LRM #I-3000

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: ______________________ (Date)

______________________ (Name)

______________________ (Agency)

______________________ (Telephone)

SUBJECT: VA Proposed Report RE: S 1757, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____________

_____ Other: ______________________

_____ FAX RETURN of _____ pages, attached to this response sheet

- No smoker reduction [illegible] [illegible]

- Cost containment - Federal expansion

DRAFT RESPONSE TO SENATOR GRAMM
June 14, 1994

DEPARTMENT OF VETERANS AFFAIRS

IMPACT OF HEALTH CARE REFORM ON VETERANS AND VA

The President's health care reform proposal will result in major improvements to VA's health care system. Limited access to VA facilities, long waiting times for appointments and complex, fragmented eligibility rules have plagued users of the system for many years. By including VA and veterans health care in the Health Security Act, the President has made veterans health care and the enhancement of the VA health system one of his top priorities.

VA and veterans throughout the nation had the opportunity to participate in the development of the President's care reform proposal. The major national veterans service organizations have endorsed the President's plan for veterans health care. S. 1757 is designed to meet veterans' health care needs more adequately by providing VA with the opportunity and means to improve access, quality, and efficiency. The President's plan would maintain an independent VA health-care system and provide for that system to be a full participant in the new national health-care arena. Significantly, the President's proposal addresses the major problems facing the VA health-care system -- (1) complicated and confusing eligibility rules that have the effect of excluding many veterans from VA care and providing only fragmented care to many other veterans, (2) complete reliance on discretionary appropriations, which are under great pressure, and (3) lack of convenient accessibility for many veterans.

Enrollment and Benefits

VA would establish VA health plans as an enrollment choice for all veterans and their families. All veterans who choose a VA health plan would receive all services included in the comprehensive benefits package that the President's proposal guarantees to all legal residents. This would ensure that all veterans receive a full continuum of inpatient and outpatient care that is not available to many veterans under current law.

In addition, veterans will retain any VA eligibility that they have under current law for benefits not included in the President's comprehensive benefit package (e.g., long-term mental health care and nursing home care and eyeglasses in certain cases). VA will also be able to offer, in exchange for premium payments, supplemental benefits not included in the comprehensive package.

1 trigger for all / coverage

CBO want define 94

Mandi Sossamon
2 9/19/?0

Sit Members & staff. Interaction.
- we must keep Don in the loop --

1 - 0 in 5
default when over 10 > Preferred reduction

2 = 2 year employment insurance reforms

3 Benefits package defined or not. → politically defined and/or
- no cost sharing subsidies
- Definition of medical necessity. paradigm or
- Preferred ceiling on what common care does -- not a dollar amount. -- related to FEHBP. Ceiling & floor?
- Premium down to 1900 - 2,000 > single → current dollars?

4 Magnitude of changes to medicaid expenditures - bill no SSI populations, but what -- way around?

5 alternative to cap.

6 subsidies for business vs. individuals

7

224 Peter Lentz ← 300 to 4000 less in benefits

Clarify to
Bain
Bev
Beth
Brenz..
Deborah Matthews

- Don't want H, just the package.
- wants FEHB number.
- Does not include medicaid, no SSI population, no retirees.
2:1 age rating
- 100 & less. / include Reg, Skill employed ~ firewall

All service-connected disabled veterans, low-income veterans, and ex-POW veterans who choose a VA health plan will receive the comprehensive benefits package totally free; they will pay no premiums, no copayments, and no deductibles. Currently, there are more than 3 million veterans with a service-connected disability. In addition, an estimated 6.8 million veterans would qualify for free care on the basis of income (including some number of service-connected veterans having dual eligibility under these criteria). For the great majority of these veterans, this will constitute a major expansion of VA preventive and outpatient care benefits, and for many it will also mean elimination of the current VA medication copayment requirements.

Other enrollees, including family members, would be required to pay cost shares (including any balance of premiums not paid by regional alliances, copayments and deductibles).

Fiscal Matters

VA will continue to receive appropriations to its medical care account. In addition, for the first time, VA will also retain payments from third parties for use in providing health-care services. VA will receive a premium payment from a regional alliance for each veteran covered by that alliance who chooses to enroll in a VA plan. To the extent that VA appropriations actually cover the costs of care for a veteran for whom VA has received a premium, VA would remit the excess premium to the Treasury.

VA will also retain the copayments and deductibles it receives from higher-income, nonservice-connected veterans, the premiums VA collects from the sale of supplemental benefits, and the payments it receives from other plans for the furnishing of care to other plans' patients. Moreover, VA will retain Medicare reimbursement for care furnished to higher-income Medicare-eligible veterans who have no service-connected disabilities.

In addition, the Health Security Act authorizes a $3.3 billion investment fund ($1 billion in FY 95, $0.6 billion in FY 96; and $1.7 billion in FY 97) to enable VA health plans to compete successfully.

Improved, More Accessible Services

For VA to meet the obligations of a health plan, it must establish networks of health care providers throughout the nation. Networks will consist of VA medical centers and outpatient clinics, affiliates, and community based clinics established through contracting and sharing agreements will DoD, local governments, community providers, and our affiliated medical schools. The network system will provide a full continuum of care, much more convenient

-Boren's staff will be coming in w/ Christy Ferguson in 10 minutes. I'll give you & Bart a report at 7:00 or so.

[illegible]

6-19

Helen

Department of Veterans Affairs

OFFICE OF THE ASSISTANT SECRETARY FOR POLICY AND PLANNING

Fax Cover Sheet

Number of Pages: 1
(Includes Cover Sheet)

TO:
Chris Jennings

Voice # 456-5560
Fax # 456-7431

FROM:
Leslie Sawen

Office of Policy and Planning (008)
Voice # 273-5033
Fax # (202) 273-5993

NOTES:

Chris,
I know that things are busy and there is nothing out there in the job market. I did want to let you know that after Fri. 6/24, you can reach me at home: 202/265-9802 if you hear of any opportunities.
All my best,
Leslie

June 7, 1994

Dear Friend:

I have enclosed two new Center analyses on budget issues.

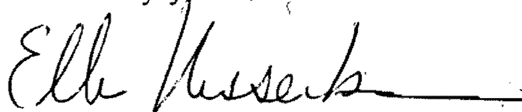
The first, "Funding for Low-Income Programs in FY 1994," examines funding for low-income non entitlement programs for the current fiscal year. The aggregate funding for these programs rose modestly over FY 1993 levels, while some programs like Head Start and child immunizations received larger increases. The increases, however, were not sufficient to offset reductions made in total funding for low-income appropriated programs during the 1980s.

The second piece analyzes a new budget process proposal, "The Common Cents Budget Reform Act of 1994", recently introduced by Representatives Stenholm, Penny and Kasich. The legislation includes four changes in current budget practices: effectively eliminating the use of current services (or inflation-adjusted) baseline budgets; establishing a procedure (a "lock box") to dedicate savings from appropriations to deficit reduction; changing the current rescission procedure to create an "expedited" rescission; and limiting the terms of emergency supplemental legislation.

This legislation may be considered in the House of Representatives in the near future.

