MEMORANDUM FOR NANCY-ANN MIN

FROM: Len Nichols

RE: Preliminary "Bottom Line" on Senate Finance Mark

DATE: 7/6/94

As you know, we received the language of the amendments to the Chairman's mark last night. OMB and Treasury staff have reviewed those amendments, and our very preliminary ballpark bottom line is:

$25 billion increase in the deficit between 1995-1999

$90 billion increase in the deficit between 1995-2004

By contrast, the Chairman's mark, sans employer mandate trigger, produced:

$80 billion decrease in the deficit between 1995-1999

$275 billion decrease in the deficit between 1995-2004

The salient differences between the final bill and the Moynihan mark are:

- HSA-like long term care program added ($158B 1995-2004)
- corporate assessment dropped ($150B)
- smaller tobacco tax increase ($20B)
- early and generous expansion for pregnant women and kids (Reigle amendment) added to subsidies ($22B)

The softest numbers, as always, are the subsidy estimates, especially the Reigle amendment subsidy estimates, since they are based upon assumptions about premiums and health insurance purchasing behavior in a voluntary yet partially reformed environment.

We will continue to refine these estimates as time and better information allows.

Final Finance Mark, 6:45 pm. 7/6

Preliminary!

	1995-1999	1995-2004
Long Term Care	19	158
Net Subsidies	211	772
Medicare Savings	(37)	(207)
Medicaid Savings	(121)	(569)
PHS/AHC Spending	40	120
Tobacco Tax*	(86)	(157)
Corporate Assessment	0	0
Net Other Revenues	(16)	(64)
Net Deficit Effect	22	87

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

*Tobacco revenues are too high, and they are adjusted for in the Net Other Revenues line.

DATE: 7/6/94
TIME: 6:10 pm

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Office of Management and Budget
Health Policy

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To: Nancy-Ann Min; Chris Jennings; Ken Thorpe

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Voice #:

From: Linda Blumberg and Len Nichols

Notes:
Following is a second version of 50/50, including transitional measures outlined by Ken. Everything needs to be fleshed out, but we wanted to make sure that this is the general direction everyone is thinking about.

Number of Pages (including cover sheet): 3

- Standard benefit package = HSA-8%

- No mandate until January 1, 1999

- Transition period = January 1, 1997 through January 1, 1999
  Transition policies are as follows:

  - Implement insurance reforms and standard benefit package rules, including non-discrimination rules. No subsidies available to employers.

  - Provide 100% subsidies to households under 75% of poverty without current coverage. Phase-out percentage of premium subsidies between 75% and 150% of poverty. The same subsidies would be available to those losing their jobs that had insurance through their employment.

  - Provide a second year of Medicaid funding for those leaving welfare for work. Coverage continues through separate Medicaid program.

  - Provide constrained growth plan package to employers not currently offering insurance in the small group (< 25) market. Package would be solicited by the federal government from private sector insurers -- plans would agree to limit premium increases to 6-7% per year -- see Florida experience for details of how to do this. If employer contributed at least 50% of premium, worker 50% share would be subsidized on an income-based schedule).

  - 2% free rider assessment

  - Tobacco tax

  - 1% assessment on 500+, if provide (2% if don't provide).

- Mandate period -- January 1, 1999 and forward.

  - As of January 1, 1999, implement 50% employer mandate on firms of >= 20 workers; individual mandate on families. Those firms with fewer than 20 workers have no mandate, but must pay a 2% of payroll assessment if they do not provide 50% coverage to their workers.

  - Employers subsidized according to retreat model 3 (3.5%-7.9%) for 50% share of standard benefit.

  - Community rating for those at or below 500 workers; experience rating above 500 workers. No opt-in to community rate, and 1% assessment on those over 500.

  - Implement a Bradley-esque high cost plan assessment.

Community Rating Pool: Target is adjusted mean in the community rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997).

Experience Rated Group: Target is adjusted mean in the experience rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997). Plan premium will be adjusted to take the pool's experience into account for firms of < 1000.

Rate is set such that revenue and subsidy losses due to growth in excess of targets is recaptured.

- Household subsidies available for 50% worker share for households up to 200% of poverty. Non-worker/Carve-out subsidies available for other 50% share to households up to 200% of poverty.
- Tax credit expansion for individual premium contributions.
- Tobacco tax
- 1% payroll assessment on the 500+ firms.

Issue Areas

The following is a list of issues that closely approximates the summary provided by the Majority Leader's Office. Slight revisions have been made to better consolidate Administration expertise in a more workable manner.

1. Insurance Reform and Health Plan Standards
   a. insured and self-funded plans
   b. market structure (HIPC's)
   c. supplemental policies
   Gary Claxton and Larry Levitt

2. Benefits and the National Health Board
   Jennifer Kline and Ken Thorpe

3. Budget Controls (fail-safe)
   Nancy Ann Min, Alan Cohen, Berry Anderson

4. Market Incentives/Private Cost Containment
   Larry Levitt and Eric Toder

5. Revenue Provisions
   Eric Toder and Marina Weiss

6. Medicaid
   Don Johnson, Rick Kronick, Andy Allison

7. Long Term Care
   Robyn Stone and Lu Zawistowich

8. Medicare
   Barbara Cooper

9. Academic Health Centers; Graduate Medical and Nursing Education, and Research; Workforce
   Brian Biles, Arnie Epstein, Lynn Margherio

10. Access to Health Care in designated Urban and Rural Areas
    Bill Corr and Bob Van Hook

11. Quality and Health Services Research
    Arnie Epstein, Lynn Margherio, Bill Corr, Barbara Gagle

12. Information Systems, Privacy and Confidentiality
    John Silva and Nan Hunter

13. State Flexibility; ERISA
    Meredith Miller and Rick Kronick

14. Malpractice
    Jennifer Kline

15. Antitrust
    Neil Roberts and Bob Potter

16. Fraud and Abuse
    George Grob

17. Remedies
    Nan Hunter and Meredith Miller

18. Other Committees

Coordination of Administration personnel will be handled by Chris Jennings and Karen Pollitz. In general, Chris will oversee issue area groups 1-5 and 13-15. Karen will oversee all other groups. If you have any questions or concerns, please contact Chris (456-5560) or Karen (690-7450).

Contacts

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NOTE TO: Jerry Klepner
cc: Health care team

FROM: Bridgett Taylor
Diane Dugard
Lori Davis

SUBJECT: Finance Committee mark up

DATE: Wednesday, July 6, 1994

Thursday, June 30, 1994

Chairman Moynihan called the committee to order.

Senator Baucus offered the first amendment to exempt small low wage businesses (with 50 or fewer employers) from the triggered employer mandate. The amendment was defeated. The roll call vote: 6-14. (The five Senators voting with Baucus were Mitchell, Daschle, Rockefeller, Conrad, and Pryor.)

Senator Packwood offered the second amendment to strike the hard trigger employer mandate and employer subsidies. The amendment was agreed to. The roll call vote: 14-6. (The six Senators voting against Packwood were Moynihan, Mitchell, Pryor, Riegle, Rockefeller, and Daschle.)

