PROBLEMS ASSOCIATED WITH THE ALTERNATIVE COMPROMISE PROPOSAL AND POTENTIAL SOLUTIONS

PROBLEM: CURRENTLY INSURING EMPLOYERS MAY DROP COVERAGE

- Community rating will cause rates to go up for some employers; this may cause employers to drop coverage.

- If employers who want to purchase insurance must purchase a standardized benefits package, some employers who currently provide less coverage may drop coverage.

- If individuals without employer contributions can receive substantial subsidies, some currently insuring employers will drop coverage, compensated by increasing wages, and allowing individuals to purchase on their own. This may both increase government subsidies and decrease coverage if only some of the newly uncovered decide to purchase.

SOLUTION:

- Age-adjusted community rating will avoid some of the most severe disruptions in rates. If employers think that a mandate will be triggered in three to five years, relatively few will drop coverage for a limited period of time.

- More than one benefits package option should be offered. If employers who want to can buy 'catastrophic' coverage, then few currently insuring employers will drop coverage entirely. We must then worry about risk-selection between high and low option packages, but this is a potentially manageable problem.

- Prior to a mandate being triggered, subsidies for individuals without employer contributions should not be so generous as to induce currently insuring employers to drop coverage. As noted above, an impending trigger will limit the number of employers who are induced to drop coverage in any case.

PROBLEM: ADVERSE SELECTION DRIVES UP RATES FOR THE INSURED

- If individuals are guaranteed purchase with 'only' a six-month pre-existing condition exclusion, they will wait until they are sick and then buy coverage. This will lead to declines in coverage, increase the amount of uncompensated care, and increase premiums for the insured.

SOLUTION:

- If the first problem is solved -- that is, if most currently insuring employers maintain coverage -- then this problem is likely to be more apparent then real. There

are approximately 39 million people uninsured and 15 million purchasing non-group coverage currently. Insurance market reforms might induce some of the 15 million to drop coverage, but this is not likely to be a large group or a serious problem. The availability of some subsidies will push in the opposite direction. Even if 10% of the total insured pool exited (much more than we should imagine), and this pool used 25% fewer services than average, premiums would go up by 2.5%. While movement of this sort would need to be accounted for in premium caps (see below), it would not have much effect on the decisions of employers or individuals.

PROBLEM: CONTINUED EXISTENCE OF UNCOMPENSATED CARE

- Without universal coverage, uncompensated care will continue to distort competition among providers and health plans. When faced with additional competitive pressure, both the providers that serve the poor and the poor themselves are likely to suffer.

SOLUTION:

- Create an uncompensated care pool that pays hospitals for services delivered to the uninsured. Simplest way to fund the pool is through an increase in premiums. Alternative is to obtain some of the revenues needed from employers who do not provide health insurance. Reduce the size of the uncompensated pool over time as the number of uninsured decreases.

PROBLEM: MEASUREMENT OF WHETHER THE TRIGGER SHOULD BE PULLED

- Existing data sources are not sufficient to determine whether the coverage targets have been achieved and whether the trigger should be pulled.

SOLUTION:

- Employers should be required to report, at the beginning of each year, whether or not they are providing coverage to their workers. These data would be used to determine whether the trigger needs to be pulled.

PROBLEM: PREMIUM CAPS WILL BE MORE DIFFICULT TO SET/ENFORCE

- If the composition of the pool of people who are insured changes from year to year, it will be difficult to know how much premiums should be allowed to increase.

SOLUTION:

- Measurement of the age/sex composition of the pool will provide a rough proxy for the extent to which the composition of the pool of insured changes over time. As universal coverage is achieved and the average age of the insured decreases, the level of premium increase allowed should be adjusted downwards. However, some leakage in the effectiveness of the premium caps should be expected.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

01-Jun-1994 02:49pm

TO: Nancy-Ann E. Min
TO: Len M. Nichols

FROM: Peter T. Nakahata
Office of Mgmt and Budget, HIMD

CC: Barry T. Clendenin
CC: William L. Dorotinsky

SUBJECT: Kennedy Mark and PHS Entitlement

CBO staff finally had a chance to look at the language in the LHR Chairman's Mark regarding the $18 Billion PHS entitlement. We understand from CBO staff that CBO would probably score the $18 billion TWICE (once as direct spending and once for the authorizations). Even though Kennedy may have intended only to have it scored once as direct spending, CBO staff note that the language is drafted such that the authorizations would be IN ADDITION TO funds "otherwise authorized to be appropriated."

We understand from LHR staff that the intention was to only have these funds scored once -- thus, if that is indeed the case, the committee should probably redraft this section (or else incur another $18 billion in costs)....

Bradley

FEHBP
Medicare

Len Nichols?