I hope these analyses are useful. If you have questions or would like additional information, please call me or Karen Lightfoot.

Sincerely yours,



Ellen Nissenbaum
Legislative Director

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Robert Greenstein, Executive Director

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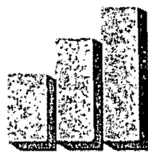

CENTER ON BUDGET AND POLICY PRIORITIES

FUNDING FOR LOW-INCOME PROGRAMS IN FY 1994

An analysis of fiscal year 1994 appropriations levels shows that non-entitlement programs for the poor received modest increases compared with fiscal year 1993 but that the overall funding level for these programs remains well below what it was when Ronald Reagan took office in 1981. Total fiscal year 1994 appropriations for low-income non-entitlement programs are $2.2 billion — or 3.7 percent — above the Congressional Budget Office estimate of the amount that was needed to maintain fiscal year 1993 levels, after adjusting for inflation.[1] (See Appendix 1.)

The programs examined in this analysis are those that either are explicitly targeted to low-income households or devote a high portion of funds to these households. The programs covered here exclude entitlements and other mandatory spending programs, such as AFDC, Medicaid, the JOBS program, and the Social Services Block Grant.

The modest increase in overall funding for these programs in fiscal year 1994 was not sufficient to offset the reductions made in these programs during the 1980s. In fiscal year 1981, some $62.6 billion was appropriated for these programs, equivalent to $105.3 billion in 1994 dollars. In fiscal year 1994, these programs received $64 billion, nearly 40 percent less in inflation-adjusted terms. (See Appendix 2.)

Much of the decrease in low-income appropriations since 1981 results from drastic reductions in appropriations for housing programs; fiscal year 1994 appropriations for these programs are 62.4 percent lower than the appropriations levels for fiscal year 1981. The deep reductions in appropriations for subsidized housing programs during this period, however, are not matched by declines in outlays for these programs. As a result, the inclusion of housing may distort the

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[1] This comparison does not reflect the impact of the emergency disaster supplemental appropriations bill on low-income programs. The supplemental appropriations bill provided emergency funding provisions for the Los Angeles earthquake, humanitarian assistance, and peacekeeping activities. Language was also included to release $300 million in previously appropriated contingency funds under the Low Income Home Energy Assistance Program. Part of the cost of this package was offset through rescissions in a number of programs, including low-income housing programs and the commodity supplemental food program.

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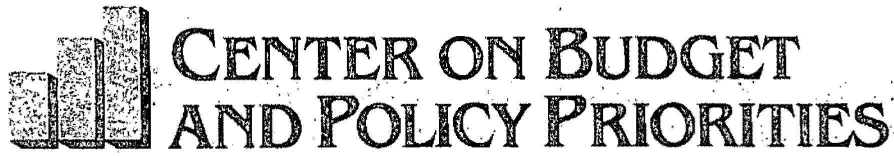

THE STENHOLM-PENNY-KASICH BUDGET PROCESS PROPOSALS

by Robert Greenstein

On May 17, Representatives Charles Stenholm, Tim Penny and John Kasich introduced a package of four budget process changes, which they call "The Common Cents Budget Reform Act of 1994." While some of the budgetary areas they address may benefit from reform, the particular changes they propose would cause some significant problems. Moreover, while one of their changes would establish a process for expedited action on rescission requests, this proposal is very different from the expedited rescission provision approved by the House last year.

Taken as a whole, the Common Cents bill would be likely to skew future budget debates in a manner that unfairly brands many Members of Congress as tax-and-spenders, makes it more difficult to shift resources from low-priority to high-priority items, and transfers substantial power from Congress to the White House. A number of these consequences could be averted if some changes were made in the bill or alternative approaches were adopted. Each of the four budget process changes contained in the bill is examined below.

1. BASELINE BUDGETING

The Common Cents bill makes a change in the "baseline" used for most budgeting decisions and does so in a manner likely to have a significant effect on how budget debates are framed. The change would have important political implications. It would enable most budgets — and most Members of Congress who vote for them — to be more easily portrayed, and attacked, as "tax-and-spenders." It also would erect a double standard regarding the treatment of inflation and economic growth.

The current budget baseline for individual discretionary (i.e., nonentitlement) programs equals the previous year's funding level, adjusted for inflation. (For total discretionary spending, the budget baseline is set equal to the discretionary cap.) For entitlements and revenue collections, the budget baseline reflects what costs and receipts will be under current laws governing entitlements and taxes.

Most budget analysts view the current procedures as the proper way to set the federal budget baseline. When a program's funding level keeps pace with inflation, this does not mean the program is expanding, serving more people, or providing richer benefits or services. The program would be providing the same level of

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Robert Greenstein, Executive Director

Larry, Gary, Chris

Attached is a cut at describing a state responsibility model. This assumed universal coverage -- that is, that states would get the block grant if they provided universal coverage. In this context, the question of flexibility is simply around defining what universal coverage means (e.g., how much individual responsibility/subsidy; nature of cost-sharing, balance billing; how much freedom of choice of plans, etc.)

In a trigger world, the question of what states must do in order to get their share of the block grant before universal coverage is required is less clear. Perhaps they must assure that some percentage of their population is insured? I will think on this tonight.

301 229 8862

Nancy Delaugh ?

HEPA participation

w/ FEHB alternative

B. Cooper?

Theresa Δ

to

Frenc

Chuck

Konigsberg

phone

needed for

Bruce Lesley -

224-1535

A MODEL WITH GREATER STATE ACCOUNTABILITY/RESPONSIBILITY

♦ Federal government gives a block grant to each state if the state operates a 'certified' system. The size of the block grant would be equal to the net federal subsidy if all of the provisions of the HSA were in place.[1]

♦ In the HSA and many alternative proposals, this block grant option is currently possible under the 'single payer' provisions. A model with greater state flexibility/responsibility would turn the 'single-payer' option into the standard model.

♦ The key policy questions are:

a) what states must do in order to receive the block grant and

b) how much flexibility they will have in designing and implementing health reform.

Potential areas of flexibility include:

- Rules for contracting with health plans
- Changes in the application/mechanism of cost controls
- Changes in the parameters of the subsidy structure for employers and/or employees
- Changes in the basic architecture of the shared employer/employee financial responsibility model
- Changes related to requirements on large employers
- Changes in cost sharing protections

AREAS IN WHICH STATES MIGHT BE GRANTED ADDITIONAL FLEXIBILITY

1) Rules for contracting with health plans

a) Not be required to contract with some plans.
b) Can limit to one fee-for-service plan.
c) Can change rules on essential community providers; centers of excellence.
d) Can freeze enrollment in high cost plans.

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[1] That is, the size of the block grant is determined by the number of employers and individuals in the state eligible for subsidies, the level of the premium target, and the state's required maintenance of effort for Medicaid recipients.

2) Changes in the application/mechanism of cost controls

a) Can assess plans differently than in the HSA (e.g., always assess high cost plans, rather than plans with rapid rates of increase)
b) Can operate one fee-for-service plan that withholds payments from providers and pays the withholds if volume is controlled.
c) Can tax high cost/volume hospitals and/or physicians.
d) Can operate without explicit cost controls.