Senators Breaux and Chafee offered the third amendment to create a commission to submit formal, specific recommendations to Congress if universal coverage (95%) is not achieved by 2002. The amendment was agreed to. The roll call vote: 12-8.

Senator Bradley offered the fourth amendment to strike the cost containment provisions in the Chairman's mark and replace them with a "high cost plan assessment". *[Begining in 1996, an annual assessment will be imposed on High Cost Plans (HCP). The IRS will determine a target each year. The targets will be set in such a manner that 40% of plans in each group for each area are above that amount. The assessment on a HCP is equal to 25% of the difference between the premium charged for the Certified Standard Health Plan plus supplementals, if any, and a reference premium.]* The amendment was agreed to. The roll call vote: 11-9.

Friday, July 1, 1994

Chairman Moynihan called the committee to order.

Senator Grassley offered the fifth amendment to provide Medicare reimbursement at 85 percent of the physician RBRVS for nurse practitioners (NP) and physician assistants in

all outpatient settings and to reimburse NPs practicing in rural areas at 65 percent of the RBRVS rate for assisting-at-surgery when referred and provided in an urban setting. The amendment's costs were offset by making Medicare reimbursement to long-term care hospitals under the Prospective Payment System. The amendment was agreed to by a voice vote.

Senator Mitchell offered the sixth amendment to provide pilot projects to test alternative methods for establishing Medicare volume performance standard rates of increase for service furnished by States. The Secretary of HHS would establish the projects and provide physicians or physician groups with the necessary data. The amendment was agreed to by a voice vote.

Senator Roth offered the seventh amendment to strike the provision which required the U.S. Postal Service to prefund health benefits for its retirees. The amendment was agreed to by a voice vote.

Senator Riegle offered the eighth amendment to modify the timing and extend subsidies in the Chairman's Mark assuring health insurance is available and affordable for all children and pregnant women in the first year of the program. The amendment creates a children's trust fund to finance these subsidies by increasing all revenue raising measures in the Senate Finance Committee document across-the-board. The amendment was agreed to. The roll call vote: 12-8.

Senator Baucus offered the ninth amendment to strike the proposed increase in excise tax on handgun ammunition and the occupational tax on importers and manufacturers of this ammunition. Also, the amendment struck the requirement that importers and manufacturers of handgun ammunition register with the Secretary of Treasury. The amendment was agreed to. The roll call vote: 15-5.

Senator Hatch offered the tenth amendment to strike the one percent assessment on large employers. The amendment was agreed to. The roll call vote: 12-7.

Senator Moynihan offered the eleventh "compromise" amendment to the Chairman's Mark. The committee staff walked through the compromise amendment. The Chairman, hearing no objection, announced the amendment was agreed to.

Senators Pryor, Rockefeller, Riegle, Conrad and Chafee offered the twelfth amendment to create a new home and community based care program for individuals with significant levels of disability, without regard to age or income. The amendment increases the current FMAP by 15 points for this program. The amendment was agreed to. The roll call: 16-4.

Senate Finance Committee Mark Up, cont.

Senator Danforth offered the thirteenth amendment on malpractice reforms, including alternative dispute resolution procedures (ADR), damage caps, severe liability, puniative damage reform, etc.. The amendment was agreed to. The roll call vote: 12-8.

Senator Wallop offered the fourteenth to strike the 1.75% premium assessment to fund academic health centers and graduate research centers. The amendment was defeated. The roll call vote: 7-13.

Senator Rockefeller offered the fifteenth amendment to sunset the age rating from the community rate in 5 years. A commission will report on whether it should continue after that time. The amendment was defeated. The roll call vote: 6-14.

Senator Hatch offered the sixteenth amendment to exclude abortion services from the comprehensive benefits package. The amendment was defeated. The roll call vote: 9-11.

Senator Grassley offered the seventeenth amendment to preserve constitutional State authority regarding abortions. The amendment was agreed to. The roll call vote: 11-9.

Senator Danforth offered the eighteenth amendment stating nothing in the Act shall be construed to require the creation or maintenance of abortion clinics or other abortion providers within any state or region of a state. The amendment was agreed to. The roll call vote: 12-8.

Senator Danforth offered the nineteenth amendment to include a conscience clause for employers, health plans and purchasers of health insurance. The amendment was agreed to. The roll call vote: 12-8.

Senator Danforth offered the twentieth amendment to strike forced subsidization of abortions by those with strong moral obligations. The amendment was defeated. The roll call vote: 12-8.

Saturday, July 2, 1994

Chairman Moynihan called the committee to order.

Senator Packwood offered the twenty-first amendment to extend the open enrollment period for preexisting conditions from 30 to 90 days. The amendment passed on a voice vote.

Senator Grassley offered the twenty-second amendment on "anti-discrimination of providers based on academic degree". The amendment was withdrawn (and reoffered later

in the mark up).

Senator Packwood offered the twenty-third amendment to allow individuals who work for employers that do not contribute toward health insurance premium for their employees to have the option to buy insurance at the community rate. The amendment was defeated. The roll call vote: 6-14.

Senators Breaux and Conrad offered the twenty-fourth amendment clarifying existing law to make it clear that state risk pools are tax-exempt if they are subsidized, there is no private inurement and the state is involved in their governance. The amendment was agreed to on a voice vote.

Senator Roth offered the twenty-fifth amendment to allow employees and the self-insured to offer / purchase a plan consisting of both (1) a catastrophic plan and (2) a medical savings account. The amendment was defeated. The roll call vote: 7-13.

Senator Wallop offered the twenty-sixth amendment to strike language allowing the automatic general revenue funding to be provided to the health insurance subsidy trust fund whenever the sources of funding for the trust fund do not fully fund the benefits. The amendment passed. The voice vote: 11-9.

Senator Conrad offered the twenty-seventh amendment regarding a premium credit for mandatory premiums paid to the United Mine Work combined fund. The amendment failed. The roll call vote: 8-12.

Senator Wallop offered the twenty-eighth amendment regarding Medicare physician self-referrals with exemptions for rural providers. The amendment was agreed to on a voice vote.

Senator Durenberger offered the twenty-ninth amendment regarding deferred compensation paid to certain group medical practices. The amendment passed on a voice vote.

Senator Dole offered the thirtieth amendment to ensure the National Health Care Commission is not authorized to address issues related to defining an "employee" for tax purposes. The amendment was agreed to on a voice vote.

Senator Durenberger offered the thirty-first amendment regarding grievance procedures / remedies and enforcement. The amendment was withdrawn.

Senator Durenberger offered the thirty-second amendment striking sections of the

Senate Finance Committee Mark Up, cont.

Chairman's Mark which modify the preemption provisions of ERISA, except that it would allow states to enact single-payer programs if they could demonstrate that such programs would significantly increase coverage or lower health care spending. The amendment failed on a vote of 10-10. Senator Mitchell changed his vote to aye, passing the amendment on a roll call vote of 11-9.