96 – 99

96

Jewish

Stanley

July 94

ADL Cousin

Quit GME

July 96

January 7th

by 200

Italian

unbelievable

HSA rates

Reverse trigger

[minimum comprehensive]
older disease

Expanding the FEHBP During a 'No Mandate' Transition to Universal Coverage

DESCRIPTION

♦ As in Senate Labor and Human Resources, expand FEHBP to contract with community rated plans (with limited adjustments for age), and allow individuals and businesses up to 1000 to purchase from these plans.

♦ Allow community rated plans outside of the FEHBP (with guaranteed issue, limited pre-ex, limited adjustments for age, etc. Same rules as inside).

♦ Below some firm threshold (i.e,. 50, 100, 250, or 500) require that businesses which purchase insurance must purchase from community rated plans. Above this threshold, allow businesses to purchase either from community rated plans or to self-insure/experience rate.

♦ Subsidies are available only to firms below 1,000, and only to firms that purchase from community rated plans.

♦ Premium caps apply only to community rated plans.

♦ Establish an uncompensated care pool to pay hospitals for services delivered to uninsured persons.

♦ Assessments on employers to be determined.

PROBLEMS AND SOLUTIONS (OPTIONS)

♦ HIGHER PREMIUMS IN THE POOL THAN OUTSIDE

Due to differences in demographics and administrative load, premiums in a community rated pool at 100 and below may well be 25% to 35% higher than premiums outside the pool (see attached memo). Employers required to participate in the community rate (if they want to purchase insurance) will see this as unfair relative to employers who can self-insure.

> Solution: Use other monies (saved by eliminating subsidies for large employers) to 'buy down' the premium in the pool to avoid the effect of non-workers and Medicaid non-cash. Could also reduce the effect somewhat by isolating the Medicaid non-cash in a separate pool.

♦ ADVERSE SELECTION BY EMPLOYERS AGAINST THE POOL

If employers above a certain size are allowed to choose the community rate or to self-

insure/experience rate, adverse selection against the community rate will result. This is partiallly mitigated by age adjusting the community rate, and by limiting subsidies to those who participate in the community rate.

> Solution: Need empirical estimates (guesses) of the magnitude of the problem at various firm size cutoffs. Could potentially have an extra assessment on employers who could participate in the community rated pool but choose not to.

♦ FEE SCHEDULE WILL STILL BE REQUIRED
If we want to guarantee a fee-for-service plan and a ban on balance billing in the community rated system along with premium caps, some organization(s) will still be required to set/negotiate a fee schedule.

♦ EFFECTIVENESS OF PREMIUM CAPS WILL BE DIMINISHED
As the pool of insured in the community rate changes the level of the premium caps will require adjustment. Making this adjustment appropriately will be problematic, and is likely to result in a reduction in the effectiveness of the caps.

♦ ADMINISTRATION OF SUBSIDIES/COLLECTION OF PREMIUMS
HSA and Kennedy give this responsibility to the states. Ways and Means gives this to HHS/IRS. A thorny problem with either approach.

♦ PER WORKER PREMIUMS

♦ UNCOMPENSATED CARE POOL

♦ DON'T WANT EMPLOYERS TO DROP COVERAGE
If the subsidies available to individuals are relatively generous (e.g., 4%-6%), then some employers may be encouraged to drop coverage. To avoid this, should probably keep subsidies to individuals above poverty relatively stingy until mandates are in place.

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	

National Health Care Commission

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

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

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

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

Among other things, the Commission would report generally on:

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

Structure of health delivery systems;

Status of insurance market reforms;

Development and operations of health insurance purchasing cooperatives;

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

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

Adequacy of subsidies for low-income individuals and employers;

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

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

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

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

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

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

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

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

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

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

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

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

Congress will consider under special fast track procedures.

7/24/94

HEALTH CARE REFORM -- OPTION 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7/24/94

HEALTH CARE REFORM -- OPTION 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Insurance Market Reforms. As follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATE LEADERSHIP PROPOSAL
QUESTIONS AND COMMENTS 7/24/94

General

- What are the default assumptions when assumptions are not specified? Applying Health Security Act (HSA) assumptions in those circumstances doesn't always work because of the difference between the mandate and non-mandate environments. No. Please inquire on specific issue.

Individual Subsidies

- Transfer payments would be included in family income for purposes of determining eligibility for subsidies. Correct? No.
- Subsidies would not be capped at the premium targets. Correct? To be determined
- We need confirmation of the income level at which people would qualify for full subsidies, 75 percent or 100 percent of poverty. (Please note that this is not a trivial modeling issue.) 75%
- Subsidies would be based on a "fixed percentage of the average premium". Does this mean the average premium in the community-rated pool? Yes.
- Would the subsidies be phased in? (Earlier material that we received suggested that might be the case.) No.
- How would individual subsidies interact with employer contributions? There are three basic approaches:

  - the subsidy is reduced dollar for dollar with the employer's contribution;
  - -- the subsidy is the lesser of the full subsidy amount to which an individual would be entitled in the absence of an employer's contribution or the employee's share of the premium; or
  - -- the subsidy is a proportion of the employee's share. (If, for example, a low-income worker would be eligible for a subsidy of 40 percent of

the premium in the absence of an employer's contribution, they would receive a subsidy of 40 percent of the employee's share under this alternative.)

