WHAT WILL HAPPEN IF WE PASS BOB DOLE'S PLAN, INSTEAD OF A UNIVERSAL COVERAGE PLAN ?

- **Middle Class Americans Will Be Left Out**
- **Small Businesses Will Pay More**
- **Government Costs Will Rise**
- **Insurance Reforms Won't Work**
- **Cost Shifting Will Continue**
- **The Number Of Uninsured Will Continue To Increase**

1. Middle Class Americans Will Be Left Out

- Without universal coverage, "**health insurance coverage would probably be more limited for middle income people** than the rich or poor." [CBO, 5/94, pp.17, 20]

- **Partial solutions** will **leave** 24 million Americans, more than two thirds of them in **middle class working families, without coverage.** Their taxes will pay for health care for millions of others who do not work, but they won't be able to get coverage for themselves. [Based on CBO, 7/93; CBO 5/94; Alain Enthoven, Health Affairs, 1993]

- "Already, the fraction of **adults who work but have no** public or private **insurance has risen to 17.5%** in 1992 from 15.3% in 1988, the Census Bureau says. And employment is growing fastest in industries that tend not to offer health insurance." [*"Health-Care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

2. Small Businesses Will Pay More

- The **high cost of insurance** is expected **to cause 30% of small businesses** currently providing insurance **to drop coverage** in the years ahead. This will further raise premiums for the smallest companies that do provide. [Health Affairs, Spring 1992]

- "By using their clout with health care providers to demand lower costs, big employers help squeeze out inefficiencies. But they also stop helping hospitals care for those with no insurance or with government insurance. Those costs won't disappear, however. **As big companies shed them, insurance premiums for smaller employers will be forced up.**" [*"Health care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

3. Government Costs Will Rise

- "Today, many who lack insurance still get health care if they get sick enough, either through federal or local government programs or through charity. But as employers squeeze the health system harder and the number of uninsured grows, free care probably will be harder to find, and the quality is likely to deteriorate. And the **government's costs**, from the Medicaid program for the poor to emergency rooms at municipal hospitals, **will climb.**" [*"Health care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

- "Most of the pending health-reform plans would [require **government to**] spend tens **of billions of dollars a year** so low-income families or their employers can afford insurance." [*"Health-Care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

- "The social and economic **consequences** of once again retreating from far-reaching reform are **clear:** more uninsured Americans and **higher costs for the government.**" [*"Health-Care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

4. Insurance Reforms Won't Work

- "**Universal coverage** is not only a fair and noble objective, consistent with America's values: it is also **essential if health care markets are to work** well." [Editorial Page, The Washington Post, 6/16/94]

- "It will be nearly **impossible without universal coverage ... to outlaw** the common industry **practice of refusing to cover people with** known medical problems, so-called **pre-existing conditions.**" [Wall Street Journal, 6/15/94]

- According to a new study by Families USA, **under a partial solution over one million Americans a month will still lose their insurance.** [Families USA Special Report, 6/94, p.1]

5. Cost Shifting Will Continue

- "Economically, universal coverage is essential to bringing health care cost increases under control; **so long as millions of Americans remain underinsured and uninsured, cost shifting will continue**, leaving a mechanism for unwarranted price inflation in health care." [Star Tribune, 6/16/94]

- "**Lack of full coverage leads to cost shifting** from those who do not pay and those who provide free care, to those who do pay for health insurance ..." [Alain Enthoven, Health Affairs, 1993]

- When the uninsured can't pay their bills, **hospitals shift** these costs onto people with private insurance -- **at a rate of approximately $25 billion a year.** [CBO, 5/93]

- **"We cannot have real savings and real cost containment without universal enrollment.** Such enrollment is not a welcome bonus delivered with cost containment dollars; it is what makes cost containment possible. Only with universality can we eliminate the practice of making patients with insurance pay the medial costs of those without it." [Rashi Fein, Medical Economics, Harvard University]

- "It is the experience of every industrialized democracy with a universal health insurance program that cost control becomes easier when the plan is universal, not harder... that counsel currently offered by critics -- go slow in adding new benefits until we can assure everyone that the savings are real -- is advice that is likely to doom the plan to failure. **Universalism and cost control go hand in hand.**" [Ted Marmor and Jerry Mashaw, Yale University, L.A. Times, 10/7/93]

6. The Number Of Uninsured Will Continue To Increase

- "As big companies shed [costs], insurance premiums for **smaller employers** will be forced up. This probably will lead more of them to **stop offering insurance, to limit coverage for workers' families** or to **rely more on part-timers and temporary workers who often don't get health insurance.**" [*"Health-Care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

- "By putting market pressure on providers to cut costs, **market reforms promoting competition -- absent universal coverage -- could exacerbate access problems.**" [Alain Enthoven]

- "The social and economic **consequences** of once again retreating from far-reaching reform are **clear: more uninsured Americans** and higher costs for the government." [*"Health-Care Inaction Can Carry a High Cost,"* The Wall Street Journal, 6/27/94]

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TO: Chris Jennings

FAX: 456-7431

FROM: Lynn Ethenedge

DATE AND TIME: FW 7/22 2:45 pm

NUMBER OF PAGES: COVER + 4

RETURN FAX NUMBER: (202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL (202)224-7675

We're helping Bobby Rozen by trying to sketch out what of Sen. Mitchell's ideas can be "fast tracked" to get benefits to the public next year.... I sent copies to Larry + Rich, who asked & let you know of the request. Thks!

Comments this afternoon?

be in place for the market to function better will be written into statute, e.g. no pre-existing condition limitations, guaranteed issue/open enrollment. Other standards, e.g. new quality reporting systems, are not essential to the coverage objective and can be phased in later, if necessary.

o Certification of plans for meeting basic standards. This is a normal function of state insurance commissioners

o Employer notification. Employers will need to be notified of new requirements, available plans and community rates. Assuming there will be no mandated contribution, it will not be necessary to issue regulations on employer contribution shares or amounts.

o Consumer information. State governments can make available the basic information on what plans are available, their rates for standardized coverage, how to sign up, etc. even if purchasing cooperatives are not available.

o Implementation. With expedited government action on the four essential steps above, the first phase of implementation could begin next year. After July 1, 1995, all new insurance contracts would be required to conform to the basic healthcare reform standards. Existing contracts could remain in effect until their expiration date or until January 1, 1996, whichever was earlier.

2. Coverage of children The healthcare reform legislation also involves income-tested vouchers for pregnant women and children coverage, e.g. to 185% of poverty. Extended coverage of these populations is a priority for improving health and for assisting lower-income families.

Actions needed:

o Administrative capability. The core administrative structure, forms, procedures for income-testing an above-welfare population already exists in state Medicaid programs. All states already have Medicaid extensions for pregnant women and young children to 133% of poverty, and 34 states already provide coverage to 185% of poverty.

o Child health benefit plans. The basic benefits will be specified in statute, but details may need to be added by a National Health Board. Insurers will need to develop child-only health policies, but will have an actuarial base for making premium bids in their family coverage policy data. As well, some 31 states already have children-only private

insurance programs.

o Procedures for issuance of vouchers to individuals and/or selected health plans. These will need to be thought out and ready to go, but there are operating models, e.g. New York's Child Health Plus program.

o Maintenance of effort rules. The federal government will need to specify the assurances needed and information that will guarantee that applicants are uninsured and that maintenance of effort (or non-discrimination) rules are being followed

o Implementation With these elements in place, states should be able to open their programs as of July I, 1995, when other program elements start.

3. FEHBP One of the publicly appealing elements of reform is to make available the FEHBP plans to all individuals in the community-rated pools.

Actions needed.

o Benefit specification, community-rating areas, other standards. FEHBP will have same requirements as other insurers, so the government actions for the non-FEHBP plans, described above, should suffice.

o Enrollment and premium collection. Plans can enroll people directly, so there is no need for the federal government to set up new mechanisms for collecting premiums and handling enrollment.