3) Changes in the parameters, but not the form, of the subsidy structure

a) Increase the 12% to some higher number, and/or decrease special subsidies for small/low wage businesses
b) Increase the 3.9% to some higher number, and/or phase out subsidies for individuals at a lower income level
c) Phase out subsidies for non-workers at some point lower than 250% of poverty.

4) Changes in the basic architecture of the employer/employee shared responsbility model

a) Allow changes in 80/20 split -- e.g., could move to 50/50 or some other ratio.
b) Allow changes in per-worker premium approach -- e.g., could move to family choice or higher earner rule in split families for employer contribution.
c) Change requirements on self-employed -- e.g., not require self-employed to pay if spouse is already providing coverage.
d) Allow changes in how money is raised: e.g., sales tax or income tax instead of 80% employer requirement.

5) Changes vis-a-vis large employers (above 5,000)

b) Allow states to impose taxes on self-insured plans

6) Changes in cost sharing options

a) Can allow balance billing (potentially only in plans with premiums above the average; must assure that some plans are available at or below average with no balance billing)
b) Can allow high cost plans (those above the average) to increase their deductible in order to restrain premium increase
c) Can change out-of-network cost sharing on PPO and point-of-service packages

Band-Aid Reforms Aren't Enough

- Republican strategist, William Kristol is once again among those leading the charge against providing guaranteed private insurance to all Americans. He advocates tinkering with the current broken system, but still leaving millions of American families in jeopardy of losing their insurance coverage. Alternatives that tinker around the edges but still allow employers to drop coverage guarantee only one thing -- hard working individuals will fall through the cracks.

- **The middle class will take the hardest hit.** Under a non-universal reform plan, 24 - 40 million Americans, the majority of which are in middle class working families, would remain uninsured because they won't be able to afford it. The poor will get more help, the rich remain secure and the middle class will pay the price.

- **Cost-shifting will continue.** Under the Band-Aid approach, those who take responsibility for insurance coverage will continue to pay for those who do not or cannot. Even Senator Chafee, a staunch Republican, has claimed that a system which does require that every American take part, will be crippled by "free-riders."

- **The deficit will increase.** Under a plan without universal coverage, the CBO says there would be over $300 billion added to the deficit from 1996 to 2004. The President's plan, according to CBO, would curb expenditures by $30 billion below the current CBO baseline by 2000, and $150 billion below the baseline by 2004.

Progress That Won't Be Blocked

- The *USA TODAY* editorial and the endorsements just add to the momentum building behind comprehensive health care reform based on the President's approach.

- The American people want reform. They want the security of health benefits that can't be taken away. For the sake of America's middle class, we can't allow propaganda to stand in the way of change. We simply cannot afford to play politics with the lives of hard working Americans.

- The momentum in Congress demonstrates that we are well on the way to guaranteeing private insurance for every American that can never be taken away. Members have heard the urgent call from the American people who want comprehensive health care reform. **There should be no turning back, we must finish the job.**

- Patti Solis
- [illegible]
- [illegible]

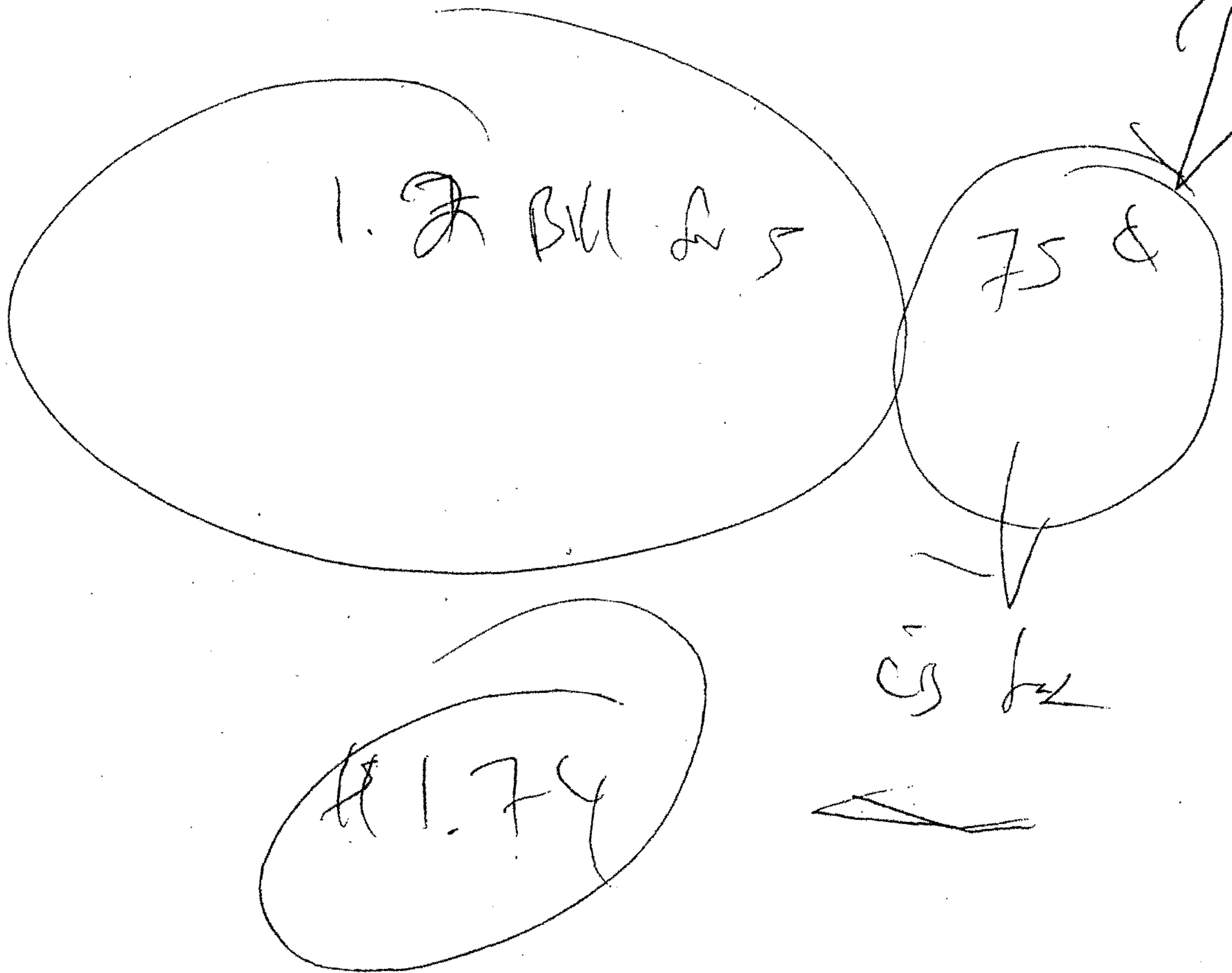
~1000 [illegible]

Before 500 [illegible] [illegible]

~1000 [illegible] [illegible]

1 [illegible] [illegible] [illegible] daily

Eric Toaster



(Families get subsidized if employer opt out?
outsourcing?