- How would subsidies be determined for the self-employed? (Note that the provisions of the Labor and Human Resources (LHR) proposal and the HSA differ.) To be determined (TBD)

- What choices would be open to dual-earner families? Does the proposal still include the provision that such families would have to obtain their insurance through the employer of the higher earner? Under a mandate world, there would be a per worker contribution. High earner rule does not apply.

- Would there be special provisions for retirees? Retirees eligible for community rated pool. For subsidy determination, retirees are treated like non-workers.

- The provisions for temporary assistance for the job losers raise several questions and concerns: See specs.

  -- How would income be determined? (Note that AGI is a calendar year ex post measure.)

  -- Would eligibility depend on the availability of coverage through a spouse?

  -- For what type of coverage would job losers be eligible? (If they had individual coverage when employed, could they get subsidies for family policies when they lost their jobs?)

  -- If job losers were subsequently reemployed in jobs without health coverage, would their subsidies continue?

  -- As currently written, the provisions would favor job losers with higher wages in their previous jobs over those with lower wages, and would favor those who had previously had employment-based coverage over those who had not. Were those outcomes intended?

Cost-sharing Subsidies

- We have received conflicting information about cost-sharing subsidies. One fax stated that people with income below poverty would pay 20 percent of the required cost-sharing, and those with income between 100 and 200 percent of poverty would pay 40 percent of the required cost-sharing. Another fax

stated that former non-cash Medicaid beneficiaries with income up to 150 percent of the poverty level would receive subsidies. In the meeting on Friday, however, we were told that cost-sharing subsidies would be the same as in the HSA. Those provisions are quite different. Same as HSA.

- The faxed material suggested that people with income below 200 percent of the poverty level would receive subsidies regardless of the type of plan in which they enrolled. It also implied that AFDC beneficiaries would not receive cost-sharing subsidies unless they met the poverty criteria. These issues also need to be clarified. All AFDC beneficiaries must purchase through HPE and are eligible for full subsidies
- Who would pay the cost-sharing subsidies--the federal government or the plans? [redacted] Plans pay.

Employer Subsidies - Note: all responses assume voluntary (not mandate) proposal.

- The proposal estimated by OMB appears to contain significantly different provisions relating to employer subsidies than those in the specifications that we have received. It is our understanding that the proposal that OMB has estimated: Provision deleted.

  -- would limit employer subsidies to employers that had not offered coverage in the previous year; Provision deleted.

  -- would place a two-year time limit on the subsidies that any employer could receive; and TBD

  - would cap the federal obligation for these subsidies after the year 2000. TBD

Are these specifications part of the proposal?

- Firms that provide insurance today would receive no subsidies under the proposal. Correct? Proposal deleted
- Could an employer who does not offer insurance claim subsidies under the terms available to employers who expand coverage? TBD
- Would there be minimum hours of work requirements for eligibility for subsidies, and would subsidy amounts be adjusted for part-time workers? (As currently written, an employee working 1 hour a year would be eligible for a premium subsidy capped at 8 percent of their wage.) Full time worker requirement (30 hours). Part time workers are pro-rated.

- 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. HIPCs 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 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.

Characteristics of the Uninsured: Work Status Of Family Head, 1994 (Millions of Persons)

Total Uninsured	40
Full Year, Never Unemployed	24.1
Full Year, Some Unemployment	7.0
Part Year, Some Unemployment	2.7
Nonworker	6.2

Labor Market Characteristics of Newly Insured By Employment Status of Head of Household (Millions)

Program Initiative	Nonworker	Worker	Total
Low Income Premium Assistance	5-6	5	11
Welfare to Work Insurance	0	2	2
Coverage for the Uninsured Unemployed	0	4	4
Pregnant Women and Children	a	4	4
Employer-Based Incentives to Expand Coverage to Uninsured Workers	0	3	3
Total	5-6	18	23-24

a Under 1 million.

Totals do not include others newly coverd through the low-income premium assistance program with incomes over 200% of poverty.

Worker totals represent those employed during some portion of the year as well as the unemployed. Those not actively seeking employment, or are otherwise outside the labor force are categorized as nonworkers.