4. Health insurance purchasing cooperatives These are not essential for a "fast start" on health reform, as health insurance plans and FEHBP plans can offer directly. But many organizations may wish to qualify, particularly if new community-rated plans become available next July. Speeding up development of the cooperatives would help to make the market work better for consumers.

Actions needed:

o Purchasing cooperative standards and certification. This will be a major state oversight responsibility. Federal regulations for a state plan will be needed, but this can be a separate state plan, review and approval process from lengthier and more complex plans that involve the spending of federal subsidy funds.

5. Fast-tracking government Expediting federal actions is one of the biggest problems for a "fast track" strategy. At the accepted-norm implementation pace, healthcare reform could take several years to get going, i.e. starting up a new National Health Board, development of regulations and specifications for state plans, state legislative actions and development of state plans, plan review and approval. Portions of this process can be fast-tracked to get priority implementation started next year.

Actions needed:

o National Health Board. The healthcare reform statute can provide for naming an "interim" National Health Board (e.g. Cabinet Secretaries) as soon as the bill is signed.

o Federal regulations. The reform statute can also provide for implementation under expedited procedures permitted by the Federal Administrative Procedures Act, i.e. issuance of immediately-effective "interim final" regulations.

o State legislative action. Most states have their legislative sessions starting in January; typically, these sessions last just a few months. Some of the "fast track" items may require legislative approval, at least in some states, e.g. okaying state agencies to carry out the health reform functions, adding staff. If the federal government misses this short "window of opportunity" key elements of healthcare reform may be delayed until 1996. Thus, the basic regulations for "fast track" elements that involve state actions need to be ready by December, 1994, preferably earlier.

SUMMARY OF RECENT OPTIONS (Effects from 1995-2004)

22-Jul-94
11:47 AM

	(A) **7.7 Plan** CR=500; exmpt<25 Mandate in 2000	(B) **7.7 Plan** CR=500; No Mandate	(C) **7.18 Plan** CR=500; exmpt<25 Mandate in 2000 No Prem Caps	(D) **7.18 Plan** CR=500; exmpt<25 Mandate in 2000 With Prem Caps	(E) **7.18 Plan** CR=500; No Mandate No Prem Caps
Subsidies	1300	1147	1077	1077	885
Medicare Savings	-249	-249	-250	-250	-250
Medicaid Savings	-544	-534	-546	-546	-518
State Medicaid MOE	-225	-225	-303	-303	-303
PHS/AHC/GME	95	95	92	92	91
Long Term Care	48	48	48	48	48
Medicare Drug	92	92	92	92	92
Subsidy Admin.	*	*	*	*	*
Tobacco Tax	-110	-110	-60	-60	-60
High Cost Plan Tax	-46	-46	-97	-65	-88
Net Other Revenues	-167	-167	-169	-185	-151
NET DEFICIT EFFECT	193	51	-116	-100	-254

All mandate plans share: ER mandate 50%
8% individual wage cap
8% HH income cap for 50% share

SUBSIDIES AND INSURANCE TAKE UP FOR 7.18 OPTION (Subsidies in Billions $, Fiscal Year)

No Mandate, Subsidy Detail

(7/20/94--4:00 pm)

	1997 Subs	%Pop Ins	1998 Subs	%Pop Ins	2000 Subs	%Pop Ins	2002 Subs	%Pop Ins	2004 Subs	%Pop Ins	1995-1999 Subs	1995-2004 Subs
Pre-M Low income vouchers	35.5	1.3-2.5	65.7	2.0-3.3	72.6	2.0-3.3	60.2	1.3-2.5	44.3	1-1.7	170.4	466.7
Pre-M Outreach for Low income	1.9	.5	3.5	.6	3.8	.6	3.2	.5	2.4	.3	9.0	24.5
Pre-M MCD Transition +	2.3	.6	4.4	.8	4.8	.8	4.0	.6	3.0	.4	11.3	31.0
Pre-M Job-Loss Cobra +	3.2	.8-1.7	5.8	1.3-2.2	6.4	2-2.2	5.4	.9-1.7	4.0	.7-1.1	15.2	41.6
Pre-M PW+K	3.2	1.1	5.8	1.5	6.4	1.5	5.3	1.1	3.8	.8	15.1	41.1
Pre-M Emp. who don't offer	0.4	.1-.3	0.7	.14-.4	0.8	.2-.4	0.8	.1-.3	0.8	.1-.3	1.9	5.9
Pre-M Emp. who don't cover all	1.4	.3-1	2.6	.6-1.3	2.7	.7-1.2	2.7	.3-1.1	2.7	.3-.1	6.6	20.1
Pre-M Medicaid Cash Subs	16.5		23.1		27.3		33.0		40.2		64.6	231.6
OOP subsidy	2.0		2.0		3.0		3.0		4.0		6.0	23.0
Total Subsidy	66.3		113.7		127.9		117.5		105.1		300.0	885.6
Baseline Percent Insured		85%		85%		85%		85%		84%		
Total Percent Insured		90-93%		92-95%		92-95%		90-93%		88-90%		
Baseline Uninsured		40		40		41		43		44		
Percent of Uninsured Covered		35-55%		52-65%		52-65%		35-55%		24-42%		
Total Percent Insured with a Mandate in 2000		90-93%		92-95%		100%		100%		100%		

IMPACT OF PRE-MANDATE POLICIES ON COVERAGE*

22-Jul-94
02:21 PM

POLICY	Number Covered (millions)	% of Total Uninsured Covered (Base=40 mill.)	% Added To Total Insured Population
Low income vouchers	10 - 11	25 - 28%	3.8 - 4.2%
Medicaid Transition	1.5 - 2	4 - 5%	0.6 - 0.8%
Job Loss COBRA	1.2 - 2.5	3 - 6%	0.5 - 0.9%
Preg Women & Kids	2.9 - 4.5	7 - 11%	1.1 - 1.7%
Empls <25, no coverage	0.8 - 1	2 - 3%	0.3 -0.4%
Empls with partial coverage	1.7 - 3	4 - 8%	0.6 - 1.1%
Other insurance reform	1-2	3 - 5%	0.4 - .8%
TOTAL	19 - 26	47 - 65%	7 - 10%

* Assumes fully implemented policies before indexing of subsidies.