IF IT DOESN'T CONTROL COSTS, IT'S NOT REFORM
LEON E. PANETTA
DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET
SUBMITTED TO THE NEW YORK TIMES
JUNE 17, 1994

Reforming our nation's health care system is a critical step in restoring our economic health. There is a clear consensus that the nation cannot sustain the inadequacies, the bureaucracy, and the waste of the present health care system. If we are going to provide security and protect families, businesses, and government budgets from skyrocketing costs, real cost constraints are essential.

The Stakes

Some argue that we should continue to rely on those in the health care system to hold down costs. But as one observer has written, the health care system has become overbuilt, overused, and overpriced. How can we provide affordable health care for all Americans and not deal directly with costs? We cannot. By the end of the decade, we will be spending 18 percent of our economic resources on health care, yet more than 40 million Americans will still have no health coverage.

The stakes in allowing national health spending to continue out of control are huge -- for families, for businesses, and for government.

For government, we reversed the trend of rising Federal budget deficits last year with the President's economic plan, but without comprehensive reform, deficits will rise again in the latter part of this decade. Why? Because the one remaining area of the Federal budget that is out of control is health care costs. Indeed, the Congressional Budget Office (CBO) projects that without reform, they will rise by over ten percent for ten consecutive years.

Businesses face the same problem. Health costs for the Big Three automobile manufacturers average over $1,000 per car. And small businesses are charged an average of 35 percent more than large businesses for the same insurance. All businesses need predictable, affordable health costs.

For families, particularly middle-class families, rising costs place them one serious illness or job change away from losing their health insurance. Protecting families is at the core of health care reform.

If someone had sought to design the highest-cost system possible, they would have come up with our current system. There are few incentives today to control spending: the consumer bears only a fraction of costs; patients do not have the information to make meaningful choices; and most consumers must pay whatever providers charge. In such a market, real competitive pressures must be created *and then guaranteed with cost constraints.*

The Solution

Our primary strategy for cost containment is private sector competition -- creating the right economic incentives to provide choices, bring costs in line, and encourage health plans to compete on price and quality. This will slow down costs, but we need to build some discipline and certainty into our system. It would be irresponsible not to back up health security with cost security.

In addition to encouraging real competition, the President's plan uses three additional protections to control costs:

Short-term protection. Today, millions of uninsured individuals cannot pay when they use the health care system. Doctors and hospitals set their fees -- and insurers set their premiums -- about 25% higher for those who *do* pay to cover these "uncompensated" costs.

With universal coverage, all Americans would be insured, so there would be virtually no uncompensated costs. We need to set an appropriate premium ceiling in the first year of health reform; otherwise, the health industry will reap a huge windfall because they will effectively be paid twice for the uninsured -- once when the uninsured get insurance and pay their premiums and *again* when everyone else still gets charged more. This windfall, worth hundreds of billions of dollars to insurance companies over the next several years, would come straight out of our pockets.

Future premiums. To provide the long-term protection that American businesses and families demand, the President's plan ties the future growth in health insurance premiums to a reasonable scale of increases.

This protection makes sense. Limits on premium increases are preferable to direct Federal micro-management of health care costs -- for example, through a system of Federal price controls for specific procedures. The Federal government should not set prices for all of the tens of thousands of private health transactions that take place every day. The President rejected that approach in favor of broad limits on the rate at which insurance companies may raise premiums. The President's plan leaves it to those who know the system best -- health plans, doctors, and nurses -- to eliminate waste while improving the quality of care.

Some argue that these limits are too stringent to maintain the high quality of care that Americans receive today. This is simply untrue. First, the ceilings allow for regional variations and demographic shifts. But more fundamentally, in 2004, even with these limits, the U.S. health industry would have an income of $2.1 ***trillion***. The average annual growth in national health spending between 1996 and 2004 would be 7.3 percent per year instead of 8.4 percent as now projected -- an important achievement but one that would more than allow the

health sector to continue the high-quality care and medical advances which are the hallmark of our system.

Deficit protection. Finally, the President's plan assists small businesses and low-income families and individuals in paying their share of the cost of insurance. However, the President rejected the notion of creating another runaway entitlement program. Therefore, the plan sets a cap on total discounts. If costs rise beyond that level, Congress and the Administration must revisit the program and fix the problem.

Regardless of the means, we need to put an end to the fantasy that we can reform the nation's health system and provide coverage to every American without containing health costs. And conversely, we cannot hope to contain costs without universal coverage. The two are inextricably linked. All the experts agree that until all Americans are insured, billions of dollars will continue to be shifted onto those with insurance coverage. And without an approach requiring universal coverage, as CBO points out, it is the middle class -- not the poor -- who largely end up without insurance.

Likewise, without cost containment, middle class families will bear the largest burden of skyrocketing costs.

For 16 years, I served as a member of Congress, and we attempted to deal with the health care problem as it slowly became a health care crisis. Those efforts failed.

If we enact health care reform that does not provide for universal coverage and control costs -- whether through the mechanisms proposed by the Administration or by some other means -- this effort, too, will have failed.

#####

DRAFT June 16, 1994 1:32pm

USING FEHBP TO ENSURE THE AVAILABILITY OF HEALTH PLANS AT REASONABLE COST

SUMMARY

In the absence of explicit limits on premium increases (at least during a transition period), employers and families are at risk for unconstrained growth in their insurance premiums. In addition, the federal government's subsidy obligation is unlimited.

◊ The risk to the federal government can be controlled by tying the annual increase in federal subsidies provided to employers to a reasonable level of premium growth.

◊ Employers and families could be protected by making health plans in the Federal Employees Health Benefit Plan ("FEHBP") available to them. In addition to its traditional function of choosing health plans for federal employees, FEHBP would responsible for ensuring that employers and families have access to a sufficient number of reasonably priced plans with good service in each area. If FEHBP were unable to make available a sufficient number of lower-cost health plans in an area, FEHBP would offer a constrained private or public fee-for-service plan with a reasonable premium in that area.

A REFORMED INSURANCE MARKET

◊ The insurance market is reformed to eliminate risk selection and encourage health plans to compete over price and service.

- Standard insurance reforms would require guaranteed issue and portability of coverage.

- Health plans would use age-adjusted community rates for employers with fewer than 1,000 employees and uninsured families and individuals. Larger employers could self-insure or purchase experience-rated insurance.

◊ All health plans would offer two standardized levels of benefits, a basic benefit package and a standard benefit package. Supplemental benefits would also be available.

LIMITING FEDERAL RISK FOR SUBSIDIES

◊ To protect the federal government from the uncontrolled growth of federal subsidy obligations, subsidies for employers would be based on the average current premium

(ACP) established in each state–established community–rating area (CRA).

◊ The ACP in each area would be based on the average cost of providing coverage to people in the area. The ACP would increase at the rate of growth assumed in the HSA.

◊ This would tie increases in federal subsidy costs to a reasonable level of premium growth.

<u>MAKING FEHBP AVAILABLE TO EMPLOYERS AND FAMILIES</u>

◊ The health plans selected by FEHBP would be available to other employers and families.