Net Effect on Level of Average Private Health Insurance Premiums

	1997			2004		
	Baseline	HSA	Senate	Baseline	HSA	Senate
Benefit Package	na	5.0%	-8.0%	na	5.0%	-8.0%
Medicaid Cost Shift						
Payment rates	2.5%	2.5%	0.5%	2.5%	2.5%	0.5%
Demographics	0.0%	3.0%	3.0%	0.0%	3.0%	3.0%
Growth rates	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%
Risk Adjustment Across Pools						
Pre-Mandate 5000+	0.0%	0.0%	2.2%	0.0%	0.0%	2.2%
Pre-Mandate 500-5000	0.0%	0.0%	2.2%	0.0%	0.0%	2.2%
Pre-Mandate < 500	0.0%	0.0%	-2.2%	0.0%	0.0%	-2.2%
Post-Mandate 5000+	0.0%	12.0%	1.5%	0.0%	12.0%	1.5%
Post-Mandate 500-5000	0.0%	2.0%	1.5%	0.0%	2.0%	1.5%
Post-Mandate < 500	0.0%	2.0%	-1.5%	0.0%	2.0%	-1.5%
High Cost Plan Assessment						
community rated plans	na	na	0.5%	na	na	3.2%
experience rated plans	na	na	0.0%	na	na	3.5%
effect on underlying growth rate						
community rated plans	na	na	-0.5%	na	na	-1.0%
experience rated plans	na	na	-0.25%	na	na	-0.5%
Uncompensated Care	8.0%	-8.0%		8.0%	-8.0%	
Pre-Mandate			-5.0%			-5.0%
Post-Mandate			-8.0%			-8.0%
Small Firm Exemption	na	0.0%	0.0%	na	0.0%	0.0%
Mandate firms	6.0%		6.0%	6.0%		6.0%
Non-mandated firms			0.0%			0.0%
Retiree community rating	na	0.0%	0.0%	na	0.0%	0.0%
Administrative load**						
5000+	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
500-5000	10.0%	13.5%	8.0%	10.0%	13.5%	8.0%
100-500	16.0%	13.5%	13.5%	16.0%	13.5%	13.5%
< 100	36.0%	13.5%	13.5%	36.0%	13.5%	13.5%
Academic Health Center Add-on	na	1.5%	1.75%	na	1.5%	1.75%

2.4

3.0

Net Total Additions

Medicare Savings (shifted?)	0	346B	250B	0	346B	250B
Hospitals		156B	90B		156B	90B
Physicians		190B	160B		190B	160B

Two Parent Family
Income = 75% of Poverty
No Employer Coverage Under Current System

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	47.0%	47.0%	54.4%	54.4%	63.0%	63.0%	76.5%	76.5%
HSA:								
7.9% Cap	2.9%	24.5%	2.9%	25.2%	2.9%	25.8%	2.9%	26.8%
Uncapped	2.9%	30.3%	2.9%	32.2%	2.9%	32.3%	2.9%	35.0%
Senate 7.18.94:								
CR - No mandate	0.0%	0.0%	0.1%	0.1%	2.0%	2.0%	4.7%	4.7%
CR - Mandate	0.0%	0.0%	0.1%	0.1%	7.3%	23.1%	12.6%	27.3%

Note: Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 150% of Poverty
No Employer Coverage Under Current System

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	23.5%	23.5%	27.2%	27.2%	31.5%	31.5%	38.3%	38.3%
HSA:								
7.9% Cap	3.9%	14.7%	4.0%	15.2%	3.9%	15.4%	4.1%	16.1%
Uncapped	3.9%	17.6%	4.0%	18.7%	3.9%	18.6%	4.1%	20.2%
Senate 7.18.94:								
CR - No mandate	14.1%	14.1%	16.6%	16.6%	19.1%	19.1%	22.7%	22.7%
CR - Mandate	14.1%	14.1%	16.6%	16.6%	8.3%	19.9%	11.0%	22.4%

Note: Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 200% of Poverty
No Employer Coverage Under Current System

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	17.6%	17.6%	20.4%	20.4%	23.6%	23.6%	28.7%	28.7%
HSA:								
7.9% Cap	3.8%	11.9%	4.0%	12.4%	3.9%	12.5%	4.1%	13.1%
Uncapped	3.8%	14.0%	4.0%	15.0%	3.9%	15.0%	4.1%	16.2%
Senate 7.18.94:								
CR - No mandate	17.6%	17.6%	20.7%	20.7%	23.3%	23.3%	27.2%	27.2%
CR - Mandate	17.6%	17.6%	20.7%	20.7%	9.3%	18.0%	11.2%	21.3%

Note: Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 300% of Poverty
No Employer Coverage Under Current System

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	11.7%	11.7%	13.6%	13.6%	15.7%	15.7%	19.1%	19.1%
HSA:								
7.9% Cap	2.5%	7.9%	2.7%	8.2%	2.7%	8.4%	2.9%	8.9%
Uncapped	2.5%	9.3%	2.7%	10.0%	2.7%	10.0%	2.9%	11.0%
Senate 7.18.94:								
CR - No mandate	11.7%	11.7%	13.8%	13.8%	15.6%	15.6%	18.1%	18.1%
CR - Mandate	11.7%	11.7%	13.8%	13.8%	7.5%	13.3%	8.8%	15.5%

Note: Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 300% of Poverty
80% Employer Coverage Under Current System