Model 7.18.94 — CR pool 500, Exemption 25, Hard Trigger in 2000, no premium caps

07/20/94
01:07 PM

	Fiscal Years											
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-200
Outlays												
Mandate Subsidies (CY, '94 $)	0.00	0.00	0.00	0.00	0.00	114.59	118.07	121.65	125.34	129.14	0	608.79
Mandate Subsidies (CY, nominal $)	0.00	0.00	0.00	0.00	0.00	136.83	145.21	154.10	163.54	173.56	0	773.23
Mandate Subsidies (FY)	0.00	0.00	0.00	0.00	0.00	102.82	143.11	151.88	161.18	171.05	0	729.84
Pre-Mandate Low income vouchers	0	0	35.496	65.7425	69.15025	17.49825	0	0	0	0	170.3888	187.89
Pre-Mandate Outreach for Low income	0	0	1.671438	3.46575	3.6455	0.9225	0	0	0	0	8.982688	9.91
Pre-Mandate MCD Transition +	0	0	2.352936	4.35775	4.58325	1.15975	0	0	0	0	11.29394	12.45
Pre-Mandate Job-Loss Cobra +	0	0	3.141	5.8165	6.1175	1.548	0	0	0	0	15.075	16.62
Pre-Mandate PW+K	0	0	3.132	5.8035	6.1085	1.546	0	0	0	0	15.044	16.59
Pre-M Emp. who don't offer	0	0	0.397688	0.7385	0.77675	0.1965	0	0	0	0	1.912938	2.11
Pre-M Emp. who don't cover all	0	0	1.330313	2.4685	2.60275	0.659	0	0	0	0	6.401563	7.06
Pre-M Medicaid Cash Subsidies	0	0	16.46453	23.12767	24.95157	6.834768					64.54377	71.38
OOP subsidy	0	0	2	2	2	3	3	3	4	4	6	23.00
Total Net Subsidies	0	0	66.1859	113.5207	119.9361	135.9837	146.111	154.8771	165.1802	175.053	299.6426	1076.85
Medicaid											0	
Baseline	96.4	108.2	121.5	136.3	152.2	170.4	190.8	213.6	239.1	267.6	614.6	1696.10
Acute											0	
DSH											0	
											0	
Proposed Savings	0	0	24.6	50.2	56.3	63.3	74.2	83.7	92.4	101.3	131.1	546.00
Acute	0	0	17.9	40.4	45.6	51.5	57.6	64.4	71.3	78.4	103.9	427.30
DSH	0	0	6.7	9.8	10.7	11.8	16.4	19.3	21.1	22.9	27.2	118.70
MOE	0	0	21.1	30.6	33.6	36.6	39.9	43.4	47	51.1	85.3	303.30
State Acute MOE	0	0	19.2	27.9	30.6	33.4	36.4	39.6	42.9	46.6	77.7	276.60
State DSH MOE	0	0	1.9	2.7	3	3.2	3.5	3.8	4.1	4.5	7.6	26.70
Net Proposed	96.4	108.2	96.9	86.1	95.9	107.1	116.6	129.9	146.7	166.3	483.5	1150.10
Acute											0	
DSH											0	
											0	
Medicare											0	
Baseline	158.1	176	194	213.1	235.5	260.6	289.1	321.1	357	397.9	976.7	2602.60
Part A											0	
Part B											0	
Premiums											0	
Proposed Savings	1.964	6.675	9.864	14.538	21.139	26.436	31.79	38.407	45.793	53.492	54.38	250.30
Part A											0	
Part B											0	
Premiums											0	
Net Proposed	156.136	169.125	184.136	204.662	226.661	247.264	271.11	297.393	326.907	361.108	940.72	2444.50
Part A	0	0	0	0	0	0	0	0	0	0	0	0.00
Part B	0	0	0	0	0	0	0	0	0	0	0	0.00
Premiums	0	0	0	0	0	0	0	0	0	0	0	0.00
											0	0.00
Other Federal Programs											0	
Baseline	0	0	0	0	0	0	0	0	0	0	0	0.00
PHS											0	
FEHB,DOD,VA											0	
AHC											0	
Net New Proposed	0	0.383333	7.011905	10.30333	11.2639	12.32722	12.54227	12.50403	12.70994	12.86473	26.96248	91.91
PHS											0	0.00
FEHB,DOD,VA											0	0.00
AHC			7.25	8.22	9.4	10.84	11.172	11.7306	12.31713	12.93299	24.87	83.66
target growth (cum. nom.)		1.07	1.13955	1.207923	1.274359	1.338077	1.404981	1.47523	1.548991	1.626441	4.691832	12.09
less ime			4.5	4.8	5.3	5.9	6.5	7.1	7.8	8.6	14.6	50.50
GME+			4.05	6.4	6.752	7.0896	7.44408	7.816284	8.207098	8.617453	17.202	56.38
less dme			2.2	2.3	2.5	2.6	2.8	2.9	3.1	3.3	7	21.70
HS Infrastructure			1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	3.9	10.40
Biomed (1/7 of 1.75%)		0.00	0.73	1.10	1.23	1.41	1.54	1.66	1.79	1.91	3.057143	11.37
WIC	0	0.383333	0.383333	0.383333	0.383333	0.383333	0.383333					
New Programs	0	0	0	7.9	15.2	16.5	18.8	23	27.1	32.1	23.1	140.60
LTC	0	0	0	1.8	2.9	3.6	.5	6.3	11.4	15.4	4.7	48.40
Medicare Drug	0	0	0	6.1	12.3	12.9	13.8	14.7	15.7	16.7	18.4	92.20
Subsidy Administration	1.05	0.825	1.05	3.9	3.825	4.125	5.325	5.025	5.475	6.15	10.65	36.75
0.75	1.4	1.1	1.4	5.2	5.1	5.5	7.1	6.7	7.3	8.2	14.2	49.00
Net Outlay Deficit Effect	-1.96	-6.49	17.63	36.39	35.36	38.47	31.56	24.67	19.80	14.13	80.92512	209.76
											0	
REVENUES											0	
											0	
Tobacco	1.2	6.8	6.7	6.7	6.6	6.6	6.5	6.5	6.4	6.4	28	60.40
Experience Rated Plan Assessment"			4.1	6.1	6.6	5.2	4.7	5.1	5.5	5.9	16.8	43.20
High Cost Plan Assessment		0	0.6	1.3	2.4	8.2	13.1	17.2	23.4	30.6	4.3	96.80
1.75% for AHC/GME		0	5.1	7.7	6.6	9.9	10.8	11.6	12.5	13.4	21.4	79.60
Cafeteria Plan Restrictions			3.5	5.5	6.7	12.6	15.9	17	18.4	19.9	15.7	99.50
MISC JCT												
MISC OTA		-0.2	-0.6	-0.7	-0.7	-0.7	-0.9	-1.2	-1.2	-1.3	-2.2	-7.50
Net Change in Tax Expenditures (s.e.)	-0.6	-0.7	-1.2	-1.3	-1.4	-1.5	-1.3	-1.4	-1.5	1.5	-5.2	-9.40
Indirect Tax Effects			1.7	3.3	4.1	0.6	-1	-0.5	-0.8	-0.8	9.1	6.60
Medicare Pt. B Recapture* (incl. HI)		1.9	3.1	2.8	2.9	2.7	2.7	2.7	2.8	3	10.7	24.60
Medicare HI tax on S&L employees											0	0.00
											0	0.00
Net Revenue Deficit Effect	-0.6	-5.9	-15.8	-22.5	-26.3	-35.7	-43.1	-49.2	-57.2	-69.7	-71.1	-326.00
Net other revenue (net net - tob, - hcp)	0.6	0.9	-8.5	-14.5	-17.3	-20.9	-23.5	-25.5	-27.4	-32.7	-38.8	-168.80
NON-ADD: Tax Expenditures											0	
baseline	84.7	92.4	99.5	107.4	117	127.3	137.8	149.2	161.5	174.5	501	1251.30
proposed	85.3	93.1	100.7	108.7	118.4	128.8	139.1	150.6	163	173	506.2	1260.70
Net Overall Deficit Effect	-2.564	-12.3917	1.833809	13.886	9.060977	2.774931	-11.5367	-24.3258	-37.4029	-55.5742	9.825119	-116.24

Model 7.18.94 — CR pool 600, Exemption 25, Hard Trigger in 2000, WITH premium caps