Senator Boren offered the thirty-third amendment to strike all single payor references in Title XIII. The amendment was defeated. The roll call vote: 10-10.

Senator Hatch offered the thirty-fourth amendment instructing the Secretary of HHS to submit to Congress a study reviewing the cost and effectiveness of providing subacute care services to individuals entitled to benefits under title XVIII of the SSA. The amendment was agreed to on a voice vote.

Senator Hatch offered the thirty-fifth amendment instructing HHS to approve and support state demonstration projects on no-fault liability. The amendment was modified by Senator Moynihan to read HHS "may" approve and support ... . The amendment was agreed to on a voice vote.

Senator Hatch offered the thirty-sixth amendment regarding the Medicare Part B penalty, striking "$115,000 for married taxpayers filing joint returns" and replacing it with "$150,000 for married taxpayers filing joint returns". The amendment was defeated. The roll call vote: 4-16.

Senator Durenberger offered the thirty-seventh amendment regarding classification of church health plans. The amendment passed on a voice vote.

Senator Hatch offered the thirty-eighth amendment regarding the definition of health professionals. The amendment passed on a voice vote.

Senators Grassley and Moynihan offered the thirty-ninth amendment regarding discrimination against health professionals based on academic degree. *[To address concerns that this was an "any willing provider" amendment, the following language was added to the original Grassley amendment by Senator Moynihan: Nothing in this law shall prevent a health plan from matching the number and type of health care providers to the needs of the plans members, require any health plan to contract with any type of provider authorized to provide services under applicable state law, or establish any other measure designed to maintain quality and to control costs.]* The amendment passed on a voice vote.

Senator Chafee offered the fortieth amendment to expand access to health care in designated urban and rural areas, specifically directing not less than 20% annually from the

infrastructure development account to award grants for the development and operation of federally qualified health centers. The amendment was withdrawn.

Senator Chafee introduced the forty-first amendment to establish a fail-safe mechanism to ensure health care reform does not increase the deficit. Senator Wallop offered a second degree amendment (# 41A) "to strike provision 5 of the Chafee amendment: Subsidies may be paid from the trust fund and the general fund subject to the deficit controls of this fail-safe mechanism." The second degree Wallop amendment was defeated. The roll call vote: 6-14. The Chafee amendment was agreed to. The roll call vote: 14-6.

Senator Danforth offered the forty second amendment establishing an advisory committee to study and report to the Finance Committee regarding the new trust funds established for academic health centers, graduate medical and nursing education, medical research, and medical schools. The amendment was agreed to on a voice vote.

Senator Dole offered the forty-first amendment limiting the standard benefit package to the subsidized population. The amendment was defeated. The roll call vote: 6-14.

The vote occurred on final passage of Chairman Moynihan's Mark as amended. The motion was agreed to. The roll call vote: 12-8.

Attachments:

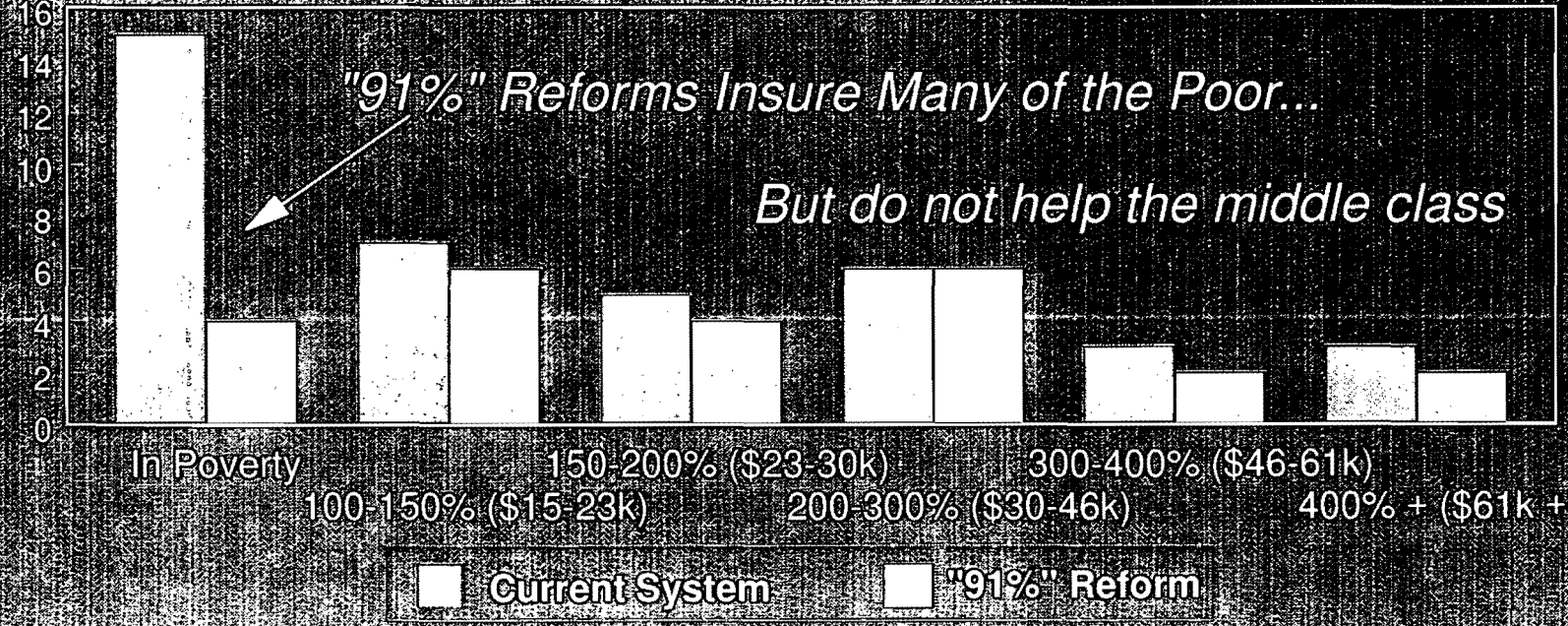
- Amendments and vote sheets

Introduction

- Making History
- Improvements in the Proposal:
  - No More Mandatory Alliances
  - Choice: You Can Keep What You Have
  - Extra Protection for Small business
- Congressional Challenge Ahead:
  - Universal Coverage?