- As under current law, FEHBP would contract with a variety of health plans in each area. FEHBP would select all health plans that meet specified price and service criteria (see below).

- Federal employees, including Members of Congress, would be able to choose from among the health plans selected by FEHBP.

- Community–rated employers (i.e., those below a certain size) and families not covered by employer–provided insurance would also be able to choose any of the health plans selected by FEHBP.

◊ Unlike today, FEHBP would pay age–adjusted community–rated premiums for federal employees instead of experience rates. That is, health plans would charge the same premiums to FEHBP as they would to other employers below a certain size (except potentially for differences in marketing fees as under the Williams and Kennedy proposals).

◊ States could assume the administrative functions of FEHBP if they meet appropriate standards.

<u>ASSURING AVAILABILITY OF PLANS AT REASONABLE COST</u>

◊ FEHBP would be required to offer a sufficient number of health plans in each area with premiums at or below the ACP. These health plans must have sufficient insurance capacity to serve a significant portion (e.g., at least 30%) of the population in that area.

◊ To accomplish this, FEHBP would review the premiums filed by community–rated health plans in each CRA. The preliminary filings would include information about premium levels, enrollment capacity and provider payment rates and methods.

Health plans that offer premiums at or below the ACP and that meet pre–established

service criteria would automatically be included in FEHBP. These health plans could also be available through other enrollment mechanisms.

◊ If a sufficient number of health plans do not have premiums below the ACP, then financial incentives would be used to encourage health plans to lower their premiums.

- A small assessment (½ – 1% of premium) would be imposed on all health plans with premiums above the ACP, and the revenues from the assessment would be offered as an incentive to health plans with premiums below the ACP.

- Health plans would be permitted to adjust their premiums in response to the assessment.

◊ If there are still an insufficient number of lower–cost health plans available in an area, FEHBP would offer a constrained fee–for–service plan to both federal employees and other employers and families in the area eligible to enroll in FEHBP.

- The constrained fee–for–service plan would be offered either by a private insurer (selected through bidding) or, if no private carrier bids, through a public program.

- The premium for the fee–for–service plan would be set at the ACP.

- The fee–for–service plan would be authorized to use Medicare–type payment arrangements.

- All health care providers would be required to participate with the plan as a condition of accepting payment from any certified health plan (or from Medicare). Balance billing of people covered by the plan would be limited or prohibited.

◊ Each year, FEHBP would then provide information about all plans available through the program in each area, identifying those plans with premiums at or below the ACP.

DATE	REQUEST BY	ASSIGNMENTS	STATUS	DONE
6/1:JL	Education and Labor	Benefit package reduction to bring their premiums down to "reality" starting with 5%, 7%, and 10%.	Assigned to JK	
6/1:JL	Ways and Means: Abernathy for Levin	Minor: Cost out new early retiree provision: limit contribution to 4% of payroll. (JL has paper on this).	KT: waiting for Stark premium to do this estimate.	
6/1:JL	Williams/Gephart	Gephart spreadsheet for Williams pkg.	Larry	
6/1:JL	Ways and Means: Abernathy	National expenditure under HSA with and w/o premium caps; impact on employer and household subsidies. (time period-- what ever is most convenient)	KT	
6/1:JL	Ways and Means: Abernathy	ASAP: Chafee -- premium/subsidies winners and losers. (needed for amendments)	Linda/Len	
6/1:JL	Gephart/E&C	1: Trigger options to univ. coverage 2. Phase-in premium caps 3. Subsidies(how) at front-end	Due by end of this week. Policy group led by Len	
6/3:LL	Bradley	Why tax on windfall profits doesn't work well.	Assign to Larry: first draft being requested of Treasury by Chris and Larry.	
6/3:LL	Bradley	Description of high cost plan surcharge.	Larry	
6/3:LL	?	Evaluation of potential risks in Kennedy mark for premium cap scoring.	Work with Larry and Gary	
6/3:LL	Bradley	Modelling (Ask Chris)	Larry	
6/3:JK	Heflin	Presentation of the benefits reductions that have been discussed with committees.	JK	

6/3:JK	Senate Finance	Possible 15% reductions in benefits package.	JK	
6/3:JK	Mitchell	Possible 10, 15, and 20% reductions in package beyond 5% reduction already considered. Benefits will be phased-in over 5 year period to reach 5% reduction level. In process of developing both fee-for-service and HMO reductions as well as appropriate phase-in schedule. Considering both cost sharing changes and elimination of benefits.	JK	
6/3:BT	Senate Finance:Kathy King and Charles Buck	What the community rate would be if you created a seprate purchasing pool for the individual market (unemployed/self employed) and compared that rate to the rate for each of the following groups: 1) 2 to 100 2) 2 to 500 3) 2 to 1000 In both mandatory and a voluntary market.	Gary and Larry Due: 6/6 COB	
6/3: CJ	Senate Labor: David Nexon	Rate shock as a result of pure community rating	Gary	

Memorandum for David Podoff

From: Chris Jennings *Chris J.*
Re: requests from this am's conference call
Date: 6/8/94

Included in or attached to this note are the additional items we spoke about with Nancy-Ann Min and Len Nichols this morning.

1. Basic subsidy schedules for the HSA for the 20% share and the 80% share.

2. The 4-6% extra income cap schedule for workers in exempt firms. This works in the following way. Households with workers in firms exempt from the mandate who choose not to offer are eligible for the extra income cap. The household is assumed to be liable for one 20% share and one 80% share, subject to their eligibility for discounts determined by the schedules. The household pays the lower of what their obligation would be under the HSA schedules (counting their wage income in the calculation of their obligation for the 80% share) and the percent of income cap applicable to them.

3. Revenue assessment numbers adjusted for the existence of the pulled employer mandate trigger in 1999. You will recall these numbers are lower than the ones Len read you over the phone because after 1999 the small firms would no longer pay their 1% or 2% assessments, unlike what he assumed in his original calculations. Below is a table with subsidies and assessments arranged by real budget windows, per your request.

	1995-1999 ($ billion)	2000-2004 ($ billion)
Subsidies	235	~~780~~ 670
Assessments	40	56

4. Growth rates of per capita premiums assumed in HSA:

1995	8.0%	2000	3.0%
1996	4.5%	2001	4.4%
1997	4.0%	2002	4.4%
1998	3.5%	2003	4.4%
1999	3.0%	2004	4.4%

cc: Nancy-Ann Min
Len Nichols

Basic HSA Structure

Employer Mandate:	80.0%
Worker Mandate:	20.0%
Household Cap:	3.9%
Wrkr Share Disregard:	$1,000
NonWrkr Share Disregard:	$1,000
Family with AGI at exactly 100% of poverty pays this % of their AGI for the Worker Share:	3.0%
Family w/non-wage AGI at exactly 100% of poverty pays this % of their non-wage AGI for the Employer share if they are non-working:	5.5%
Worker subsidies more generous than the HH cap stop at this income relative to poverty:	150%
Non-worker subsidies stop at this level of non-wage AGI relative to poverty:	250%
Actuarial Premium relative to CBO HSA:	1

