1	8 - 8.8	9.6-10.1
Medicaid savings	0	0	0	
TOTAL	3.2-3.5	10.9 - 11.4	14.1 - 14.9	

PROGRAMS	1995	1996	1997	
Self-employment deduction	0.1	0.5	0.7	
Kids/PW	0	8-10		
Welfare to work				
Portability	0	0		

ALTERNATIVE MULTI -TIER TRIGGER OPTION--HEALTH REFORM

1996 (IF WE CAN AFFORD):

- Phase in uninsured (for a year) kids into Medicaid (phased-out at 240% of poverty)--don't call it Medicaid. Range: Approximately $10-11 billion to cover approximately 6 million children.
- Add pregnant wormen to above-mentioned policy costs approximately $3 billion to cover about 800,000 women.
- Welfare to work expansion. Range: $4 billion to cover roughly 1.8 million people.
- Implement the portability reform.

1997

- Implement the rest of insurance reforms.
- Require states to establish purchasing co-ops (voluntary alliances) for all firms up to 500.
- Risk adjustment payment from experienced rated self-insured firms.
- Mandate all firms 500 and above to cover all employees (with a 50/50 mandate), but not their dependents. No individual mandate.
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1999

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- Mandate that all individuals obtain coverage.
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Cost Containment: Trigger to premium cap for non-competitive areas

Financing:
Tobacco tax
Cafeteria plans
Medicare cuts and revenues
Medicaid integration--non-cash issue?

(DRAFT - 7/22/94)

THE MITCHELL PLAN:
Responding to the Concerns fo the American People

Senator Mitchell's health care plan is a moderate and reasonable approach that will move this country toward universal health coverage in a defined time frame. And it does so without a mandate or a government takeover of our health care system. It addresses the criticism of the Presidents plan by building in a deliberate way on the best elements of our current system and targeting resources to maximize their impact in extending coverage as quickly as possible to those who currently lack protection. The Mitchell plan preserves the right for more businesses to self insure, allowing their employees to continue with the plans that are satisfied with today. It builds in extra protections for small businesses and working Americans to ensure that insurance is available. It strengthens coverage for seniors by including a prescription drug benefit under Medicare and establishing a new home and community based long-term care program. It is fiscally sound with built in protections for the federal budget.

CUTS BUREAUCRACY AND REGULATION:

- Replaces large mandatory government alliances with voluntary purchasing pools to help small businesses and individuals get affordable insurance coverage.

- Eliminates intrusive government cost containment mechanism relying on more market-oriented approach.

MINIMIZES DISRUPTION TO CURRENT SYSTEM:

- All firms with more than 500 employees are allowed to self insure rather than firms with more than 5,000 employees under the President's plan. Many more firms that sponsor their own high-quality plans and are effective at controlling costs will have the opportunity to continue to do so.

- Eliminating mandatory alliances gives people and businesses more choices in how they purchase insurance coverage including the opportunity to stick with plans they are satisfied with today..

PROVIDES EXTRA PROTECTION FOR SMALL BUSINESSES:

- By eliminating the employer mandate, the Mitchell bill addresses one of the major concerns about the President's plan -- namely that such a mandate would hurt small businesses imposing a financial burden they could not handle and costing numerous jobs.

- It provides new targeted subsidies to help the most vulnerable small businesses afford private insurance coverage.

- Should voluntary efforts not achieve universal coverage, the fall-back trigger mechanism would exempt firms with fewer than 25 employees, protecting those businesses least able to handle the burden of providing insurance coverage to their workers. Even for those businesses with more than 25 employees, the Mitchell plan dramatically scales back how much they would be asked to contribute. Under the plan, employers and employees would split the cost of insurance evenly, a significant reduction from the 80/20 requirement of the President's plan.

FISCALLY SOUND WITH ADDED PROTECTION TO THE FEDERAL BUDGET:

- The plan pays for itself through realistic savings to the Medicare and Medicaid programs, an assessment on high cost insurance plans and an increase in the tobacco tax by 45 cents per pack.

- To provide ironclad protection to the federal budget, the plan provides a fail-safe mechanism to ensure that the cost of reform does not exceed the savings and revenues in hand.

RELIES ON MARKET ORIENTED COST CONTAINMENT:

- Rather than an intrusive government sytem for controlling costs by regulating insurance premium increases, it fosters market forces and harnesses them to keep costs down. By placing an assessment on high cost plans, it encourages plans to lower their premiums and employers and individuals to choose more efficient, better priced plans.