07/29/94
01:07 PM

	Fiscal Years 1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-200
Outlays												
Mandate Subsidies (CY, '94 $)	0.00	0.00	0.00	0.00	0.00	114.59	118.07	121.65	125.34	129.14	0	608.79
Mandate Subsidies (CY, nominal $)	0.00	0.00	0.00	0.00	0.00	136.83	145.21	154.10	163.54	173.56	0	773.23
Mandate Subsidies (FY)	0.00	0.00	0.00	0.00	0.00	102.62	143.11	151.68	161.18	171.05	0	729.64
Pre-Mandate Low income vouchers	0	0	35.496	65.7425	69.15025	17.49825	0	0	0	0	170.3888	187.89
Pre-Mandate Outreach for Low income	0	0	1.871438	3.46575	3.6455	0.9225	0	0	0	0	8.982688	9.91
Pre-Mandate MCD Transition +	0	0	2.352938	4.35775	4.58325	1.15975	0	0	0	0	11.29394	12.45
Pre-Mandate Job-Loss Cobra +	0	0	3.141	5.8165	6.1175	1.548	0	0	0	0	15.075	16.62
Pre-Mandate PW+K	0	0	3.132	5.8035	6.1085	1.546	0	0	0	0	15.044	16.59
Pre-M Emp. who don't offer	0	0	0.397688	0.7385	0.77675	0.1965	0	0	0	0	1.912938	2.11
Pre-M Emp. who don't cover all	0	0	1.330313	2.4685	2.60275	0.659	0	0	0	0	6.401563	7.06
Pre-M Medicaid Cash Subsidies	0	0	16.46453	23.12767	24.95157	6.834768					64.54377	71.38
OOP subsidy	0	0	2	2	2	3	3	3	4	4	6	23.00
Total Net Subsidies	0	0	66.1859	113.5207	119.9361	135.9837	146.111	154.6771	165.1802	175.053	299.6426	1076.85
Medicaid											0	
Baseline	96.4	108.2	121.5	136.3	152.2	170.4	190.8	213.6	239.1	267.6	614.6	1696.10
Acute											0	
DSH											0	
											0	
Proposed Savings	0	0	24.6	50.2	56.3	63.3	74.2	83.7	92.4	101.3	131.1	546.00
Acute	0	0	17.9	40.4	45.8	51.5	57.8	64.4	71.3	78.4	103.9	427.30
DSH	0	0	6.7	9.8	10.7	11.8	16.4	19.3	21.1	22.9	27.2	118.70
MOE	0	0	21.1	30.6	33.6	36.6	39.9	43.4	47	51.1	85.3	303.30
State Acute MOE	0	0	19.2	27.9	30.6	33.4	36.4	39.6	42.9	46.6	77.7	276.60
State DSH MOE	0	0	1.9	2.7	3	3.2	3.5	3.8	4.1	4.5	7.6	26.70
Net Proposed	96.4	108.2	96.9	86.1	95.9	107.1	116.6	129.9	146.7	166.3	483.5	1150.10
Acute											0	
DSH											0	
											0	
Medicare											0	
Baseline	158.1	176	194	213.1	235.5	260.8	289.1	321.1	357	397.9	976.7	2602.60
Part A											0	
Part B											0	
Premiums											0	
Proposed Savings	1.964	6.675	9.864	14.538	21.139	26.436	31.79	38.407	45.793	53.492	54.38	250.30
Part A											0	
Part B											0	
Premiums											0	
Net Proposed	156.136	169.125	184.136	204.662	226.661	247.264	271.11	297.393	326.907	361.108	940.72	2444.50
Part A	0	0	0	0	0	0	0	0	0	0	0	0.00
Part B	0	0	0	0	0	0	0	0	0	0	0	0.00
Premiums	0	0	0	0	0	0	0	0	0	0	0	0.00
											0	0.00
Other Federal Programs											0	
Baseline	0	0	0	0	0	0	0	0	0	0	0	0.00
PHS											0	
FEHB,DOD,VA											0	
AHC											0	
Net New Proposed	0	0.383333	7.011905	10.30333	11.2639	12.35579	12.59941	12.57546	12.76709	12.93615	26.96248	92.20
PHS											0	0.00
FEHB,DOD,VA											0	0.00
AHC			7.25	8.22	9.4	10.64	11.172	11.7306	12.31713	12.93299	24.87	83.66
target growth (cum. nom.)		1.07	1.13955	1.207923	1.274359	1.338077	1.404981	1.47523	1.548991	1.626441	4.691832	12.09
less ime			4.5	4.8	5.3	5.9	6.5	7.1	7.8	8.6	14.6	50.50
GME+			4.05	6.4	6.752	7.0896	7.44408	7.816284	8.207098	8.617453	17.202	56.38
less dme			2.2	2.3	2.5	2.6	2.8	2.9	3.1	3.3	7	21.70
HS Infrastructure			1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	3.9	10.40
Biomed (1/7 of 1.75%)		0.00	0.73	1.10	1.23	1.44	1.60	1.73	1.64	1.99	3.057143	11.66
WIC	0	0.383333	0.383333	0.383333	0.383333	0.383333	0.383333					
New Programs	0	0	0	7.9	15.2	16.5	18.8	23	27.1	32.1	23.1	140.60
LTC	0	0	0	1.8	2.9	3.6	5	8.3	11.4	15.4	4.7	48.40
Medicare Drug	0	0	0	6.1	12.3	12.9	13.8	14.7	15.7	16.7	18.4	92.20
Subsidy Administration	1.05	0.825	1.05	3.9	3.825	4.125	5.325	5.025	5.475	6.15	10.65	36.75
0.75	1.4	1.1	1.4	5.2	5.1	5.5	7.1	6.7	7.3	6.2	14.2	49.00
Net Outlay Deficit Effect	-1.96	-8.49	17.63	36.39	35.36	38.50	31.62	24.95	19.85	14.20	80.92512	210.05
											0	
REVENUES											0	
											0	
Tobacco	1.2	6.8	6.7	6.7	6.6	6.6	6.5	6.5	6.4	6.4	28	60.40
Experience Rated Plan Assessment*			4.1	6.1	6.6	5.3	4.9	5.3	5.7	6.2	16.8	44.20
High Cost Plan Assessment		0	0.8	1.3	2.4	5.2	6.4	11.5	15	20.2	4.3	64.60
1.75% for AHC/GME		0	5.1	7.7	8.6	10.1	11.2	12.1	12.9	13.9	21.4	61.60
Cafeteria Plan Restrictions			3.5	5.5	6.7	12.2	15.3	16.3	17.5	18.8	15.7	95.60
MISC JCT												
MISC OTA		-0.2	-0.6	-0.7	-0.7	-0.7	-0.9	-1.2	-1.2	1.8	-2.2	-4.40
Net Change in Tax Expenditures (s.e.)	-0.6	-0.7	-1.2	-1.3	-1.4	-1.5	-1.3	-1.4	-1.4	-1.5	-5.2	-12.30
Indirect Tax Effects			1.7	3.3	4.1	2.5	1.9	2.6	3.8	4.5	9.1	24.60
Medicare Pt. B Recapture* (incl. HI)		1.9	3.1	2.8	2.9	2.7	2.7	2.7	2.8	3	10.7	24.60
Medicare HI tax on S&L employees											0	0.00
											0	0.00
Net Revenue Deficit Effect	-0.6	-5.9	-15.8	-22.5	-26.3	-34.4	-41.1	-46.6	-53	-64.1	-71.1	-310.30
Net other revenue (net net - tob. - hcp)	0.6	0.9	-8.5	-14.5	-17.3	-22.6	-26.2	-28.6	-31.6	-37.5	-38.8	-185.30
NON-ADD: Tax Expenditures											0	
baseline	84.7	92.4	99.5	107.4	117	127.3	137.8	149.2	161.5	174.5	501	1251.30
proposed	85.3	93.1	100.7	108.7	118.4	126.8	139.1	150.6	162.9	176	506.2	1263.60
Net Overall Deficit Effect	-2.564	-12.3917	1.833809	13.886	9.060977	4.103502	-9.47954	-21.6544	-33.1458	-49.9028	9.825119	-100.25