100% of Poverty:

Single	$7,179
Couple	$9,713
Single Parent	$12,247
Dual Parent	$14,781

AHCPR Composites Relative to Basic HSA Composite Premiums

HSA	This Plan	% Change
1680	1680	0
2315	2315	0
3033	3033	0
3033	3033	0

	single	couple	1 parent	2 parent
Employer Composites:	1680	2315	3033	3033
Family Share:	420	840	819	1113
Actuarial Premiums:	2100	4200	4095	6565
	HH Share Marginal Rate 1:	HH Share Marginal Rate 2:	Employer Share Marginal Rate 1:	Employer Share Marginal Rate 2:
single	0.0349	0.0570	0.0639	0.1193
couple	0.0334	0.0570	0.0613	0.1222
1 parent	0.0327	0.0570	0.0599	0.1284
2 parent	0.0322	0.0570	0.0590	0.1001
Applies to income between	$1,000	100%	$1,000	100%
and this % of poverty	100%	150%	100%	250%

Plus, a cap that says, no household pays more than 3.9% of AGI for the household share.

Note: The marginal rates for the household share of the premium shown here represent a slight "smoothing" of payment requirements relative to that specified in the HSA. The "smoothing" does not effect the subsidy cost.

Income Caps for Households in Exempt Firms

% of poverty	% of income cap (no household pays more than x %)
150%	4.0%
150-175%	4.5%
175-225%	5.0%
225%+	6.0%

91% coverage could be achieved through a voluntary approach like the Cooper plan, but the following trade-offs would be required:

THE COST OF THE PLAN AS WRITTEN IS PROHIBITIVE

- CBO says the Cooper plan would add $300 billion to the deficit over ten years.

- This $300 billion figure assumes tens of billions from a tax cap pegged at the lowest cost plan. Without the tax cap, the deficit problem would grow.

CUTTING BENEFITS TO REDUCE COST

- CBO says the Cooper plan could be made approximately deficit neutral by dramatically reducing the benefits package (e.g. eliminating coverage for mental health, prescription drugs, preventive care, and dental, and limiting hospital coverage).

- However, providing a bare bones benefits package presents significant trade-offs:

  - Significant cost shifting remains. 97% of health care costs would no longer be covered under the plan.

  - State demonstrations show that few businesses and families would voluntarily purchase bare bones insurance, even if it is offered at very low rates. The only way to increase coverage with a bare bones package is to pay all or nearly all of the premium for the poor.

  - We would be spending a great deal of money for a benefits package that few people really want.

REMAINING COST PROBLEM

- Even with a dramatic reduction in the benefits package, the plan would still increase the deficit without a tax cap.

- Options to fill this gap include:

  - More Medicare cuts, which would be difficult to do without providing additional benefits for the elderly.

  - A tobacco tax, which may be difficult to achieve without universal coverage.

Chris,
DRAFT for
comments.
RLK

A MODEL WITH GREATER STATE ACCOUNTABILITY/RESPONSIBILITY

DESCRIPTION

- ♦ The federal government gives a block grant to each state if the state operates a 'certified' system.[1]

- ♦ In order to receive this block grant, a state must file a state plan which demonstrates:

  - All residents of the state are covered by health insurance providing a federally specified package of benefits;

  - The health insurance is portable -- that is, it covers medical expenses while residents are temporarily in other states;

  - All residents, and particularly those from disadvantaged groups, receive quality health care; and

  - The state provides federally specified encounter-level information on health care utilization.

- ♦ Within these parameters, states have broad flexibility to figure out:

  - How to raise money (e.g., employer/employee mandates, income tax financing, sales tax financing);

  - How to spend money (e.g., managed competition with competing health plans; state-run analogue to Medicare Part C; direct budgeting of hospitals);

- ♦ Financial inducements to the states to accept the block grant offer are strong:

  - Tobacco tax, elimination of federal DSH funding, cap on federal contributions to Medicaid, and Medicare savings are imposed nationwide. If state does not accept block grant, it loses its share of the savings generated by these measures. Like the Medicaid program in 1965, the federal government makes states an offer they are unlikely to refuse.

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[1] The size of the block grant would obviously be a hotly contested issue. As a starting point, assume that the block grant would be equal to the net federal subsidy if all of the provisions of the HSA were in place. That is, the level of block grant is determined by the number of employers and employees in the state eligible for subsidies under HSA subsidy rules (or some alternative subsidy rule), by the level of the premium target in each state, and by the state's required maintenance of effort for Medicaid recipients.

OPEN ISSUES

♦ Federal back-up, if any, if a state does not accept the block grant offer (see attached).

♦ Federal tax treatment of health insurance: if status quo is maintained, then tax expenditure is left exposed if states do not control costs. Further, if status quo is maintained, then states that want to shift from employer based financing to some other system (e.g., income tax or sales tax), would be discouraged from doing so.

ADVANTAGES

♦ Allows for universal coverage and control of federal expenditures without requiring federally imposed employer mandates or premium caps.

♦ Unites administrative and fiscal responsibility at one level of government, rather than giving fiscal responsibility to the federal government but asking states to administer the system. Places decisions about how and whether to control health expenditures closer to the local level, rather than in a distant, formula-driven National Health Board or HCFA.

DISADVANTAGES

♦ Pending decision on federal back-up mechanism, may not guarantee universal coverage.

♦ Degree of financial protection for low income persons may vary across states.[2]

♦ Precipitates a formula fight, as states argue over the level of initial premium targets, the state's required maintenance of effort, and the rate of adjustment to the national average.

♦ Despite federal assurances, some states will find creative ways to disadvantage the poor.

♦ Large multi-state employers will be extremely upset at potentially being subject to different rules in 50 states.

♦ Many governors and state legislatures will object to being put on the financial hook.

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[2] That is, some states may adopt more regressive financing systems than other states. Although the federal government could, in theory, require a minimum level of financial protection for individuals for their health insurance payments, unless the federal government approved every aspect of the state tax structure, it could not in practice provide equal financial protection to low income persons across states.

At a minimum, the legislation should require that if the federal government increases the guaranteed benefits package in the future, it must be required to increase the subsidy payments as well. Additional protections for states should be considered: for example, the ability to increase the deductible for upper income persons. Stronger protections, but ones that come at some federal cost, might:

- Tie the rate of growth of federal subsidy payments to the per capita rate of growth of Medicare expenditures.[3] This would provide some protection to state budgets against arbitrary cutbacks in subsidies (if the federal government is willing to take the heat from providers and constrain Medicare expenditure growth, then states should be willing to so so also).

- Have the federal government share the risk of overruns with the states. If most states are over their premium target, then one might assume that the targets are too low and the federal share of the overrun might be relatively large. If only a few states are over the target, then one might assume that the states did a poor job of managing expenditures, and the federal share might be relatively low.

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[3] The Medicare rate of growth should be adjusted for benefit changes (e.g., the addition of prescription drugs). Also, to make this budget neutral with respect to the HSA, the rate of subsidy increase might be specified as Medicare per capita minus X percent -- with the justification that with the advance of medical technology a greater percentage of expenditures should go the elderly.