(DRAFT - 7/22/94)

THE MITCHELL PLAN:
Preserves the Best Elements of the President's Plan

Senator Mitchell's plan includes the elements that the American people want most out of health care reform. While any of these features were included in the President's plan, the Mitchell plan acomplishes these goals in a volunatry way, with less government involvement, building gradually but deliberately on our current system, with the least disruption possible. It provides affordable insurance for working families with security of coverage that can never be taken away. It expands choices of doctors and insurance plans and ensures high-quality care. Finally, like the President's plan, it preserves and strenghten coverage for older Americans under Medicare.

ACHIEVES PRESIDENT'S GOAL OF UNIVERSAL COVERAGE:

- It ensures that all hard working American families have the insurance protection that they deserve.

PROVIDES PROTECTION TO THE MIDDLE CLASS:

- By capping household insurance expenses at 8% of income and providing targeted subsidies to middle class families, the Mitchell plan insures that insurance protection is within everyone's reach.

REFORMS INSURANCE MARKET:

- The plan embraces the consensus insurance reforms that enjoy overwhelming support in the Congress. It levels the playing field for small businesses and indviduals by community rating premiums for firms with fewer than 500 employees and individuals.

- It eliminates abusive insurance company practices by guaranteeing issue and enrollment, eliminating preexisting condition exclusions and lifetime limits and open enrollement.

- It establishes voluntary purchasing pools to help small businesses and individuals negotiate rates only large companies can get today.

ENSURES HIGH-QUALITY CARE:

- The core benefits package will emphasize primary and preventive care to help keep people healthy not just treat them once they become sick.

- A portion of each premium will be earmarked for medical research to encourage the technological advancements and improvements that have made American medicine the finest in the world.

PRESERVES AND STRENGTHENS COVERAGE FOR SENIORS:

- The Medicare program is preserved and the benefits seniors enjoy today will be expanded to include coverage for outpatient prescription drugs. Starting in 1998, Medicare will cover the cost of prescription drugs with a $500 deductible, 20% copay and a cap on out-of-pocket expenditures.

- In addition, the Mitchell plan establishes a new home and commuinty-based long-term care program to give older Americans and those with disabilities additional options for care.

SENATE LEADERSHIP PROPOSAL
QUESTIONS AND COMMENTS 7/25/94

Trigger

- How would coverage be defined for purposes of determining whether the trigger would be pulled? For example, would everyone with income below the poverty level--who would be presumptively eligible--be considered covered even if they hadn't enrolled in a health plan?

- The timeframe for implementing the mandate if the trigger was pulled would be short. How could the infrastructure changes that would be necessary to switch from a voluntary to a mandatory world be accomplished in a year?

Mandate

- How would two-worker families be treated in a mandate world without compulsory alliances? To whom would non-enrolling employers make payments?

- Who would be responsible for calculating the extra-worker adjustments for employer premium payments?

- Would single and two-parent families be pooled for purposes of determining the employer's share--as in HSA?

- As currently written, all employers would be eligible for subsidies under the mandate. Is that correct? Would those subsidies be time-limited?

- What are the provisions for the individual mandate?

- It is possible that workers could get bigger subsidies in the mandate world than non-workers, but that would depend on the interaction between employers' contributions and subsidies. (See previous memo.)

Medicaid

- Would Medicaid continue to pay for emergency services for illegal aliens? Yes.

- Under the proposal, states would have to make general maintenance of effort payments on behalf of non-cash beneficiaries. As written, all DSH payments, not just those attributable to non-cash beneficiaries, would be included in those payments. Is that correct? No. Only ~~xxxxxxx~~ DSH payments attributable to non-cash benes ~~for~~ would be included.

Medicare Drug Benefit

- Medicare beneficiaries would have the choice of a regular fee-for-service drug benefit or a managed benefit (PBM) for drugs only. The skimming opportunity for the PBMs could increase the cost of the drug benefit considerably. How would Medicare pay the PBMs?

- The proposal does not include the additional rebate that is in the HSA. Was that intended? (The rebate would protect Medicare against rapid growth in drug prices that manufacturers could use to offset other rebates.)

1) Skimming - could attract healthier population to PBM's.