Model 7.18.94 **CR pool 500, NO MANDATE, no premium caps**

07/20/94
01:07 PM

	Fiscal Years											
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-200
Outlays												
Mandate Subsidies (CY, '94 $)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	0.00
Mandate Subsidies (CY, nominal $)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	0.00
Mandate Subsidies (FY)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0	0.00
Pre-Mandate Low income vouchers	0	0	35.496	65.7425	89.15025	72.64923	66.78462	60.14051	52.65302	44.25381	170.3888	486.87
Pre-Mandate Outreach for Low income	0	0	1.871438	3.46575	3.6455	3.830036	3.520856	3.170581	2.775844	2.333041	8.982688	24.81
Pre-Mandate MCD Transition +	0	0	2.352938	4.35775	4.58325	4.81505	4.426355	3.985996	3.48974	2.933056	11.29394	30.94
Pre-Mandate Job-Loss Cobra +	0	0	3.141	5.8165	8.1175	8.426986	5.908168	5.32039	4.658001	3.914957	15.075	41.30
Pre-Mandate PW+K	0	0	3.132	5.8035	8.1085	8.418683	5.900535	5.313518	4.651983	3.909899	15.044	41.24
Pre-M Emp. who don't offer	0	0	0.397688	0.7385	0.77875	0.8	0.8	0.8	0.8	0.8	1.912938	5.91
Pre-M Emp. who don't cover all	0	0	1.330313	2.4685	2.60275	2.7	2.7	2.7	2.7	2.7	6.401563	19.90
Pre-M Medicaid Cash Subsidies	0	0	16.46453	23.12767	24.95157	27.33907	30.08387	33.00225	36.44689	40.21531	64.54377	231.81
OOP subsidy	0	0	2	2	2	3	3	3	4	4	6	23.00
Total Net Subsidies	0	0	66.1859	113.5207	119.9361	127.9791	123.1044	117.4332	112.1755	105.0601	299.6426	885.39
Medicaid											0	
Baseline	98.4	108.2	121.5	136.3	152.2	170.4	190.8	213.8	239.1	267.8	614.6	1896.10
Acute											0	
DSH											0	
											0	
Proposed Savings	0	0	24.8	50.2	56.3	63.3	70.1	77.1	84.4	91.9	131.1	517.90
Acute	0	0	17.9	40.4	45.8	51.5	57.8	64.4	71.3	78.4	103.9	427.30
DSH	0	0	6.7	9.8	10.7	11.8	12.3	12.7	13.1	13.5	27.2	90.60
MOE	0	0	21.1	30.8	33.8	36.6	39.9	43.4	47	51.1	65.3	303.30
State Acute MOE	0	0	19.2	27.9	30.8	33.4	36.4	39.6	42.9	46.6	77.7	276.60
State DSH MOE	0	0	1.9	2.7	3	3.2	3.5	3.8	4.1	4.5	7.6	26.70
Net Proposed	96.4	108.2	96.9	86.1	95.9	107.1	120.7	136.5	154.7	175.7	483.5	1178.20
Acute											0	
DSH											0	
											0	
Medicare											0	
Baseline	158.1	176	194	213.1	235.5	260.8	289.1	321.1	357	397.9	976.7	2602.60
Part A											0	
Part B											0	
Premiums											0	
Proposed Savings	1.964	6.875	9.864	14.538	21.139	26.436	31.79	38.407	45.793	53.492	54.38	250.30
Part A											0	
Part B											0	
Premiums											0	
Net Proposed	156.136	169.125	184.136	204.662	226.661	247.264	271.11	297.393	326.907	361.108	940.72	2444.50
Part A	0	0	0	0	0	0	0	0	0	0	0	0.00
Part B	0	0	0	0	0	0	0	0	0	0	0	0.00
Premiums	0	0	0	0	0	0	0	0	0	0	0	0.00
											0	0.00
Other Federal Programs											0	
Baseline	0	0	0	0	0	0	0	0	0	0	0	0.00
PHS											0	
FEHB,DOD,VA											0	
AHC											0	
Net New Proposed	0	0.383333	7.011905	10.30333	11.2639	12.2415	12.42798	12.38974	12.58137	12.73615	28.96248	91.34
PHS											0	0.00
FEHB,DOD,VA											0	0.00
AHC			7.25	8.22	9.4	10.64	11.172	11.7306	12.31713	12.93299	24.87	83.66
target growth (cum. nom.)		1.07	1.13955	1.207923	1.274359	1.338077	1.404981	1.47523	1.548991	1.626441	4.691832	12.09
less ime			4.5	4.8	5.3	5.9	6.5	7.1	7.8	8.6	14.6	50.50
GME+			4.05	6.4	6.752	7.0896	7.44408	7.816284	8.207098	8.617453	17.202	56.38
less dme			2.2	2.3	2.5	2.6	2.8	2.9	3.1	3.3	7	21.70
HS Infrastructure			1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	3.9	10.40
Biomed (1/7 of 1.75%)		0.00	0.73	1.10	1.23	1.33	1.43	1.54	1.66	1.79	3.057143	10.80
WIC	0	0.383333	0.383333	0.383333	0.383333	0.383333	0.383333					
New Programs	0	0	0	7.9	15.2	18.5	18.8	23	27.1	32.1	23.1	140.60
LTC	0	0	0	1.8	2.9	3.8	5	8.3	11.4	15.4	4.7	48.40
Medicare Drug	0	0	0	6.1	12.3	12.9	13.8	14.7	15.7	16.7	18.4	92.20
Subsidy Administration	1.05	0.825	1.05	3.9	3.825	4.125	5.325	5.025	5.475	8.15	10.65	36.75
0.75	1.4	1.1	1.4	5.2	5.1	5.5	7.1	6.7	7.3	8.2	14.2	49.00
Net Outlay Deficit Effect	-1.96	-6.49	17.63	36.39	35.36	30.38	12.54	-6.08	-25.34	-46.60	80.92512	45.84
											0	
REVENUES											0	
											0	
Tobacco	1.2	6.8	8.7	6.7	6.6	6.6	6.5	8.5	6.4	6.4	28	60.40
Experience Rated Plan Assessment*			4.1	6.1	6.6	8.4	6.6	7.1	7.7	8.4	16.8	53.00
High Cost Plan Assessment		0	0.6	1.3	2.4	7.4	11.6	15.5	21.2	27.7	4.3	87.90
1.75% for AHC/GME		0	5.1	7.7	8.6	9.3	10	10.8	11.6	12.5	21.4	75.60
Cafeteria Plan Restrictions			3.5	5.5	6.7	10.3	12.3	13.2	13.8	14.6	15.7	79.90
MISC JCT												
MISC OTA		-0.2	-0.6	-0.7	-0.7	-0.7	-0.9	-1.2	-1.2	-1.8	-2.2	-4.40
Net Change in Tax Expenditures (s.e.)	-0.6	-0.7	-1.2	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.8	-5.2	-13.60
Indirect Tax Effects			1.7	3.4	4.2	1.6	0.4	0.8	0.7	0.9	9.3	13.70
Medicare Pt. B Recapture* (incl. HI)		1.9	3.1	2.8	2.9	2.7	2.7	2.7	2.8	3	10.7	24.60
Medicare HI tax on S&L employees											0	0.00
											0	0.00
Net Revenue Deficit Effect	-0.6	-5.9	-15.8	-22.6	-26.4	-33	-38.5	-43.9	-50.7	-62.1	-71.3	-299.50
Net other revenue (net net - tob. - hcp)	0.6	0.9	-8.5	-14.6	-17.4	-19	-20.2	-21.9	-23.1	-28	-39	-151.20
NON-ADD: Tax Expenditures											0	
baseline	84.7	92.4	99.5	107.4	117	127.3	137.8	149.2	161.5	174.5	501	1251.30
proposed	85.3	93.1	100.7	108.7	118.4	128.8	139.4	150.9	163.3	176.3	506.2	1264.90
Net Overall Deficit Effect	-2.564	-12.3917	1.833809	13.786	8.960977	-2.61543	-25.9576	-49.984	-76.0362	-108.696	9.625119	-253.66