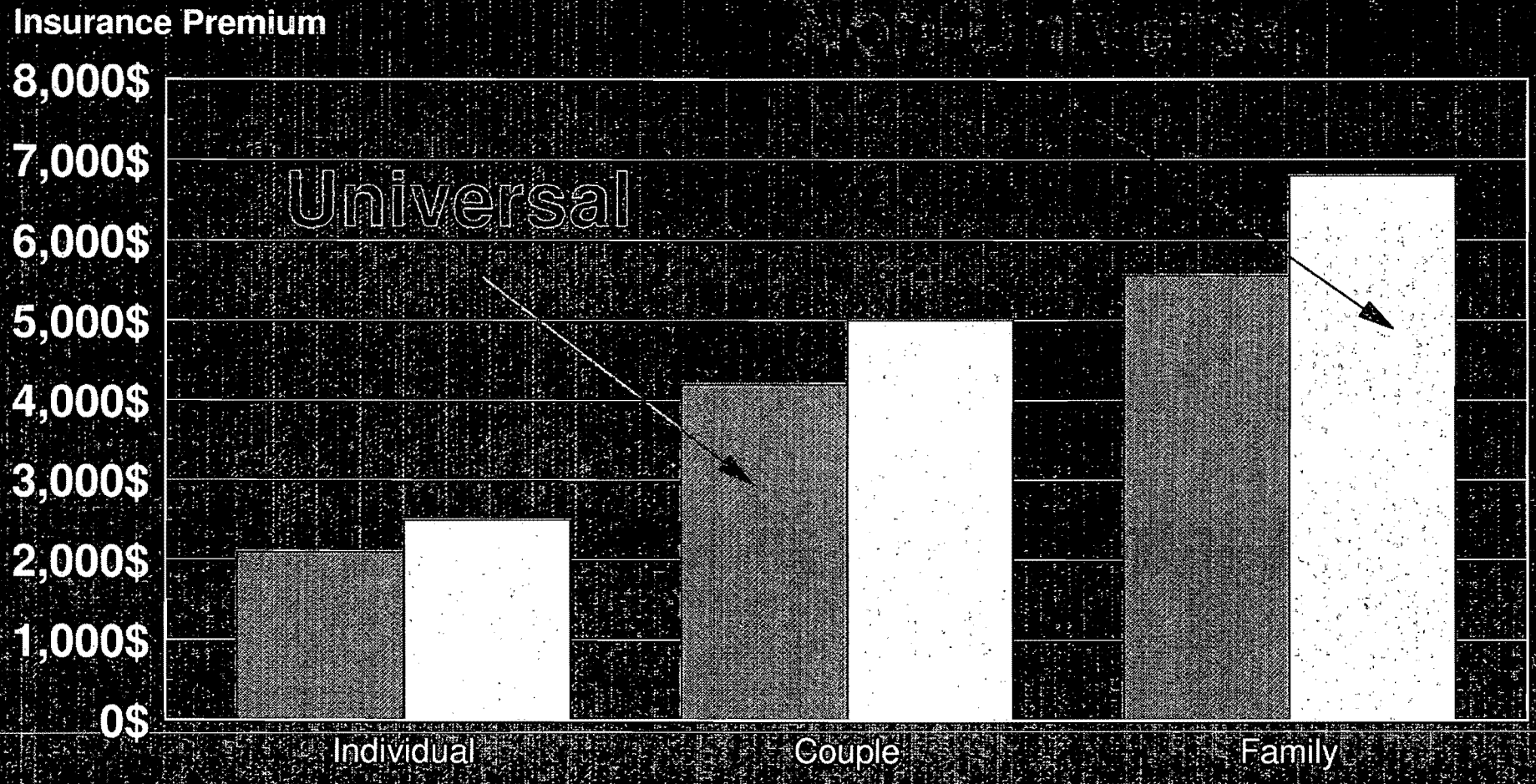
Partial Reform Does Not Help The Middle Class

Millions left uninsured



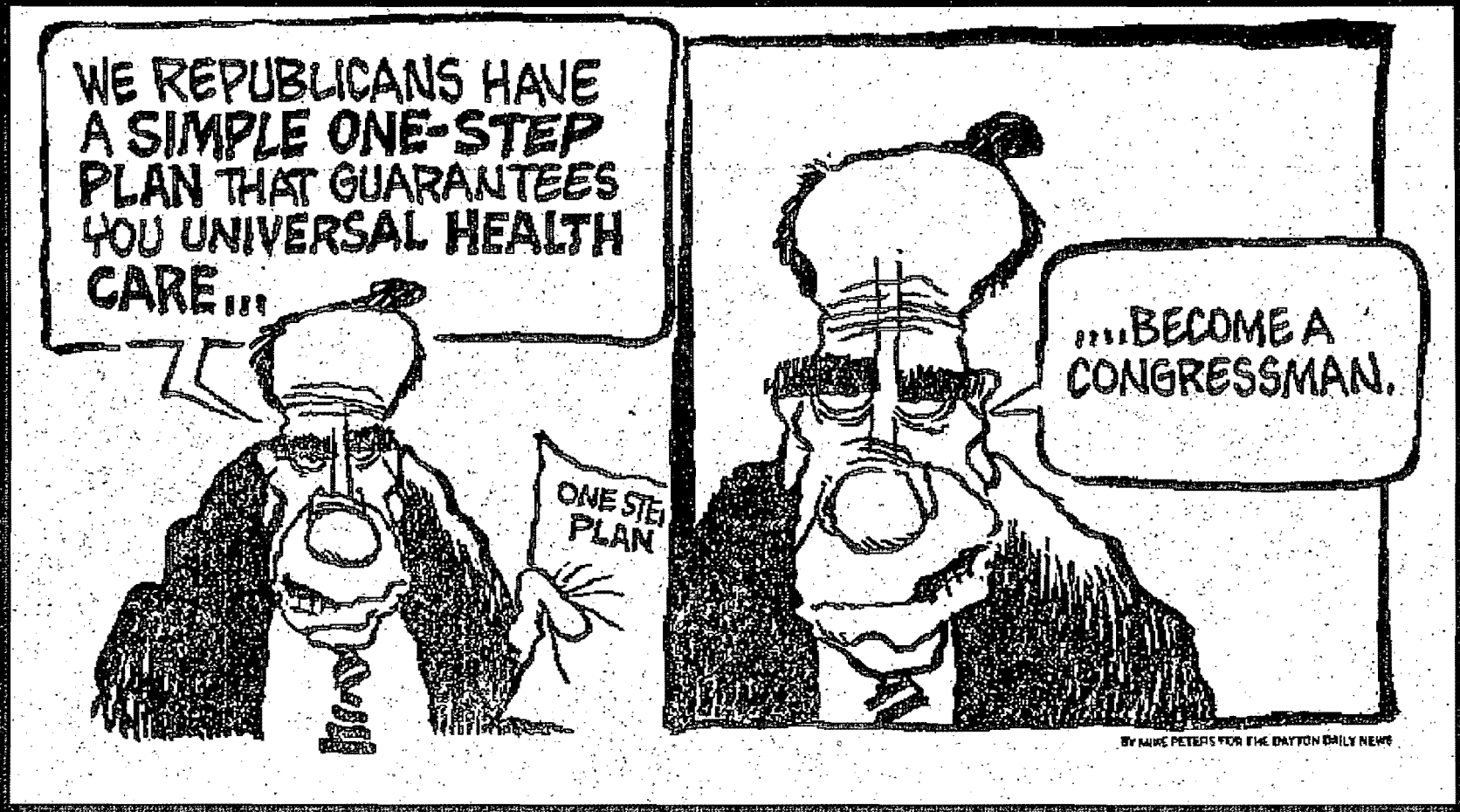
Source: CBO, 5/94, Tables 4-1, 2
Incomes categorized by percentage of poverty; dollar ranges shown for family of four