Pharmacists → Medicare pay PBMs - require equivalent of rebate applied on a per patient basis. AARP - give to them immediately. Anti-Merck movement.

Cost Containment recommendation & Bobby

Trigger Proposal

- On January 15, 1999, the Health Care Coverage Commission would determine whether the voluntary system has achieved 95 percent coverage.

- If the Commission determins 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.

- Such legislation would be referred to the relevant committee(s) and would be considered in both the House and the Senate under the expedited process provided for in the Finance Committee bill. The legislation would be fully amendable and require the President's signature.

- In order for the legislation to be eligible for this expedited procedures, GAO would have to certify that the legislation would in fact achieve universal coverage in a deficit neutral manner. Prior to the bill being brought up on the Senate floor, prior to third reading, and prior to final passage of the conference report, a 60 vote point of order would lie against such legislation if it does not have the GAO certification.

- If universal coverage legislation is not enacted by November 1, 1999, an employer mandate would go into effect on January 1, 2000.

- 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 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.

  - Non-workers or those in exempt firms would be eligible for the same targeted subsidies available under the voluntary system. For those below 75 percent of poverty, for instance, subsidies would equal 100 percent of their premium contribution. For persons with incomes between 75 percent and 200 percent of poverty, the subsidies would range from 100 to 0 percent.

ALTERNATIVE MULTI -TIER TRIGGER OPTION--HEALTH REFORM

1996 (IF WE CAN AFFORD):

- Phase in uninsured (for a year) kids into Medicaid (phased-out at 240% of poverty)--don't call it Medicaid. Range: Approximately $10-11 billion to cover approximately 6 million children.
- Add pregnant women to above-mentioned policy costs approximately $3 billion to cover about 800,000 women.
- Welfare to work expansion. Range: $4 billion to cover roughly 1.8 million people.
- Implement the portability reform.

1997

- Implement the rest of insurance reforms.
- Require states to establish purchasing co-ops (voluntary alliances) for all firms up to 500.
- Risk adjustment payment from experienced rated self-insured firms.
- Mandate all firms 500 and above to cover all employees (with a 50/50 mandate), but not their dependents. No individual mandate.
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Financing: Tobacco tax
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Medicare cuts and revenues
Medicaid integration--non-cash issue?

FUNDING SOURCE	1995	1996	1995-1996	1997
Tobacco	1.8	2.4	4.2	3.5
Medicare revenue provisions	0	1.9	1.9	3.1
Medicare savings	1.4-1.7	6.6-7.1	8 - 8.8	9.6-10.1
Medicaid savings	0	0	0	
TOTAL	3.2-3.5	10.9 - 11.4	14.1 - 14.9	

Proposed Children's Vaccine Provision
in Health Care Reform
July 25, 1994

General Requirements

o Every family health insurance policy (including self-insured health plans) which is issued or renewed during 1995 will be required to include coverage for children's preventive health care.

o During first policy year, family health plans would cover, at a minimum, without deductibles and coinsurance:

-- childhood immunizations, including administration

-- well child care (as defined by American Academy of Pediatrics)

o During second policy year, family health plans would add coverage, at a minimum, for:

-- prenatal care
-- delivery
-- new born care

Changes in VFC Program

o The current VFC program would be modified in two major ways:

-- Eligibility would be changed to remove any reference to the "underinsured"

-- States ability to purchase additional vaccines at the CDC price for non-VFC children would be restricted.

States' Ability to Purchase Additional Vaccine

o Current 12 "universal purchase" States would be grandfathered.

o Current 11 States that have indicated their intention to become universal purchase States (at CDC price) may do so only if:

-- they purchase the three major vaccines for all additional children -- MMR, DPV, DTP

-- they purchase vaccine during the current CDC contract negotiations for use beginning October 1, 1994

o No State (except New Hampshire) may establish a trust fund, or other similar dedicated funding source, for the purpose of seeking contributions from private insurance companies to allow the State to purchase additional vaccine

o All States would be allowed to purchase vaccine under current "optional use" provision in CDC contracts

Enforcement

o Civil action to enforce insurance mandate may be brought by covered individuals, State Attorney General, the U.S. Attorney General, and the Secretary of Labor in the case of a self-insured plan. Civil money penalties are applicable.

- Big Companies & Insurers won't object according to Lederle

- Cost: 2% of premium - or maybe 0.5%!