If the President and Congress pass a health plan, do you think quality will get better, stay the same, or get worse:

Quality better:	25%
About the same	32%
Will get worse	37%

Timing

Should Congress pass a plan this year, or continue and act next year?

	June	May
This year	37%	34%
Wait	57%	58%

Should Congress and the President continue efforts, or leave the system as it is now?

Continue	71%
Leave system as is:	25%

General Approval Ratings

President's Approval Rating:	June	May
Approve	52%	57%
Disapprove	39%	37%

Positive/Negatives

The President: 46 positive
36 negative
17 neutral
[in May 94: 48+/34-; 18 neutral]

Fall Elections

In congressional elections, do you plan to vote:

	June	Jan.	10/93
For the Republican candidate:	30%	29%	34%
For the Democratic candidate:	35%	34%	32%

General Approval on Handling of Health Care

Bill Clinton	43% approve 47% disapprove
Congress	26% approve 61% disapprove

Clinton Plan	June	March
Favor	38%	37%
Oppose	46%	45%

universal coverage [illegible] mandate or [illegible] [illegible] [illegible]

individual mandate or [illegible] political

- 250
- 461 Billion [illegible] 10 years
  - [illegible] [illegible] [illegible] gap
  - [illegible]
  - no coverage

premise is [illegible] [illegible] [illegible] to [illegible] [illegible] [illegible]

- Republicans will want to kill your No bill strategy..

Jam them.

Cut [illegible] off universal coverage

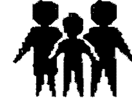
[illegible] no hard trigger
soft trigger. [illegible] [illegible] a [illegible] . Flow [illegible] [illegible].

- Trend going down

- [illegible] - 160

FAX

Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

TO: Chris Jennings
FROM: Len Nichols

Fax Destination
Organization:
Phone Number:

Number of Attached Pages: 2

Notes:

HD Fax Number: *202/395-3910*
Voice Confirmation: *202/395-4922*
202/395-4926
202/395-3844

Labor and Human Resources Mark

Savings

	(billions)
Better Targeted Subsidies (Administration Estimate?)	$35
Payroll Assessment Revenue (Administration Estimate?)	$38 (44)
$1.50 Increase in Cigarette Tax (Administration Estimate?)	$30 + (32) 42.4
1% Premium Tax NIH	$8
Long Term Care Investment Savings	$4
Federal/State Savings Distribution	$31 (14) 7
Modification to Employer Subsidy Schedule (Administration Estimate?)	$10

= 156 +

- ALL ADMIN. ESTIMATES PRELIMINARY + UNOFFICIAL
- ADMIN # CONVEYED, CIRCLED
- NO CIRCLE, NO ADMIN. ESTIMATE PROVIDED
- WE SAID NET PREMIUM SUBSIDY SAVINGS ≈ 20 = 35 (ABOVE)
  -27 HH MORE GENEROUS
  +13 CARVEOUT

Labor and Human Resources Mark

Costs

	(billions)
Eliminate HSA CBO Deficit	$74
Exempt Small Business (up to 10) (Administration Estimate?)	$16.2
Additional Cost Sharing Protections (Administration Estimate?)	$18–20
Medical Research investment	$8
Academic Health Centers	$27
DSH Hospital Protection Expansion	$3
Premium Subsidies for State and Local Employees	$9

= 155.2 – 157.2

* HE CLAIMED THIS TURNED TO $20 BY LOADING IT ONTO A PREMIUM SURCHARGE

A COMPARISON OF THE HSA, GEPHARDT, AND MITCHELL BILLS

- Academic Health Centers
- Research

DRAFT 8/2 6:30 PM

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Coverage	Universal coverage achieved by 1998.	Universal coverage achieved by 1999.	If 95% of the population is not covered by 2000 through voluntary measures, then a Commission makes recommendations to expand coverage, which Congress must consider on a fast track. If Congress does not act on the recommendations, then a 50–50 employer–individual mandate goes into effect for firms with 25 or more workers in States with less than 95% coverage. Firms with 26 or fewer workers are exempted.
Subsidies	Firm costs would be capped at 7.9% of payroll; firms with fewer than 75 workers and average wages of less than $24,000 eligible for caps of between 3.5% to 7.9% of payroll. Individuals costs capped at 3.9% of wages. Workers earning up to 150% of poverty level and nonworkers with incomes of up to 250% of poverty eligible for subsidies.	Individuals under 100% of poverty would receive a full premium subsidy, which phases out between 100 and 240% of poverty. Employers with 50 or fewer workers and average payroll of less than $26,000 would be eligible for a tax credit which would reduce their liability for health premiums. Firms with under 25 workers would be eligible for a maximum credit of 40 percent of the Medicare Part C premium (50% of the employer share); firms with 26 to 50 workers would be eligible for a credit equal to 30% of the premium.	Subsidies available for low–income people and some small, low–wage firms beginning in 1997. Low–income pregnant women and children up to 300% of poverty eligible for subsidies first. Low–income individuals eligible for subsidies can enroll at any time of the year. Temporarily unemployed eligible for enhanced income protection subsidies for up to 6 months. Employers who expand coverage from existing levels to all employees also eligible for subsidies beginning in 1997 and available for 5 years; firms pay the lesser of 50% of premium or 8% of newly–insured workers wages.
Employer / Individual Requirements	Employers required to contribute 80 percent of the average price plan in a geographic area. Subsidies available for small, low–wage firms (see above). All individuals required to have insurance and pay 20% of the premium, with subsidies available for low–income individuals.	Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Subsidies in the form of tax credits available to firms of 50 or fewer workers, based on average payroll. Small businesses could enroll workers in Medicare Part C. Individuals required to buy insurance. Employees of small (100 or fewer) businesses could choose expanded FEHBP or Medicare Part C (if low–wage). Unemployed covered under new Medicare Part C or private plan.	No employer contribution until possibility 2002 (see Coverage). Large employers (500 or more) must offer a choice of at least three plans (FFS, POS, HMO) to their employees and have option to self–insure; small firms must offer their employees option to join a HIPC or provide choice of at least three plans through private insurer. Employers who contribute for any workers must contribute for all. No individual mandate until possibly 2002. However, workers must buy policies through employer–offered plans or their local HIPC to qualify for premium contribution from their employers.
Cost Containment	Competition among health plans as main cost control mechanism. Limits on premium increases through a national health care budget, reducing to CPI plus per capita over 5 years for covered services. Incentives for individuals to choose lower cost plans. Slowdowns in growth of Medicare and Medicaid.	Competition among health plans as main cost control mechanism. A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 to control costs if expenditures were exceeding targets. Congress must either approve cost containment provisions along the lines of Medicare's payment methods or pass alternate measures to hold down health spending.	Competition among health plans and reductions in Medicare and Medicaid spending growth are main cost control mechanisms. High cost health plans would be assessed 25% on the portion of their costs above a target determined by Treasury Secretary. A National Cost and Coverage Commission would issue annual reports starting in 1999 on national and State trends. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, then Commission makes recommendations to Congress, who must act on them in an expedited fashion. A "fail safe" limit in national health care spending starting in 1997 included as backup protection; if costs exceed projected baseline, reform spending (except subsidies for pregnant women and children) would be reduced. (Also see taxes/revenue provisions).