Special Targeted Subsidies Under Alternative Drop-Off Assumptions

FY (No Mandate)	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999	1995-2004
phase:			0.75				0.875	0.75	0.625	0.5		
Pre-Mandate Low income vouchers	0	0	35.5	65.7	69.2	72.6	66.8	60.1	52.7	44.3	170.4	466.9
Pre-Mandate Outreach for Low income	0	0	1.9	3.5	3.6	3.8	3.5	3.2	2.8	2.3	9.0	24.6
Pre-Mandate MCD Transition +	0	0	2.4	4.4	4.6	4.8	4.4	4.0	3.5	2.9	11.3	30.9
Pre-Mandate Job-Loss Cobra +	0	0	1.6	2.9	3.1	3.2	3.0	2.7	2.3	2.0	7.5	20.7
Pre-Mandate PW+K	0	0	3.1	5.8	6.1	6.4	5.9	5.3	4.7	3.9	15.0	41.2
Pre-M Emp. who don't offer	0	0	0.4	0.7	0.8	0.8	0.8	0.8	0.8	0.8	1.9	5.9
Pre-M Emp. who don't cover all	0	0	1.3	2.5	2.6	2.7	2.7	2.7	2.7	2.7	6.4	19.9
Total Special Subsidies			46.2	85.5	89.9	94.4	87.1	78.8	69.4	58.9	221.6	610.1

FY (No Mandate)												
phase:			0.75									
Pre-Mandate Low income vouchers	0	0	35.5	65.7	69.2	72.6	76.3	80.2	84.2	88.5	170.4	572.3
Pre-Mandate Outreach for Low income	0	0	1.9	3.5	3.6	3.8	4.0	4.2	4.4	4.7	9.0	30.2
Pre-Mandate MCD Transition +	0	0	2.4	4.4	4.6	4.8	5.1	5.3	5.6	5.9	11.3	37.9
Pre-Mandate Job-Loss Cobra +	0	0	1.6	2.9	3.1	3.2	3.4	3.5	3.7	3.9	7.5	25.3
Pre-Mandate PW+K	0	0	3.1	5.8	6.1	6.4	6.7	7.1	7.4	7.8	15.0	50.6
Pre-M Emp. who don't offer	0	0	0.4	0.7	0.8	0.8	0.8	0.8	0.8	0.8	1.9	5.9
Pre-M Emp. who don't cover all	0	0	1.3	2.5	2.6	2.7	2.7	2.7	2.7	2.7	6.4	19.9
Total Special Subsidies			46.2	85.5	89.9	94.4	99.0	103.9	108.9	114.3	221.6	742.1

Adjustments for premiums sans growth and HCPA

Mitchell 7.18.94

Post-Mandate

	500 CR	500 ER
benefit package	0.92	0.92
demographics	1.02	0.98
cost-sharing for AFDC	1.01	1.01 → DIRECT FEDERAL COST
AHC/GME add. to HSA	1.0025	1.0025
Risk adjustment across pools	0.985	1.015
NET PREMIUM ADJ.	0.935901	0.926586

Pre-Mandate

	500 CR	500 ER
benefit package	0.92	0.92
demographics	1.02	0.98
selection (voluntary)	1.04	1.02
cost-sharing for AFDC	1.01	1.01
AHC/GME add. to HSA	1.0025	1.0025
Risk adjustment across pools	0.97705	1.02295
NET PREMIUM ADJ.	0.965481	0.95252

Final premium paths multiples for CBO premiums, $1994

year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
baseline real premium growth, per capita	1.050595	1.051587	1.051587	1.048611	1.048611	1.047619	1.044643	1.043651	1.052	1.049
Mitchell/Bradley target growth 7/18	1.050595	1.051587	1.03	1.025	1.02	1.02	1.02	1.02	1.02	1.02
CR target path (net premium adj. = 1)	1.050595	1.104793	1.137936	1.166385	1.189712	1.213507	1.237777	1.262532	1.287783	1.313539
CR/ER actual, baseline - 1	1.050595	1.094287	1.139795	1.183804	1.229512	1.275765	1.319961	1.364379	1.421683	1.477128
CR/ER actual, baseline - 1/2	1.050595	1.09954	1.150764	1.20095	1.253325	1.306741	1.358544	1.411052	1.477372	1.542376
net potential add for HCPA, CR vs. baseline-1	0	0	0.000571	0.00515	0.01133	0.01708	0.021792	0.026126	0.032964	0.038762
net potential add for HCPA, ER vs. baseline-1/2	0	0	0.005547	0.006242	0.007919	0.007593	0.006613	0.006285	0.009026	0.008046
Mandate in 2000 (no caps)										
CR Target	1.01433	1.066657	1.098656	1.126123	1.148645	1.135722	1.158437	1.181606	1.205238	1.229342
CR actual (w/ tax)	1.01433	1.056513	1.100736	1.145516	1.192735	1.20253	1.246249	1.289987	1.347037	1.401827
ER actual (w/tax)	1.000713	1.047334	1.0989	1.14705	1.197777	1.214604	1.262114	1.310604	1.373425	1.433167
No Mandate Ever (no caps)										
CR Target	1.01433	1.066657	1.098656	1.126123	1.148645	1.171618	1.19505	1.218951	1.243331	1.268197
CR actual (w/ tax)	1.01433	1.056513	1.100736	1.145516	1.192735	1.240267	1.285294	1.330345	1.38909	1.445521
ER actual (w/tax)	1.000713	1.047334	1.0989	1.14705	1.197777	1.248493	1.297347	1.347198	1.41174	1.473168
Mandate in 2000 (w/caps)										
CR Target	1.01433	1.066657	1.098656	1.126123	1.148645	1.135722	1.158437	1.181606	1.205238	1.229342
CR actual (w/ tax)	1.01433	1.056513	1.100736	1.145516	1.192735	1.174587	1.218981	1.261393	1.304143	1.359142
ER actual (w/tax)	1.000713	1.047334	1.0989	1.14705	1.197777	1.174103	1.218207	1.260381	1.302922	1.357576

JULY 7 OPTIONS

7/22/94; 12:10 pm

Benefit Package	HSA - 8% actuarial value; premium path through time attached
Community Rating Pool	Individuals and firms of <= 500 are in the community rated pool. There is no opt in for firms over 500.
Transition Policies: Pre January 1, 2000 Measures to Voluntarily Increase Coverage See Prose Description of Policies, Attached (A1)	
Mandate Policies: 1/1/2000 and Beyond	
Specifications of the Mandate	50% employer mandate on firms of 25 workers or more. Individual mandate on individuals/families Switch to Per Worker Premium
Employer Subsidies	8% individual wage cap on employer's 50% share. Employers in the community rated pool are subsidized on the community rated premium mean; employers in the experience rated pool are subsidized on the minimum of the experience rated pool mean and the community rated pool mean.

Household Subsidies	Workers are subsidized on marginal rate schedule (attached, A2) for household's 50% share. These special subsidies phase-out at 200% of poverty. In addition, no family pays more than 8% of AGI for their family 50% share. Non-workers and workers who are "carved-out" are also subsidized on the "employer" 50% share, according to another marginal rate schedule (attached, A2) which also phases out at 200% of poverty. Non-workers' reference incomes are non-wage AGI; carved-out workers' reference incomes are AGI.
Experience Rated Plan Assessment	Experience rated plans with premiums below those in the community rated plans will pay an assessment into the community rated pool. For modelling purposes, we assume that this assessment has the effect of reducing the adverse selection differential between the experience rated and community rated pools with an effectiveness of 75%. See adjustment in mandate premium path as well.
High Cost Plan Assessment	See detailed explanation, attached (A3). Included in the premium path.
Tobacco Tax	Same level as HSA
Medicare Savings	Same as in Finance Mark No drug benefit Long term care benefit (show separately)
Medicaid	Non-Cash: "In" - treated like all other low income units. AFDC Cash: "In" - treated like all other low income units. SSI Cash: "Out"

A1

TRANSITION PERIOD POLICIES: JANUARY 1, 1997 TO JANUARY 1, 2000

Beginning in 1997, a series of reforms will be implemented to expand coverage of the uninsured.