- 70% of HMO currently have

- 52% of Fee for Service

CBO ON Senate Finance

We've been down this road before.

Apparently CBO will say that the Senate Finance bill, like other bills they have looked at, leaves 24 million uninsured, and has all the failures of other incremental approaches --

- o premiums will go up for those currently with insurance (Catholic Health Association/Lewin study);

- o working Americans will remain at risk of losing their health coverage when they lose a job, change a job or get sick;

- o insurance reforms will actually make things worse, increasing the number of uninsured, raising premiums, and government spending.

CBO's analysis must confirm what they found with Cooper -- there is no way to achieve universal coverage without shared responsiblity. Non-universal plans actually make things worse for businesses and middle-class families.

Remember back to Cooper. Everyone thought it was an easy solution to health care problems, and instead, when it was held up to scrutiny, it had fatal problems. It had an enormous deficit of hndreds of billions; the tax cap clearly had violent opposition; and it had all the problems of non-universal solutions.

Just like Cooper, you need to look carefully at CBO's analysis. Read the fine print -- like other non-universal bills this bill will make things worse for a lot of middle-class bills and small businesses.

SENATE LEADERSHIP PROPOSAL
QUESTIONS AND COMMENTS 7/25/94

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- Would Medicaid continue to pay for emergency services for illegal aliens?

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or
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Chris J
Did you
see this?
M

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Public hospitals push universal health care

By BRUCE ALPERT
Washington bureau

WASHINGTON — Passing incremental health-care reform without universal coverage could be worse than doing nothing at all and catastrophic to public hospitals, a group of health-care providers warned Monday.

All of the proposals, including those the group supports, would cut the federal Medicare program that provides health coverage for the elderly to pay for reforms. But those cuts would be "catastrophic" unless universal coverage is achieved, the psoviders said.

Perry Rigby, director of health-care systems at Louisiana State University Medical Center in New Orleans, said public hospitals such as Louisiana's Charity Hospital system and academic medical facilities would continue to provide medical care for thousands of uninsured people if universal coverage is not achieved. And they would be forced to do so with significantly less money from Medicare.

"The public hospitals obviously care for the patients left out by other facilities — a safety net — and we feel it is important that Congress provide a funding stream for such facilities," Rigby said at a Capitol news conference.

Rigby pointed to a new study released by Lewis-VHI, a health consulting firm, evaluating a proposal by Senate Republican Leader Robert Dole. The Dole proposal would provide $100 billion in subsidies for the poorest of Americans, bringing coverage to some of the 37 million Americans without it, but would fall short of President Clinton's goal of universal coverage.

It would pay for some of those subsidies with Medicare cuts that would reduce payments to hospitals between 1996 and 2000 by $25 billion, the Lewis-VHI report said. Factoring in the increased revenue from people newly insured under the Dole bill, the plan would still end up costing hospitals about $14.5 billion, the report said.

In Louisiana, the loss would be $369 million, the report said.

Similar criticism of the Dole proposal was voiced Monday by Labor Secretary Robert Reich.

Rep. Billy Tauzin, D-La., said the argument that universal coverage is needed to save public hospitals is 'ridiculous.'

But Dole referred to the criticism of the plan he wrote with Sen. Robert Packwood, R-Ore., as "the latest effort by the administration to focus on everyone's plan but their own. The goal of the Dole-Packwood plan is to preserve what's best about our system for everyone, the old and the young, and to fix the real problems that are out there."

Rep. Billy Tauzin, D-La., an advocate of some of the incremental reforms criticized by the health-care providers, said the argument that universal coverage is needed to save public hospitals is "ridiculous."

He said the cuts in Medicare are being proposed to increase the numbers of Americans who qualify for health insurance, and for such new entitlements as pharmaceutical and long-term care coverage. The cuts would not be needed, he said, if Congress were to adopt a bill that relies primarily on insurance reforms — such as an end to discrimination against people with pre-existing conditions.

Sen. Majority Leader George Mitchell, D-Maine, is considering putting off the president's call for immediate requirements that employers provide insurance to their workers, and replace the mandate with a series of so-called triggers. Under such a plan, employer mandates would take effect only if insurance and other reforms had failed to achieve the desired level of coverage.

There also is talk that if mandates are to be required the burden on businesses should be reduced. Clinton would require businesses to pay 80 percent of the cost, while Mitchell is considering a 50-50 mix.