Without Universal Coverage Everybody Pays More



- **The Insured pay more to offset the costs of the Uninsured**

Source: CBO, February 1994;, April 1994



- **Non-Universal Reforms Leave Four Ways to Get Guaranteed Health Care:**
  - Become a Member of Congress
  - Go to Work for the Government
  - Go on Welfare
  - Go to Jail

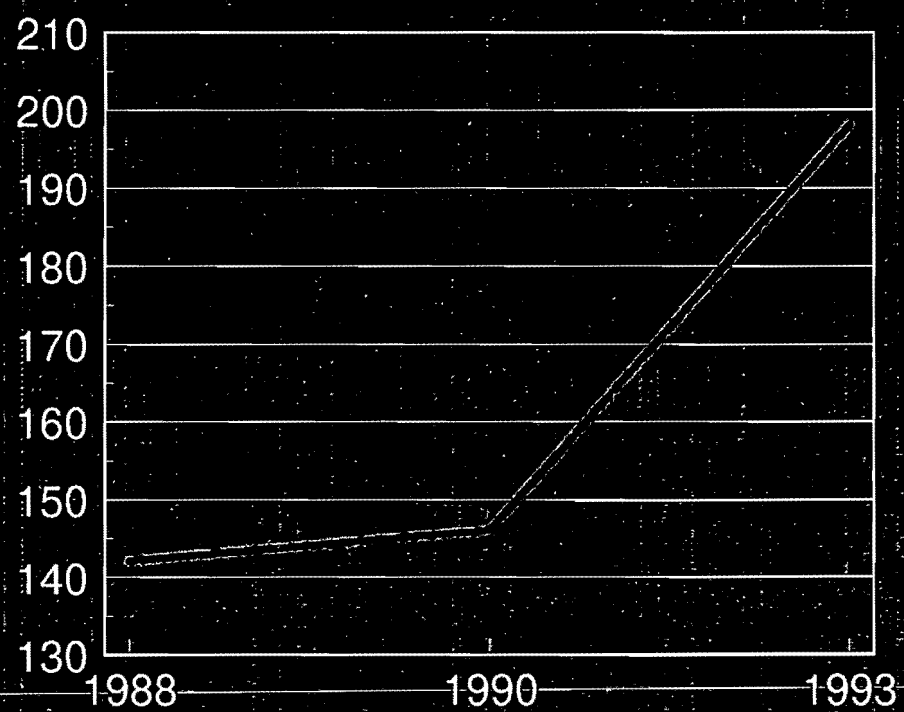
States Have Already Tried Non-Universal Reforms

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

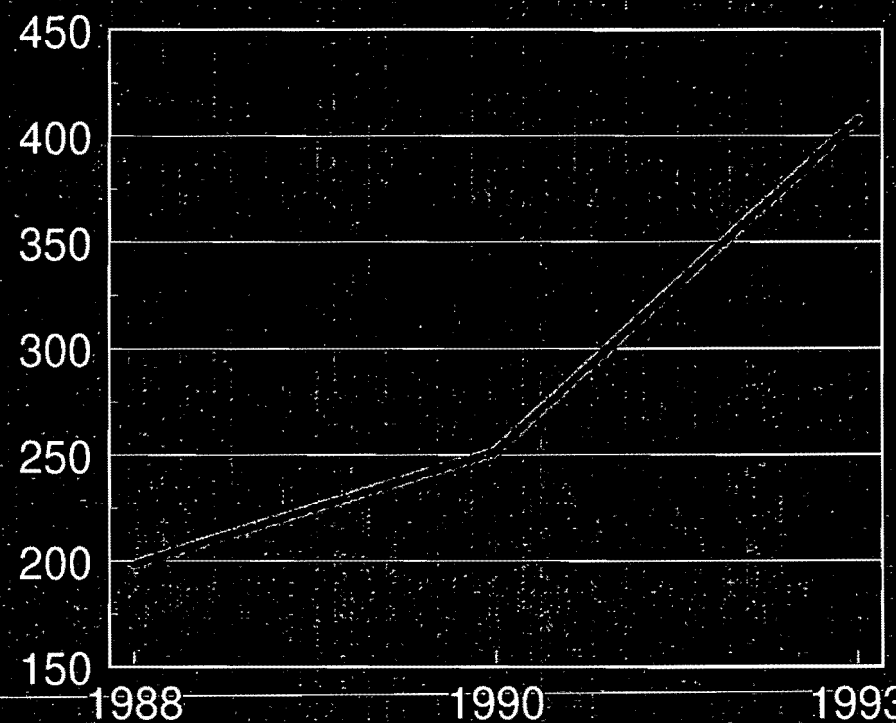
Source: Intergovernmental Health Policy Project, George Washingotn Universiiy, June 1994