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Taxes/Other Revenue Provisions	Cigarette tax increased $.75; assessment on self-insured plans; tax deductibility of cafeteria plans phased-out; savings in Federal programs.	Includes a $.45 increase in the cigarette tax and a 2% surcharge on private premiums (not Medicare Part C). A portion o the premiums paid by non-enrolling employers would be retained during a transition period.	Cigarette tax phased in from $.15 to $.45 over five years. Also includes an assessment on premiums of high growth plans. Also eliminates tax deductibility of health benefits as part of cafeteria plans.
Insurance Reform	Interim insurance reforms, including portability, guaranteed renewal, and pre-existing condition limitations, all begin right away. Guaranteed issue, community rating, standard benefits package and elimination of lifetime limits begin when a State phases in to universal coverage (outside date: January 1, 1998).	Insurance reforms include guaranteed issue, guaranteed renewal, standard benefits package, ban on pre-existing condition exclusions and an end to lifetime limits. Insurers selling in individual and small group insurance markets must offer insurance at community rate (no age bands). Firms above 100 can self-insure Reforms not implemented until universal coverage (outside date: January 1, 1998).	Beginning in 1995, portability, guaranteed renewal and a limit on pre-existing condition exclusions (6 mos.) Starting in 1997, insurance reforms include guaranteed issue, standard benefits package, elimination of lifetime limits and modified community rating (modified for age at a rate of 2:1). Firms/groups above 500 can self-insure or buy experience-rated policies.
Medicare	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1996-2000=$118.3 billion.	Retained and strengthened through added coverage for prescription drugs, mammography and mental health services. Medicare expanded through new "Part C program effective in 1999. Savings levels not yet clear.	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1995-1999 = $55 billion; 10 year figure = $278 billion.
Medicaid	All current Medicaid recipients choose from among a community rated plans available through the regional alliance system. If a low cost sharing plan (HMO) is available at or below the weighted average premium, then AFDC and SSI recipients who choose that plan have their cost sharing reduced to $2 for a physician visit and $1 per prescription; the HMO must absorb this extra cost-sharing subsidy. If no low cost sharing plan is available at or below the weighted average premium, AFDC and SSI recipients can choose a high cost sharing plan and be subsidized down to the $2/$1 level. State and local governments pay the plan for most of this subsidy. "Wrap-around" benefits extended to AFDC and SSI recipients and "non cash" children.	Medicaid recipients with modified adjusted gross incomes under 100% of poverty would receive a full premium subsidy; those with incomes above 100% of poverty would be required to pay part of their premium. Medicaid recipients, like other individuals, could enroll in Medicare Part C or a private plan, which they would pay for with a voucher. All AFDC and SSE recipients, all persons below 100% of poverty, all children and pregnant women with incomes below 200% of poverty are eligible for supplemental benefits currently covered by EPSDT. Payments for supplemental would be made out of the Part C trust fund.	AFDC and non-cash recipients with incomes below 100% of poverty and pregnant women under 185% of poverty receive a full premium subsidy. Non cash recipients with incomes above 100% of poverty (who are not pregnant women or children) pay for part of their premium if they want coverage. AFDC recipients in HMOs pay 20% of the cost sharing amount otherwise required (Unclear whether this is absorbed by the plan or paid for by the government).

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Benefits	Comprehensive benefits include hospital and health professional services, preventive services (w/ no cost sharing), prescription drugs, mental illness and substance abuses services, pregnancy-related services (including abortion) and family planning. Three kinds of cost sharing offered: lower (HMO), higher (fee-for-service) and combination (PPO). Out of pocket costs capped at $1500/individual and $3000/family.	Similar to those offered in HSA, with preventive services for children (with no cost sharing), preventive services for adults (some without cost sharing), pregnancy related services (which appear to cover abortion). Individual out of pocket costs capped at $3000; families capped at $6000. HHS Secretary defines 10 supplemental packages that insurers must make available.	Sixteen different categories of covered services in the standard package are specified in the bill, including nearly all those in the HSA package. Abortion and family planning are covered. A National Benefits Board will define scope and duration of services and can seek parity (ie cost sharing) for mental illness and substance abuse services. Three cost-sharing schedules (as in HSA). Individual also have option of purchasing an "alternative standard" package with a high deductible.
Alliances/ Purchasing Cooperatives	Individuals in firms with 5000 or fewer workers must belong to a single, mandatory regional health alliance, which collects premiums and pay health plans on behalf of enrollees. Firms above 5000 have option to self-insure.	States could establish voluntary or mandatory health cooperatives. Health plans sold through a health cooperative would be sold at the community rate that would otherwise apply, adjusted by an administrative discount.	Health Insurance Purchasing Cooperatives (HIPCs) set up as voluntary competing non profit agencies responsible for contracting with plans and employers, enrolling individuals, collecting and distributing premiums and publishing information on plans. HIPCs must accept all enrollees and offer choice of at least a fee-for-service plan, a point-of-service option, and an HMO. If a HIPC not available in community-rated area, then FEHBP is required to sponsor HIPCs in that area. (see FEHBP)
FEHBP	Terminates on December 31, 1997 (except for employees abroad).	An expanded "Universal" FEHBP established after insurance reforms take effect and would contract with community-rated plans. A small (100 or fewer) employer may offer coverage through UFEHBP.	OPM will run a HIPC for federal employees. Premiums for federal workers will be based on current methodology and will not be age-adjusted. Workers in firms of 500 or fewer employees, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at age-adjusted community rate. Federal workers and nonfederal individuals will pay same community-rated premium after the phase-out of age-rating in 2002.
Choice of Plan/Provider	Individuals guaranteed choice of menu of health plans, including one fee-for-service plan and a point of service option for HMOs.	Individuals have choice of at least one fee-for-service, and one managed care plan (which must offer point-of-service option), Medicare Part C (if eligible), FEHBP (for employees of small employers) and a catastrophic plan with a medical savings account.	Individual have choice of at least 3 health plans, including 1 fee-for-service plan. Small and medium sized employers must offer workers the chance to buy a policy through a HIPC and may also offer a choice of 3 plans, including a fee-for-service plan, and HMO, and a POS plan. Workers in firms with less than 500 workers, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at the age adjusted community rate.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
State Duties	Must establish alliances, assure enrollment and eligibility, regulate budgets, monitor quality standards and implement risk adjustment mechanisms. States could opt for single-payer, all-payer or other mechanism so long as coverage levels attained.	States can design individual reform programs, including a single payer option, so long as they meet coverage and cost control targets. States are responsible for implementing a long-term care program, an enrollment assistance program and solvency standards for self-insured plans.	States have ability to implement federal reforms on a "fast track". States could choose the single-payer option, and existing state waivers would be grandfathered. Responsibilities include certification of HIPCs and maintenance of effort for certain Medicaid recipients; States can pay per capita amount for SSI/Medicaid recipients who go into certified health plans.