Tauzin opposes employer mandates because of concerns businesses would respond by laying off workers.

But John Sweeney, president of the Service Employees International Union, said requiring employers to provide coverage is the only fair way to ensure that middle-class workers who pay taxes so that the poor can be covered "are not left out."

"The (Republican) plan is reduced to subterfuge because it refuses to deal with employers who are freeloading off the current system, employers like Pepsico, which owns Pizza Hut, and McDonald's," Sweeney said. "These are big profitable corporations, whose employees' health-care costs are being paid by other employers, taxpayers through federal and state taxes, and providers."

Meanwhile, Sen. John Breaux, D-La., called reports the Congressional Budget Office is about to release "shockingly good news." One report indicates that a bill he supports without employer mandates would provide coverage for 91 to 93 percent of Americans, and add a less than expected $17 billion to the federal budget deficit.

New Orleans Times-Picayune
July 26, 1994

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- Would employer's subsidies depend on whether their workers had access to coverage through their spouses' employers? If so, how would that be monitored? TBD

- Would employers that currently pay into union sickness funds be classified as employers that offer coverage? Yes.

- Are employers' subsidies a function of their employees' wages or family incomes? (The language in the proposal is ambiguous.) If subsidies are a function of incomes, how would employers determine this? Wages.

- Subsidies would be available for firms expanding coverage. Does this mean just the expansion of coverage to new classes of workers? What about firms that previously covered only individual policies that expanded coverage to family policies? TBD

- If an employer expanded coverage to previously uninsured part-time workers, offering to pay 100 percent of the premium, would those employees have to pay any part of the employees' share. (Note that the employer would be paying just 8 percent of their wages.) Based on 50% of premium with pro-rata reduction for part-timers.
- As currently written, the proposal provides incentives for firms to establish new classes of workers in order to maximize their subsidies. How will classes of workers be defined? Will they include more than full-time/part-time distinctions? TBD

- The proposal also provides strong disincentives for small firms established between now and 1997 to offer coverage. Provision dropped.

- Are the income eligibility criteria the same for newly covered firms as for firms that expand coverage. (The proposal is unclear on this issue.) First proposal dropped.
- How would the self-employed be treated under these provisions? TBD

- Would the subsidy be available to employee leasing firms? (Note that there is a large gaming potential here.) TBD

- Would state and local governments be eligible for subsidies? TBD

Employer Obligations

- What maintenance of effort requirements would there be for employers? None

- Would there be non-discrimination provisions? If so, what would they be? In particular, what requirements would be placed on employers making contributions in a market in which premiums were age-adjusted? See Finance bill.

Special Subsidies for Children and Pregnant Women

- These subsidies would phase out linearly between 185 percent and 240 percent of the poverty level. Correct? Yes.

- If families can obtain both regular subsidies and special subsidies for children and pregnant women, this could be very expensive for the federal government and result in the overpayment of premiums. What constraints, if any, are there on this option, and how would they be implemented? See specs

Presumptive Eligibility

- Could anyone who was eligible for a full subsidy be declared presumptively eligible at the point of service? Yes.

- How would such a provision work in practice? Note that the only experience to date with presumptive eligibility has been for a limited group of people (pregnant women), who are eligible for a public program (Medicaid), and who can have the eligibility determined presumptively by a special group of public and non-profit providers who have received special training to do this. Providers in the current program are at no risk for 45 days during which the woman has to have full eligibility determined. The federal and state governments carry the full risk if she turns out not to be eligible. Similar to current operation of presumptive eligibility for Medicaid.

Insurance Market Reforms

- The proposal is ambiguous about what firms would be in the community-rated (CR) market. There is language suggesting that 500+ firms might have the choice of being in the CR or the experience-rated (XR) markets? Was that intended? No. 500+ firms must do XR.

- The proposal states that plans could modify their premiums for age, geography, etc. Does this mean that modified community -rating would be an option open to plans? TBD

- What are the open enrollment provisions? Is it proposed to have year-round

open enrollment for everyone? (Note that this raises issues of adverse selection.) No. State determines open season period for each CR area.