Working Household Payments as Percent of AGI

	1994		1997		2000		2004	
	Household	Total	Household	Total	Household	Total	Household	Total
Current System:	2.3%	11.7%	2.7%	13.6%	3.1%	15.7%	3.8%	19.1%
HSA:								
7.9% Cap	0.0%	9.3%	0.0%	10.0%	0.0%	10.0%	0.0%	11.0%
Uncapped	0.0%	9.3%	0.0%	10.0%	0.0%	10.0%	0.0%	11.0%
Senate 7.18.94:								
CR - No mandate	2.3%	11.7%	2.9%	13.8%	3.0%	15.6%	2.8%	18.1%
CR - Mandate	2.3%	11.7%	2.9%	13.8%	0.8%	13.3%	0.2%	15.5%

Note: Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Full (unsubsidized) Employer Payment for Standard Benefit Package

	1994	1997	2000	2004
Current System (80%)	4,167	5,270	6,667	9,121
Current System (50%)	2,604	3,294	4,167	5,700
HSA	3,033	3,542	3,890	4,780
Senate 7.18.94:				
no mandate (80%)	4,167	5,355	6,593	8,649
no mandate (50%)	2,604	3,347	4,121	5,405
mandate (50%)	2,604	3,347	3,071	4,002

* Under reform, early retirees are eligible to receive coverage through community-rated health plans. This policy generally would not increase private sector costs, although it would result in a shift of costs from large employers (who now covered the retirees at experience rated in their own plans) to smaller employers (would would pay somewhat higher community rates as a result of including the retirees in the community-rated pools).

  This shift could be reduced (but probably not eliminated) if community-rated premiums were fully age adjusted (rather than limit the age adjustment to 2:1). This shift also could be reduced if a risk adjustment that spreads the above-average costs of individual purchasers across all health plans were implemented.

(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 ~~Medicaid~~ 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 - to them immediately.

AARP - give to them

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.

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;

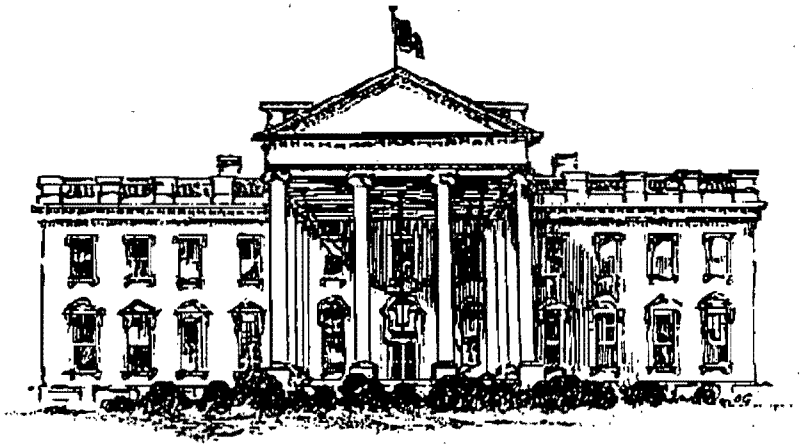
- o 24 million people, most of them hard-working middle class families, remain without health coverage.

CBO's analysis must confirm what they found with Cooper -- no one has found a 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.

How does Senate Finance pay for its subsidy program - taxes on those who currently provide insurance, meaning businesses and families that currently provide coverage will pay more to cover those who are without.

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.



THE WHITE HOUSE

To: Jennings, Chris Date: 7-27-94

From: Jason Goldberg Page 1 of 11

Shared Responsibility: The American Way

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

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

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

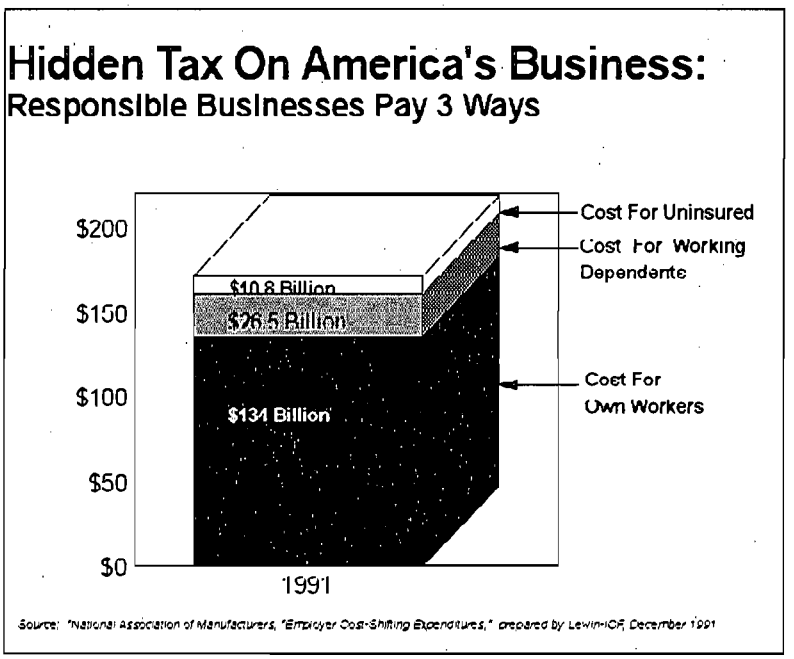
The American people overwhelmingly support Universal Coverage: 78% according to a recent *ABC News/Washington Post* Poll [June 27, 1994]. And shared responsibility is the fairest, and least disruptive way to get there.