Insurance Reforms Without Expanded Coverage For Workers

Thousands Working Without Insurance



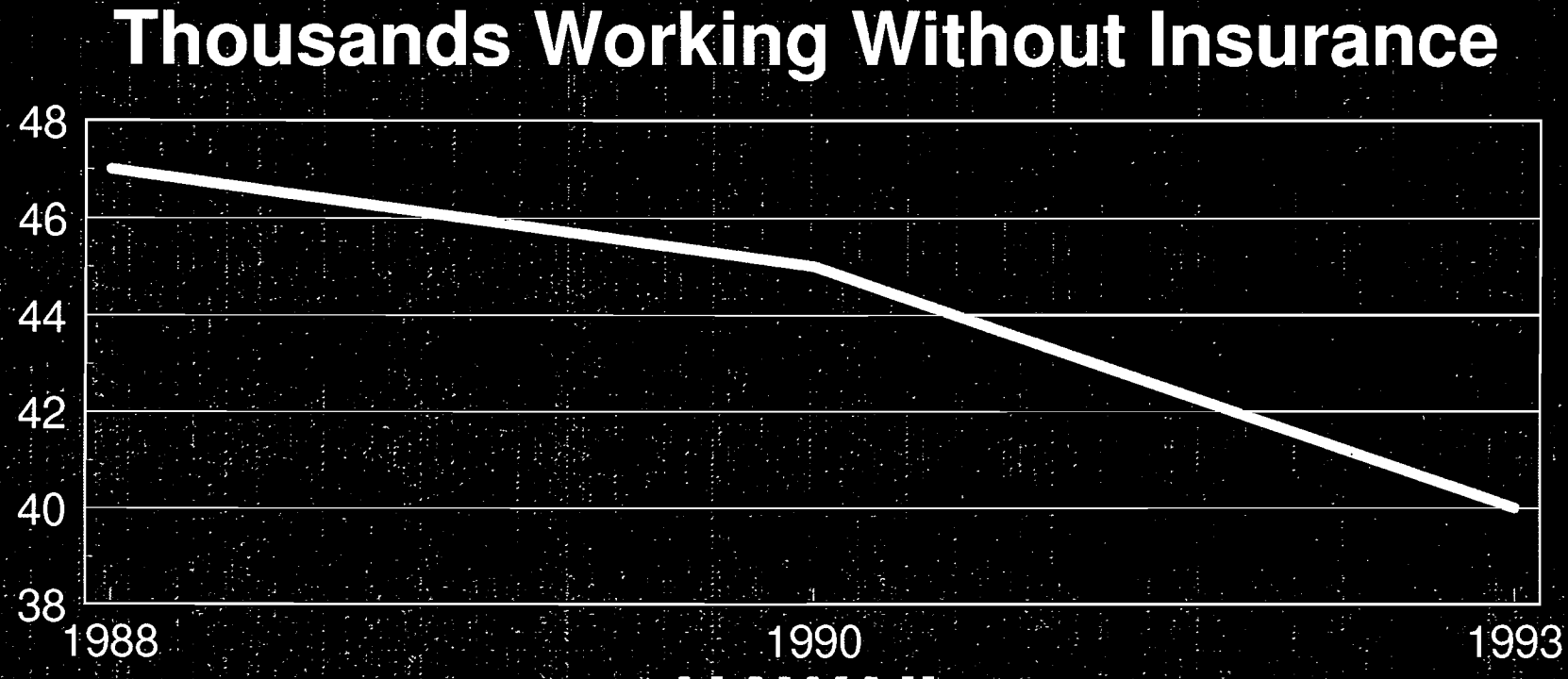
IOWA
Dole Style Reform



SOUTH CAROLINA
Cooper Style Reform

Sources: 1988, 1990, 1993 CPS

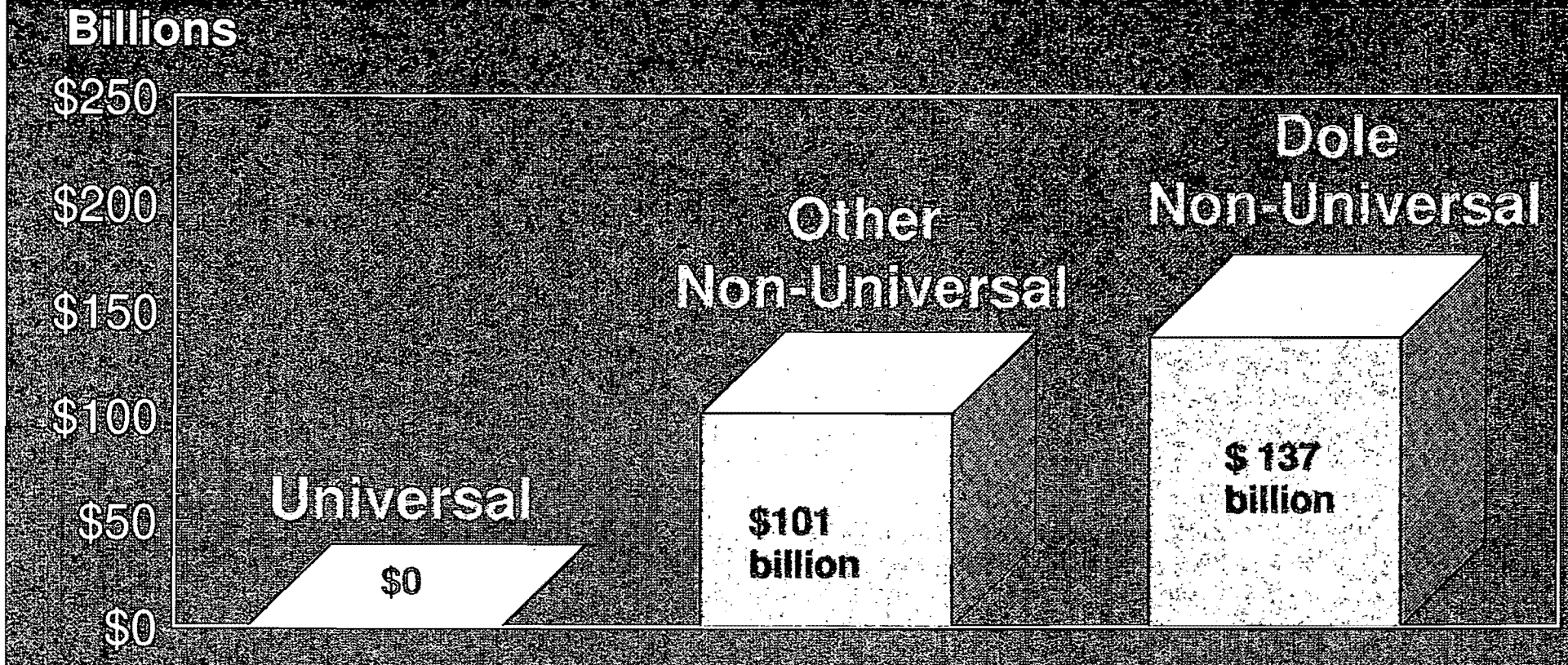
Insurance Reforms With Expanded Coverage For Workers