- Could alliances limit the number of plans that they offered? Yes. HIPCs can negotiate on price, quality, etc. HIOCs are under no obligation to contract with all plans.
- Could alliances negotiate discounts for reasons other than economies of scale in administration and marketing? Yes.
- What would the enrollment processes be for people not enrolling through alliances? Direct enrollment through plans or employers.
- The proposal apparently envisions two risk adjustment processes: one in the CR market and one between the XR and the CR market. The provisions here are confusing. The internal CR market adjustment process—if it could be implemented--would redistribute premiums in the CR market to reflect differences in the risk of enrollees. So, within that market, compensation would take place. The XR payments--which would be extremely difficult to implement--would be distributed to CR plans apparently as if no internal risk adjustment had occurred. True. Note that there is no internal risk adjustment for experienced rated plans.
- Are the risk adjustment payments from the XR to the CR market intended to reflect just the higher risk of individual enrollees or their higher administrative costs also? TBD.
- The language on the high-cost plan assessment states that CR premiums would be uniform. Elsewhere, the proposal states that premiums could differ inside and outside alliances (reflecting administrative cost differences.) Which is correct? CR premiums are uniform. Marketing fees which are added to the premium could vary.
- What would the rules be for plans offering supplemental coverage--both for supplemental benefits and cost-sharing. Specs will be sent Monday am.
- What would the role of FEHBP be in this structure? See specs (to be sent)

Administrative Costs

- Would plan and alliance administration be funded by assessments on premiums? Would there be a specific assessment? Plans: Yes. Alliances: TBD
- Would the cost of health cards be included in premiums? Yes. Plans issue cards.
- What information would be required to be collected on a national data

network. Would such a network be federally sponsored? See specs. Network would not be federally sponsored.

- Would the federal government be responsible for determining the premium targets for each health care coverage area? Yes.

- Would there be a guaranty fund for self-insured plans? If so, how would it be funded? Would the Department of Labor be responsible for paying benefits? Yes. Funding mechanism & exec branch responsibility to be decided.

Tax-related Questions

- The proposal refers to sections of the Finance Committee's proposal that, in turn, contain references to sections of the Internal Revenue Code that are apparently being rewritten. We do not have this language from the Finance Committee yet, and we need it in order to understand the proposal. Call Mary Schmidt of [redacted] JTC.

- The proposal is silent on the deductibility of the high-cost plan assessment (HCPA). Is it a deductible expense for insurers and employers who self-insure, as in the Senate Finance Committee proposal? Yes.

- For purposes of determining the HCPA, what constitutes a "plan sponsor" in the experience-rated market--for firms that purchase insurance and for firms that self-insure? TBD.

- When determining the HCPA, the average premium equivalent of an experience-rated plan would include "any payments required under risk adjustment". Are the risk-adjustment payments included those paid by experience-rated firms to the community-rated market to compensate plans in that market for high-cost enrollees? If not, what risk-adjustment payments are included? There is no mention that experience-rated plans would have risk adjustments applied to their premiums in order to determine if they are high-cost plans. TBD.

- Only the standard benefit package, not including cost-sharing or supplemental benefits coverage, be taken into consideration in the calculation of a plan's average premium, when calculating HCPA liability. The Senate Finance Committee bill included cost-sharing coverage in the high cost plan assessment calculation. Is it the intention of this bill to exclude cost-sharing coverage, despite the weakening of cost-containment incentives brought by this exclusion? Please call Bob Rozen to discuss.

- The target growth rate would not, apparently, give credit to plans and

coverage areas that have held costs down before the HPCA is put into effect? Is it the intention to exclude such a distinction despite the weakening of cost-containment incentives during the period preceding the imposition of the assessment? TBD

- The exclusion from employee income of employer -provided health care would be limited "in a manner similar to the Administration bill". Coverage for the certified standard benefit package, including cost-sharing amounts under the package, would be excludable from employee income for tax purposes. Would supplemental coverage for additional services also be excludable from employee income? The Administration bill allowed exclusion of this type of supplemental coverage through 2003. What is the intended treatment of supplemental coverage for additional services? Benefits excluded would be defined as in HSA, with adult vision, dental, and cost sharing not included in income.
- The self-employed would be allowed a deduction for 50 percent of expenses and that the deduction for individuals (as per the Senate Finance Committee bill) would be deleted. Is it intended that individuals who are not self-employed but who purchase health insurance be allowed no deduction for these expenses other than the present-law deduction of medical costs, including health insurance costs, only to the extent that these costs exceed 7.5 percent of adjusted gross income? Yes.

Additional Topics

- Questions will follow on the trigger and the employer mandate, as well as Medicare and Medicaid provisions.