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

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

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

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

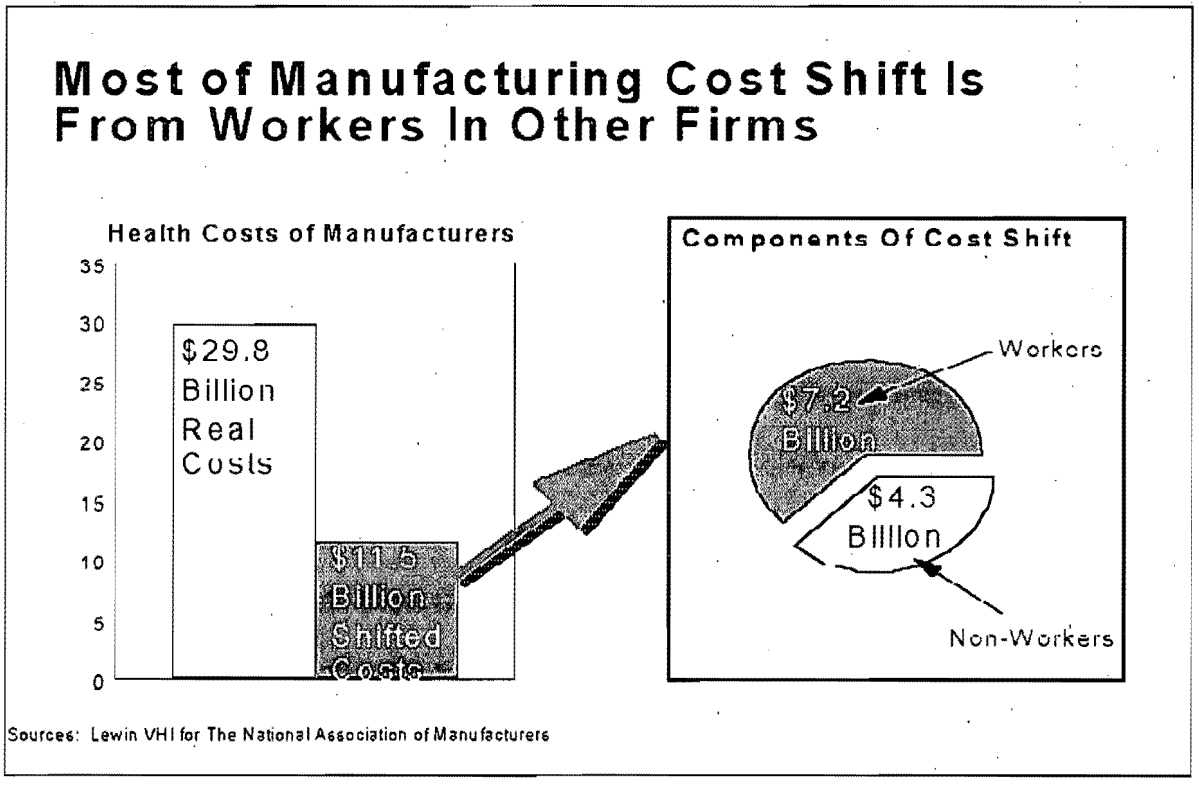


- That same year, employers who took responsibility for their employees' insurance also had an additional $10.8 billion added to their premiums to cover the uncompensated hospital costs of people without any insurance. Nearly half of these were to pay for **"workers, or dependents of workers, in firms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

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

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

- One study estimates that 28% or $11.5 billion of the health care costs paid by manufacturing companies are a result of cost shifting. Manufacturers buy insurance for over 3 million workers in other industries. [National Association of Manufacturers, *"Employer Cost-Shifting Expenditures,"* prepared by Lewin-ICF, December 1991]



- **Universal coverage will eliminate the penalty on businesses that provide coverage.** *"Universal coverage would mean that those firms that now offer insurance would no longer need to pay indirectly through higher doctor and hospital bills for the care given to uninsured*

workers and their families. On the other hand, firms that do not now provide insurance could no longer ride free." [CBO, 2/94]