HAWAII

Near Universal Coverage

Hidden Health Care Tax Of Non-Universal Coverage

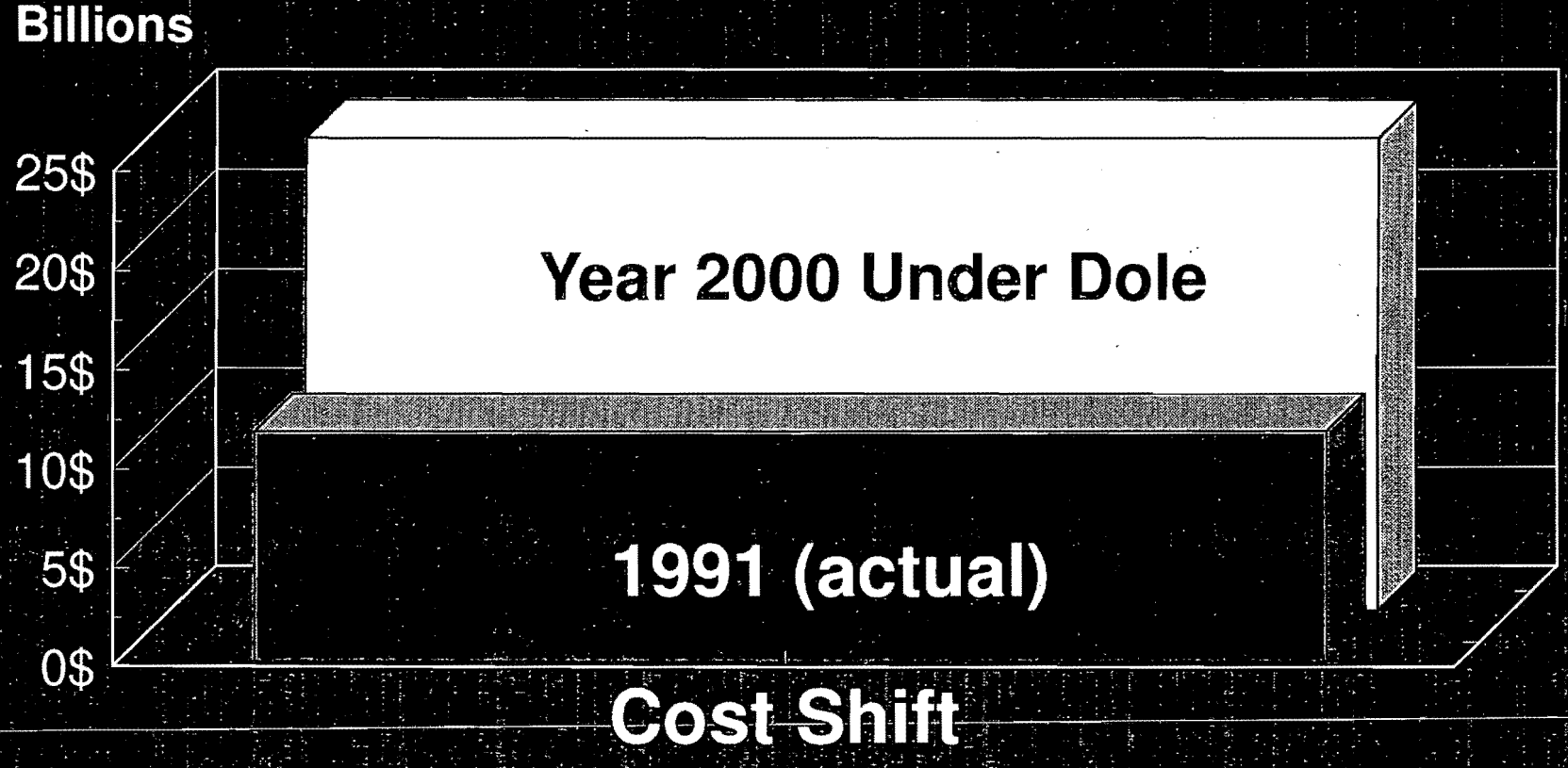


1998-2003 Uncompensated Care Cost Shift

Sources: Calculations based on "Financial Impact of the Managed Competition Act"; "Lewin Analysis of the Health Security Act"; The Dole Plan; CBO April 1994

DOLE PLAN

Hidden Tax On Manufacturers



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

Non-Universal Reforms Fail Other Key Tests

- **Portability:**

"I have great trouble seeing how you get portability without universal coverage." *- Sen. John Chafee (R-RI)*

- **Eliminating Pre-existing Condition Exclusions:**

"[I]t will be nearly impossible without universal coverage."
- The Wall Street Journal

- **Incentives to Work:**

The Cooper plan would create "devastating disincentives to work," resulting in a "near poverty trap."
-Henry Aaron, Brookings Institution

The Dole plan would "make working irrational."
- David Super, Center on Budget and Policy Priorities

Table 10.
Change in Tax Liability for Families Before Transfers If the Tax Exclusion Is Repealed

Income (Dollars)[a]	Number of Families (Millions)	Change in Tax Liability: Income Tax (Millions of dollars)	Change in Tax Liability: Payroll Tax (Millions of dollars)	Change in Tax Liability: Total (Millions of dollars)	Average (Dollars)
1 to 9,999	15.3	-20	240	220	10
10,000 to 19,999	18.3	1,160	1,650	2,810	150
20,000 to 29,999	16.9	4,650	3,700	8,360	500
30,000 to 39,999	13.8	5,150	4,440	9,590	700
40,000 to 49,999	10.7	5,290	4,550	9,850	920
50,000 to 74,999	17.3	11,480	8,770	20,250	1,170
75,000 to 99,999	7.5	7,770	4,040	11,810	1,590
100,000 to 199,999	5.4	6,710	2,490	9,200	1,710
200,000 or More	1.4	1,570	320	1,890	1,390
Total, All Incomes[b]	108.1	43,780	30,290	74,060	690

SOURCE: Congressional Budget Office.

NOTES: Families are groups of related people who live together; people not living with relatives are considered one-person families.

The figures in the table assume that repeal occurs in 1994, based on projected levels of income.

a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.

b. Includes families with negative or zero income.

Removing the tax subsidy would improve the allocation of labor among firms because the subsidy benefits large firms more than small firms (which in spite of the subsidy often do not offer insurance). Repeal would enhance labor mobility because fewer workers would have to worry about losing (or gaining) insurance based on their choice of job. But privately purchased insurance would be more expensive after taxes, and that could provide an additional disincentive to work for low-income households who would qualify for Medicaid if they stayed out of the labor market. As a result, employment of low-wage workers might decline.

The most serious drawback to repealing the tax subsidy without providing an alternative subsidy is that many fewer people would be insured; in addition, some of those who remained insured would face higher premiums because of adverse selection. Based on empirical estimates of how participation responds to changes in price, the number of people covered by insurance could fall by 16 percent to 26 percent if the average price of insurance increased by 35 percent.[20] The people most likely to become uninsured are those who are healthier than average (because without a tax subsidy, insurance would be a bad deal for them) and those who can no longer afford the premiums because of low income or poor health status of a family member. In addition, underwriting costs (determining who is a good or bad risk for health insurance) would increase because there would be fewer group policies. Thus, the gains in efficiency from repealing the subsidy might be offset by the inefficiencies that are inherent in a very selective and costly market for health insurance.

20. These estimates are derived by using the average participation elasticities of -0.6 (estimated by Long and Marquis) and -1.0 (estimated by Gruber and Poterba) as arc elasticities and computing the percentage change, based on an average increase in price from Table 4 of 35 percent (0.26/0.74). See Chapter 4 for a discussion of the elasticity estimates for participation.

Plausibility of

1.5 / 3 / 4.5 phase in of employer model
not ii fully
stakeholders for whole

- Kids 1st

- Bradley employer assessments. free order
cost shift moderate ability
for dependents not providing
moderate ability

free order

Table 4.
Premiums and Tax Subsidies for Families with Employment-Based Health Insurance, by Income

Income (Dollars)[a]	Percentage of Families in Income Class	Average Premium (Dollars)[b]	Employer Share of Premium (Percent)[b]	Average Subsidy (Dollars)	Tax Subsidy as a Percentage of Premiums[b]
1 to 9,999	8	1,830	83	190	11
10,000 to 19,999	34	2,370	80	450	19
20,000 to 29,999	62	3,080	84	800	26
30,000 to 39,999	78	3,650	84	900	25
40,000 to 49,999	85	4,370	86	1,090	25
50,000 to 74,999	89	5,080	87	1,320	26
75,000 to 99,999	91	6,010	87	1,740	29
100,000 to 199,999	89	6,410	88	1,910	30
200,000 or More	76	5,530	89	1,830	33
All Incomes[c]	61	4,310	86	1,130	26

SOURCE: Congressional Budget Office.

NOTE: The table excludes families in which all members are covered by Medicare or Medicaid.

a. Adjusted gross income reported on tax returns plus certain nontaxable forms of income including employers' contributions to the cost of health insurance premiums and tax-exempt interest.