I. SUBSIDIES FOR LOW-INCOME FAMILIES

In general. Low-income individuals and families will receive a subsidy worth a fixed percentage of the average premium. For those below 75% of the Federal poverty level, these subsidies will be equal to 100% of the premium. For persons with incomes between 75% and 200% of poverty, the subsidies will range on a sliding scale from 100% to 0.

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

Extra protections.

Cash assistance recipients. Cash assistance recipients receive 100% subsidies.

Former non-cash Medicaid eligibles. Eliminate program as of January 1, 1997. For those medically needy and other non-cash recipients (i.e., other than pregnant women and kids and those enrolled for transition benefits picked up elsewhere) as of January 1, 1997, purchase insurance coverage for 6 months.

People leaving welfare for work. As former welfare recipients, these people would receive 100% subsidies not only for one year, as under current law, but for two full years.

Women and kids. Pregnant women and children under age 19 with incomes up to 185% of poverty would be eligible to receive 100% premium subsidies. For those with incomes between 185% and 240% of poverty, the subsidies will range on a sliding scale from 100% to 0. As above, individuals determined to be presumptively eligible for 100% subsidies would be automatically enrolled at point-of-service. (Note: Pregnant women would receive a policy covering standard benefit package, i.e. more than pregnancy-related services covered under current law. Pregnancy would not be treated as a pre-existing condition.)

Temporarily unemployed, uninsured. People working for six months in a job with insurance will receive special treatment if they lose their job (with notice supplied by employer). Eligible persons will receive an income-related subsidy for up to 6 months.* In calculating these persons' eligibility for low income subsidies,

* Could be 12

AGI will be adjusted to exclude (1) unemployment compensation and (2) monthly income up to twice the poverty level (calculated appropriate to family size).

A. INCENTIVES FOR THE EXPANSION OF EMPLOYER COVERAGE

1. Employers that Currently Offer Insurance to Some (but not all) Employees:

Employers who expand coverage to their employees after January 1, 1997 will receive a subsidy for the premiums of those employees. The employer will pay the lesser of 50% of premium or 8% of each newly insured employee's wages. The employee will pay 50% of premium. Workers with incomes under 200% of the poverty level are eligible for subsidies described above. Subsidies that exceed the worker's 50% share of the premium will be credited toward the employer's contribution.

2. Employers that Do Not Currently Offer Insurance:

In addition to #1, for employers with fewer than 25 workers who have not offered insurance before January 1, 1997, the low-income subsidies available to individuals and families will be extended to their employers. That is, an employer will be eligible for 100% subsidies for their 50% share for workers at 75% of poverty, and partial subsidies for their share for workers up to 200% of poverty. Employees will be similarly eligible for subsidies for their family share. (Although this option does not alter eligibility for subsidies, marketing to small employers by state-established cooperatives could enhance participation.)

II. INSURANCE REFORMS BEGINNING IN 1997

1. Market Segments and Boundaries

a. Community-rated segment: Firms with fewer than 500 Workers and Individual Purchasers. Firms with fewer than 500 employees, the self-employed, individuals outside the workforce, and Medicaid-eligible individuals would be required to purchase community-rated health coverage.

1) Community Rating Requirements Community rated health plans could modify their rates based on coverage category (e.g. Single, Family) and geographic location, but rates could not vary based on health status,

claims experience, age or other personal factors. Age rating permitted (2 to 1)

2) Community Rating Areas To supply geographic boundaries for community-rated pools, states would establish "health care coverage areas" (HCCAs). States would have the flexibility to create more than one HCCA and to accommodate inter-state HCCA arrangements; however, they would not be permitted to designate as an HCCA an area with fewer than 250,000 residents, and they would be prohibited from sub-dividing an MA into more than one HCCA.

Each Health Plan would be required to establish a single set of rates for the standard benefit package applicable to all individuals and groups within the community-rated segment of the HCCA. (However, rates for HIPCs could be discounted to reflect administrative savings - see 3c. below).

b. Experience-rated Segment: Firms with more than 500 Employees and Other Eligible Organizations A second segment of the market would be permitted to self-insure or purchase experience rated coverage. This segment would be comprised of firms with 500 or more employees, existing Taft-Hartley Plans and rural cooperatives with 500 or more members.

2. Health Plan Requirements

In addition to complying with the community rating parameters identified above, health supplemental benefits must be priced and sold separately from the comprehensive benefits package.

Comprehensive benefits policies and optional policies covering cost sharing amounts must be purchased through the same insurer.

a. Guaranteed Issue Plans would be required to issue coverage to all individuals except when:

- additional enrollment would cause the plan to exceed approved service or financial capacity; or
- an individual or group did not request enrollment during the open enrollment period.

b. Guaranteed Renewal During the transition to universal coverage, plans would be prohibited from terminating coverage except for:

- non-payment of premiums;
- fraud; or

- misrepresentation.

c. Open Enrollment States would establish annual open enrollment periods for each health coverage area. During the open enrollment period, health plans would be required to offer coverage to all groups and individuals in the community-rated market segment.

d. Pre-existing Conditions Health Plans would be prohibited from denying or limiting coverage based on pre-existing conditions. Health plans can limit coverage of preexisting conditions (for 6 months) for new enrollees that were not previously insured.

e. Exit from the Market If a Health Plan elects not to renew or make available coverage to an individual or group, the plan must terminate all coverage in the HCCA after providing sufficient notice to the state and enrolled individuals. The Health Plan would not be permitted to re-enter the coverage area for five years.

3. **Additional Reforms**

a. Risk Adjustment A "National Health Board" (NHB) would develop risk adjustment and reinsurance methodologies to address risk-related differences between the enrollees of different health plans.

In addition, the HHS would develop a mechanism to account for higher costs in the community-rated market due to the assimilation of nonworkers and Medicaid recipients.

b. Guaranty Funds States would be required to establish guaranty funds for all Health Plans in the community-rated market based on federal standards.

c. Health Insurance Purchasing Cooperatives (HIPCs) Individuals and groups in the community-rated segment could purchase coverage directly from a private insurer or join a HIPC. If a HIPC was not available in every HCCA by 1996, states would be required to sponsor or establish HIPCs in unserved areas.

1) Nature and Scope of HIPC Responsibilities HIPCs would be responsible for entering into agreements with health plans and community-rated employers, enrolling individuals in health plans, collecting and distributing premium payments, coordinating out-of-area coverage with other HIPCs, and providing consumers information on health plan quality and cost.

They would be prohibited from negotiating payment rates with providers, assuming insurance risk, or engaging in other tasks outside their realm of responsibility as established by federal and state regulation.

2) Operational Requirements HIPCs would be required to accept all eligible individuals and employers in the HCCA. They would also be required to provide enrollees with a choice of at least three plans, one of which must be Fee-for-Service (FFS) and one of which must be Point-of-Service (POS). For rural areas, Governors could waive the requirement that three plans be offered as long as a FFS plan is made available. The NHB would establish fiduciary standards for HIPCs.

Insurers could not form a HIPC, but could administer a HIPC as a fiscal intermediary.

HIPCS would be permitted to negotiate discounts with Health Plans reflecting economies of scale in administration and marketing.

3) Employer and Individual Responsibilities Eligible employers (firms with less than 500 employees) opting to join a HIPC could choose from among the HIPCs in their HCCA.

In order to qualify for employer premium contributions, employees would be required to purchase health insurance through the HIPC chosen by their employer. Employees could join any of the Health Plans sponsored by the HIPC.

d. Self-insured Plans In general, self-insured plans must comply with the above specified 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.