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

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

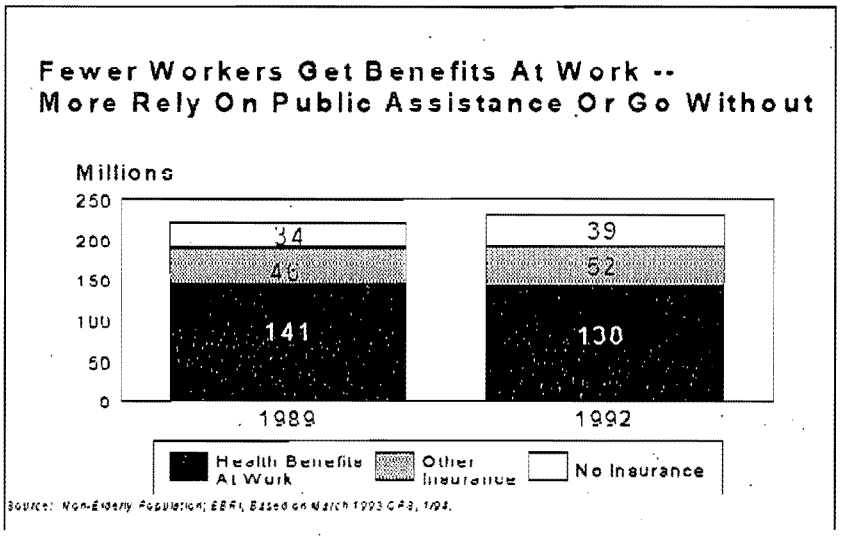
- Under one proposed plan, where benefits were not guaranteed at work, two million workers in small businesses would lose their employer's contribution. [CBO, 2/94]

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

- If employers do not take responsibility, every worker in the United States will be at risk of having to bear the entire burden of health insurance alone -- $3,900 or more each year. ["Families and National Health Reform," Kaiser Commisssion on the Future of Medicaid, 5/94]

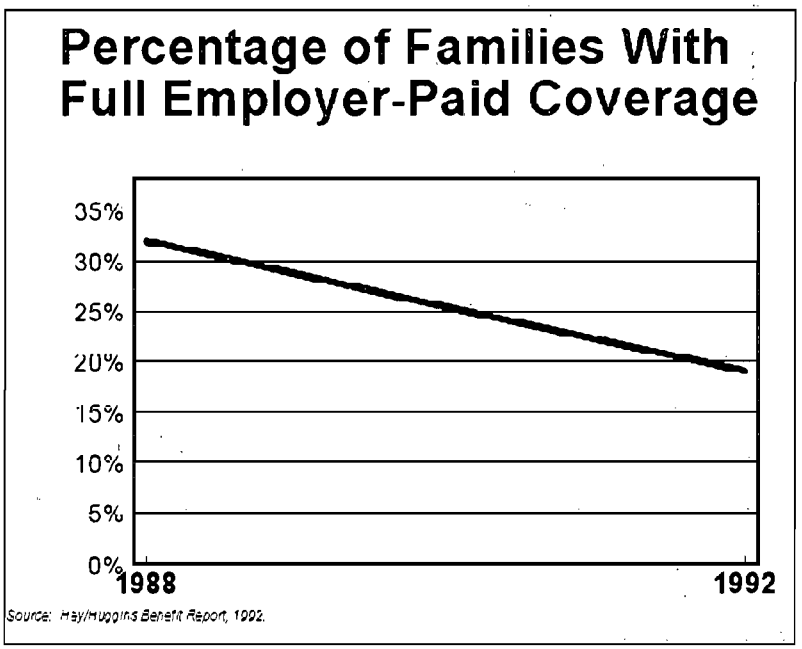
More and more, employees are being hurt as rising costs force companies that take responsibility to cut back.

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



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

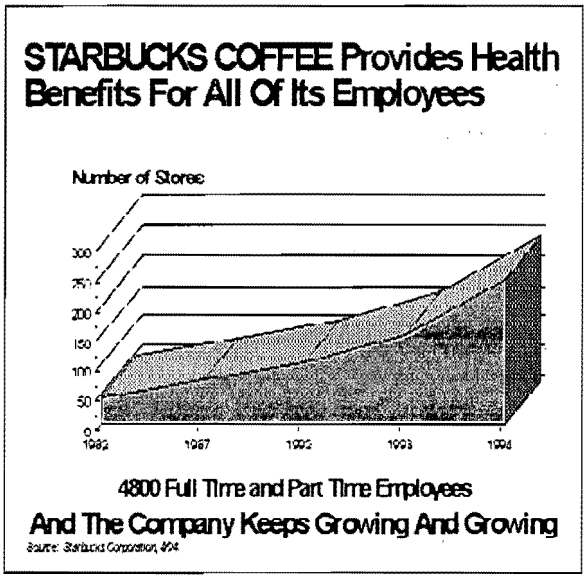
- Steve Burd, President and Chief Executive Officer of **Safeway** Inc -- one of the world's largest food retailers -- said his company competes "*with some very large companies that don't offer the same kind of coverage.*" If health reform doesn't pass with the employer mandate, Burd fears that Safeway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