Vertical Equity

Another principle of tax policy is that people with more ability to pay should pay more tax than people with less ability to pay. This principle has been applied to policies like the tax exclusion for health insurance, but it is not clear that the principle is relevant in this case. Although it is easy to show that higher-income people benefit more than lower-income people from most tax exclusions, the net distributional effect of any policy depends on how it is financed. Other aspects of the tax code, such as higher marginal tax rates on other income, are likely to be designed so that the tax code as a whole, including its tax preferences, meets current social perceptions of vertical equity.[1]

1. Charles Clotfelter, "Equity, Efficiency, and the Tax-Treatment of In-Kind Compensation," *National Tax Journal*, vol. 32, no. 1 (1979).

The likelihood of being insured and the amount of the premiums from employment-based health insurance that can be excluded from taxation both increase with income. The average premiums for a family with income of less than $20,000 a year will be under $2,400 in 1994, whereas the average premiums for returns with income of more than $50,000 will be more than twice that amount (see Table 4). The differences in premiums reflect several factors. Higher-income families are more likely to be covered by multiple policies and have family rather than self-only coverage. People in lower-income families are more likely to have been unemployed for part of the year and thus to have had premiums paid for only a portion of it.

The average employer share increases slightly with income, from 83 percent for families with less than $10,000 of income to 89 percent for families with income of more than $200,000. The benefit of the tax exclusion is greatest for high-income people

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David Nexon:

① -Cost containment: voluntary cost containment
followed by triggered premium caps
$47 Billion cost
10 year window & impose controls
- affordable funds and access
not competition

② assessment of premium & base targets

- premium targets subsidies to level.

- alternatives to holding subsidies

Coverage alternatives
- trigger at 93% → individual
hard trigger
soft trigger to
behind the
employer at less than a

cost of core plan 3,000 deductible at
70 probably not covered
- comprehensive for children

- triggers down the way.

DRAFT - 7/5/94

Ideas for Reducing the Number of Uninsured--
without Mandates

NOTE: CBO baseline number of uninsured is 39 million in 1996 (14.6% of the U.S. population), growing to 44 million in 2004. Recent survey data suggests upward revision of baseline (to 41 million in 1996, for example).

(1) Target individual subsidies based on income. Advantage: Targeting low income groups avoids giving subsidies to many people who already have private insurance (less than 25% of the poor have private insurance). Disadvantage: Subsidy has to cover virtually the entire premium if very low income are to get insurance.

Family income as a percent of poverty	Percent of uninsured in category	Percent of uninsured below poverty threshold
<50	13%	13%
50-100	15	28
100-150	18	46
150-200	14	60
200-250	11	71
250-300	8	79
300+	21	

(2) Target pregnant women and children. Advantage: further restricts subsidies, even within the low-income population. Disadvantage: relatively small reduction in the number of uninsured, especially as Medicaid expands through 2002.

By 2002, Medicaid will cover all pregnant women and children under 19 below poverty. Children under 6 below 133% of the poverty line are covered, too.

Children under 19 by family income as a percent of poverty	Percent of uninsured children	Percent of total uninsured	Cumulative reduction in total uninsured by poverty threshold
<50	*18%	*5%	*5%
50-100	*17	*4	*9
100-150	22	6	*15
150-200	16	4	*19
200-250	9	2	*21
250-300	6	2	*23
300+	12	3	*26

(3) Automatic enrollment for Medicaid eligibles. In government surveys, only about three-quarters of those eligible for Medicaid actually report Medicaid coverage. Amounts to as many as 16 percent of uninsured. Advantage of automatic enrollment: reduction in uninsured without altering existing program. Disadvantage: would increase participation in AFDC as well.

(4) Develop mechanisms to extend existing coverage, eliminating shorter uninsured spells. Advantage: targeting the loss of coverage directs public money to those who would otherwise be uninsured. Strategies include (a) extending unemployment insurance (tax and benefits) to subsidize continuation of employer-sponsored coverage for some specified time period; (b) extending subsidies to those losing employer-sponsored coverage under circumstances specified by COBRA; (c) extending coverage to working Medicaid recipients for a second year.

Family income as a percent of poverty	Percent of uninsured	
	Length of spell in months	
	1-24	25 or more
<50	5%	8%
50-100	6	9
100-150	8	10
150-200	6	8
200-250	5	6
250-300	4	4
300+	10	11
All incomes	44	56

(5) Non-discrimination rule. Require employers to insure all employees if they insure any of them (part of Senate Finance bill ?). Advantage: would extend coverage to a significant number of uninsured, if employers choose to offer rather than drop. Disadvantage: some employers will drop rather than cover all employees. Subsidies could be offered as an inducement to insure rather than drop.

Uninsured persons (workers and dependents) associated with firms offering insurance.	Percent of uninsured
All*	32%
Full-time workers	28
Under poverty	4
100 - 150% poverty	5
150 - 200% poverty	5
200 - 250% poverty	4
250 - 300% poverty	3
>300% poverty	8
Part-time workers	4

*Excludes those eligible for Medicaid.

(6) Extend assessment on firms not offering insurance to firms that insure some, but not all of their workers. See (5) above. Such firms account for about half of uninsured workers and their dependents. Will provide revenue to fund bad-debt/charity care or other objectives, but will probably not have much effect on the number of uninsured.

(7) Allow ERISA exemption to permit states to tax providers or premiums (including self-insured plans) to fund bad-debt/charity pool.

(8) Mandate coverage for full-time workers.

Full-time workers and their dependents	Percent of uninsured
All*	54%
Poor	10
100 - 150% of poverty	10
150 - 200% of poverty	10
200 - 250% of poverty	7
250 - 300% of poverty	5
> 300% of poverty	12

*Excludes those eligible for Medicaid.

(9) Make subsidies available only to uninsured employees/employers. Equity considerations aside, such a subsidy scheme is easily gamed. Employers and employees have an incentive to drop coverage in order to qualify for the subsidy.

(a) One approach might be to require individuals/employers to provide evidence of being uninsured for some extended waiting period (2 or 3 years).

(b) Another approach might be to start by extending the coverage of the initially insured, and phase-in subsidies for long uninsured spells over time as follows.

Institute a subsidized extension of coverage for people who lose their employer-sponsored insurance, as in (4). These short-term, time-limited subsidies could be painted as insurance against the possibility of losing one's insurance, and financed by an additional premium or an assessment on payroll. (The short-term subsidies would only be payable for changes in insurance relating to the work- or family-related circumstances of individual workers, not when the employer instituted a wholesale change in benefits affecting some specified percentage of employees.) Individuals would still be required to make a substantial premium contribution, perhaps related to income, during the short-term extension of coverage.

Anyone who exhausted their short-term coverage would then become eligible for a different, long-term subsidy (which would surely be tied to income). Eligibility for the long-term subsidy would be established by participation in the short-term program.

Neither the short-term nor long-term subsidies should be so generous as to compete with the tax-break on employer contributions for middle and upper income families. This kind of an approach should probably be coupled with subsidies to very low-income families at the outset (since they'll never come into insurance). Perhaps the short-term subsidies could be extended to those who lose Medicaid, as well as employer-sponsored insurance.