III. UNIVERSAL COVERAGE AFTER JANUARY 1, 2000

Effective January 1, 2000, all individuals would be entitled to comprehensive health care coverage. Following is a brief overview of the proposed universal health care system.

A. EMPLOYER RESPONSIBILITIES

Employers with 25 workers or more would generally contribute 50% of the premium for a standard benefit package.

Employer Subsidies To reduce the liability for low wage firms, employer contributions would be capped such that employers would pay no more than 8% of each employee's wages for health coverage. For community-rated plans, the 8% cap would be compared to the community-rated mean (the average rate for all community rated standard

benefit plans in the HCCA). For experience rated plans, the 8% cap would be compared to the experience-rated mean (the average rate for all experience-rated plans in the HCCA).

Exempt Employers (firms with fewer than 25 workers) that choose to cover their employees would also be eligible for the 8% wage-cap subsidy. Exempt Employers that opt not to cover their workers would be subject to a 2% payroll assessment.

B. INDIVIDUAL RESPONSIBILITIES

Individuals would be required to obtain health coverage for themselves and for their dependents. They could obtain such coverage through their employer or through a HIPC, or they could purchase coverage directly from a private insurer.

Individual Subsidies Workers with income under 200% of poverty would be subsidized for their 50% of premium on a sliding scale basis. No family would pay more than 8% of their adjusted gross income (AGI) for their family's 50% share.

Non-workers and exempt workers would also be subsidized on the "employer" share of premium. A different subsidy schedule would be used, but benefits would still phaseout at 200% of poverty.

IV. FINANCING

Disproportionate Share Hospital. Under current law, DSH payments are made to hospitals to cover the costs of uncompensated care and the Medicaid underpayment. Under this proposal, a new insurance pool would be established that would provide subsidies to low-income individuals. As of January 1, 1997, acute care services for Medicaid AFDC and non-cash recipients would be included in this subsidy pool and would no longer be paid for under Medicaid. In addition, with incentives to cover uninsured individuals, the number of uninsured would be reduced by 60 percent. Hence, Medicaid DSH payments would be reduced proportionately.

Further, by January 1, 2001, universal coverage would be achieved, so the Medicaid DSH can be eliminated completely. A residual Federally-funded program (VPA) would be established to make payments to hospitals to cover costs associated with any individuals uncovered, or the high costs of serving low-income individuals.

As the DSH program is discontinued, Federal and State spending would be reduced. States would be required to pay some portion of their DSH allotment as an DSH MOE payment as the DSH program is discontinued. [The exact DSH MOE percentage needs to be determined.]

Maintenance of Effort. The States would be required to continue to contribute to the health care needs of their low-income residents after the new insurance subsidy pool program is established. A lump-sum maintenance of effort (MOE) would be required to be paid by the States on a quarterly basis to the insurance subsidy pool. The amount would be calculated based on each State's historic Medicaid spending for services covered by the new insurance program for AFDC recipients and former non-cash Medicaid recipients. The base year (1993?) amount would be trended forward to January 1, 1998 based on a factor (growth in national health care expenditures) to establish the first MOE payment. This MOE payment would then be trended forward each successive year based on a factor (growth in national health care expenditures).

In addition, the State would be required to pay some portion of its DSH allotment as the DSH program is discontinued. DSH payments would be proportional to the number of uninsured remaining during the transition period.

MEDICAID SAVINGS AND MAINTENANCE OF EFFORT

MEDICARE SAVINGS

TOBACCO TAX

HIGH COST OF PLAN ASSESSMENT

ASSESSMENT ON NON-OFFERING FIRMS

Mitchell 7/7 A2

Family Subsidy Marginal Rates
Senate 50/50 series

	Single	Couple	1 Parent	2 parent
Poverty line:	7,158	9,685	12,211	14,737
Year 2000				
Community rate <500				
Carve-out < 25				
Premium path	1.2651			
Composite factors	1.0000	1.4591	1.9360	1.9360
Actuarial premiums:	$2,657	$5,313	$5,181	$7,040
Employer composite:	1,328	1,938	2,572	2,572
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1456	0.1601	0.1706	0.1345
Carve-out < 50				
Premium path	1.2651			
Composite factors	1.0000	1.4604	1.9498	1.9498
Actuarial premiums:	$2,657	$5,313	$5,181	$7,040
Employer composite:	1,328	1,940	2,590	2,590
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1456	0.1603	0.1721	0.1357
Community rate <100				
Carve-out < 25				
Premium path	1.2814			
Composite factors	1.0000	1.4591	1.9360	1.9360
Actuarial premiums:	$2,691	$5,382	$5,247	$7,131
Employer composite:	1,345	1,963	2,605	2,605
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1480	0.1627	0.1733	0.1368

Family Subsidy Marginal Rates
Senate 50/50 series

	Single	Couple	1 Parent	2 parent
Poverty line:	7,158	9,685	12,211	14,737
Year 2004				
Community rate <500				
Carve-out < 25				
Premium path	1.4648			
Composite factors	1.0000	1.4591	1.9360	1.9360
Actuarial premiums:	$3,076	$6,152	$5,998	$8,152
Employer composite:	1,538	2,244	2,978	2,978
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1749	0.1917	0.2038	0.1621
Carve-out < 50				
Premium path	1.4648			
Composite factors	1.0000	1.4604	1.9498	1.9498
Actuarial premiums:	$3,076	$6,152	$5,998	$8,152
Employer composite:	1,538	2,246	2,999	2,999
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1749	0.1919	0.2056	0.1635
Community rate <100				
Carve-out < 25				
Premium path	1.483635			
Composite factors	1.0000	1.4591	1.9360	1.9360
Actuarial premiums:	$3,116	$6,231	$6,075	$8,256
Employer composite:	1,558	2,273	3,016	3,016
Worker rate 1:	0.0465	0.0446	0.0436	0.0429
Worker rate 2:	0.1200	0.1200	0.1200	0.1200
Composite rate 1:	0.0465	0.0446	0.0436	0.0429
Composite rate 2:	0.1776	0.1947	0.2070	0.1647

for 7/7 option

A3

DRAFT July 11, 1994

HIGH COST PLAN ASSESSMENT

- Health plans whose premium for the standard benefit package exceeds an annual target would pay an assessment.
  - For community-rated plans, the assessment would apply as follows:
    - -- Establish area premium targets similar to HSA (appropriate adjustments for voluntary market).
    - -- Target growth rates are as follows: baseline through 1996; 1997 is CPI+3; 1998 is CPI+2.5; 1999 and thereafter is CPI+2.
    - -- Health plans whose premiums in an area exceeded the premium target would pay an assessment of 25% of the difference between the plan's premium and the target premium.
  - For experience-rated employers, the assessment would apply as follows:
    - -- Experience-rated employers are subject to an assessment based on the rate of growth of their premiums (or premium equivalents). Employers pay an assessment equal to 25% of the difference between the target growth rate and their actual growth rate.
    - -- Growth would be measured based on a three year moving average to enhance stability. Therefore, there would be no assessment revenue from experience-rated employers until year four.

      Note: We still need to work out some details here. For modelling purposes, we suggest beginning the assessment in year four for experience-rated employers and simply calculating it based on premium increases (over a moving three year period) versus the annual target growth rates (over a three year period). Any alternative suggestions?

- The targets and assessments would apply only to premiums for the standard benefit package. Experience-rated plans (including self-funded plans) would be required to establish separate premiums (or premium equivalents) for the standard benefits. Regulations would specify how the separate premiums would be calculated for experience-rated plans.

Supplemental benefits would be treated as under the HSA. Generally, employer contributions toward supplemental benefits (other than cost-sharing supplemental benefits) would be included in employee income as of 2004.