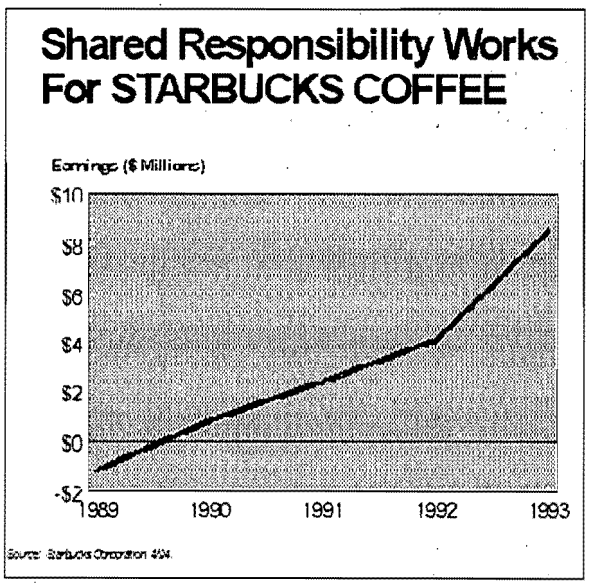


III. SHARED RESPONSIBILITY IS GOOD BUSINESS

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

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





- **PictureTel**, the technology and market leader in video conferencing, has doubled the number of its employees since 1991 to 863. They are able to provide health care benefits to all their employees and yet still grow at world class rates -- an astonishing compounded growth rate of 97% over the past five years. PictureTel is the market leader both in the U.S. and in Europe.

Shared responsibility works around the world.

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

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

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

- **McDonald's** does not cover hourly or part time workers at its restaurants in the United States. However, McDonald's does pay for coverage for its workers in Belgium, Germany, Japan, and The Netherlands. Germany is one of McDonald's six largest markets, with 27,000 employees and revenues of nearly $1 billion in 1992. Likewise, in The Netherlands, McDonald's now has 100 stores a 17.6 percent increase over last year. In Japan, the number of McDonald's restaurants (1,018) has increased 8 percent since 1993.

IV. SHARED RESPONSIBILITY HAS A SMALL IMPACT ON BUSINESS

"In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection." [President Richard M. Nixon, "Special Message to the Congress proposing National Health Strategy," 2/18/71]

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

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

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

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

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

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

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

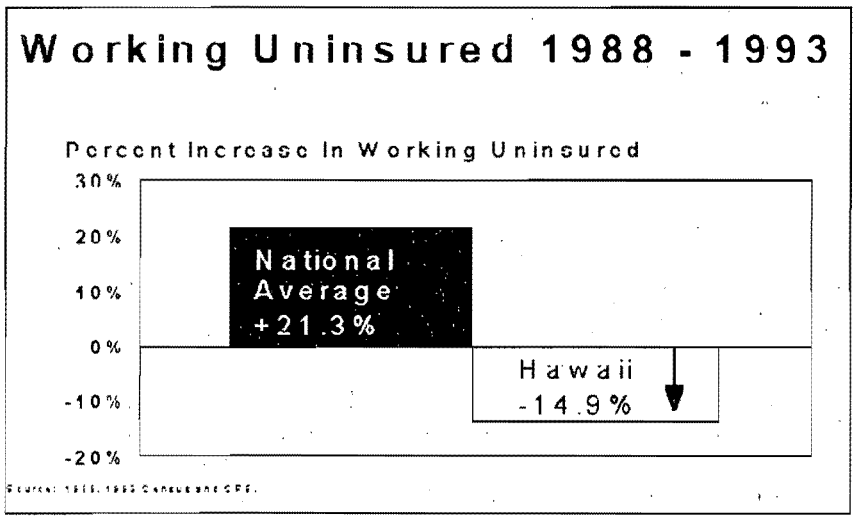
V. HAWAII: HEALTHIER BUSINESSES, HEALTHIER PEOPLE

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

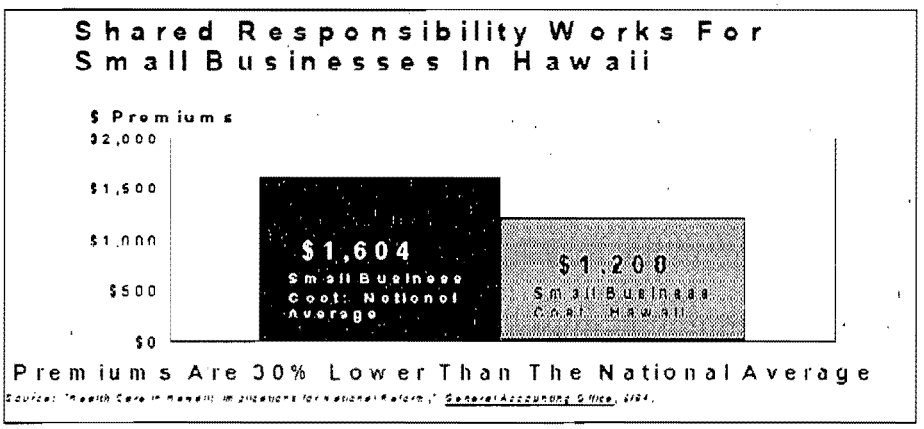
Shared responsibility is neither an untried novelty nor an exotic import unsuited to the American way of business.

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

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



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



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

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