RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

1. There are no premium caps. Health plans may charge whatever price results from a more competitive market.

2. To protect the federal budget from the risk of higher premiums, excess federal costs are recaptured through an assessment on high cost health plans.

   The assessment serves two purposes: To maintain budget neutrality, and to exert downward pressure on premiums.

   (The federal budget is at risk for subsidy payments and tax revenue loss resulting from higher premiums. Higher premiums could be caused by windfall payments resulting from universal coverage -- particularly in the short term -- or by a failure of competition to bring down premium increases over time.)

3. The assessment on high cost plans could work as follows:

   a. It could be applied only in states (or substate areas) where competition is ineffective. It is triggered automatically in a state if the average premium exceeds the "target premium" in that state.

      The target premium for a state (or substate area) is based initially on current health care costs, but with added funding for the uninsured and assuming no windfall for providers or insurers. The target premium grows from year to year at pre-established rates based on reasonable expectations for a more competitive health care marketplace.

   b. It could be structured in a variety of ways. Two options are:

      i. The assessment for a health plan is X% of the difference between the plan's premium and the target premium.

      ii. The assessment is applied to a plan's entire premium, but the percentage assessment rises by Y percentage points for each dollar the plan's premium is above the target premium.

      (Note: After the first year, the assessment could be applied based on a health plan's rate of growth instead of its premium relative to the target premium.)

   c. The assessment could be applied after the fact (i.e. lagged a year) or set prospectively based on bids from health plans.

   d. The assessment could be administered as a tax, or as an offset to payments to health plans (assuming there is a premium clearinghouse or reinsurance pool of

some kind).

If administered as an offset to payments to health plans, the assessment would in turn be used to offset federal subsidy payments to the state (or substate area).

e. The percentage assessment is set nationally each year, and is calculated in order to recoup excess federal costs. While the same assessment percentage applies everywhere, it is triggered only in areas where competition is ineffective. If the assessment raises too much or too little revenue to recapture excess federal costs, the percentage is adjusted accordingly in the following year.

4. The assessment would apply to community rated plans, but could be broadened to experience rated and self-insured plans as well (with some modifications).

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + _____ DATE: _____

TO: Chris Jennings

Fax: _____

Phone: _____

FROM: Debbie Chang

Fax: (202) 690 - 8168

Phone: _____

REMARKS:

Here's the detailed estimates on the 3 options ~~Frances~~ Mitchell's office requested.

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

7/24

Additional Medicare Savings Options

(1) MB-2 (98-04) for urban hospitals
MB-1 (98-04) for rural hospitals

(2) MB-2 (99-04) for urban hospitals
MB-1 (99-04) for rural hospitals

(3) MB-2 (01-04) for all hospitals
MB-2 (00) for urban hospitals

Notes:

- All options are relative to base package of MB-1 (97-00) for all hospitals.
- There is no affect on savings for proposals which have MB-1 for rural hospitals beginning with 1998 or 1999 since MB-1 is in the base package for these hospitals.

MB-2 (98-04) urban
MB-1 (98-04) rural

Net of Interaction
Relative to MB-1 (97-00)

	95-00	01-04	95-04
MB-2 (01-04) (urban)	—	20,061	20,061
MB-1 (01-04) (rural)	—	1,499	1,499
	0	21,560	21,560
[redacted] urban	[redacted]	[redacted]	15,469
[redacted] rural	0	[redacted]	0
	[redacted]	21,449	15,469
GRAND TOTAL	4,020	33,009	37,029

MB-2 (99-04) urban
MB-1 (99-04) rural

Net of Interaction
Relative to MB-1 (97-00)

	95-00	01-04	95-04
MB-2 (01-04) urban	—	20,061	20,061
MB-1 (01-04) rural	—	1,499	1,499
	0	21,560	21,560
MB-2 (99-00) urban	2,086	9,633	9,719
MB-1 (99-00) rural	0	0	0
	2,086	7,633	9,719
GRAND TOTAL	2,086	29,193	31,279

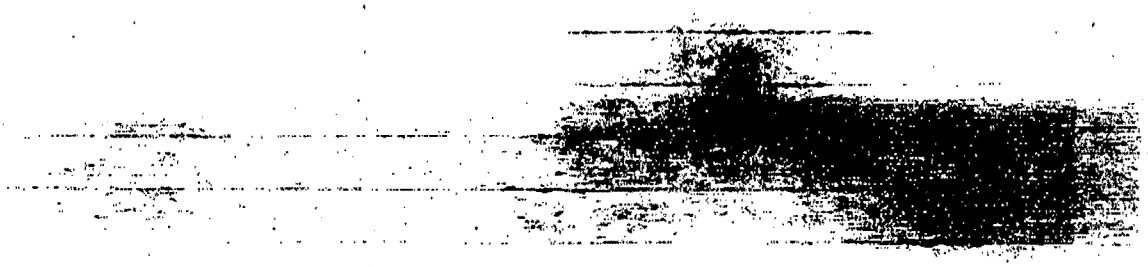
	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
MB-1 01-04 (urban)				—	—	—	1,650	3,776	6,201	9,055	20,682
MB-1 01-04 (rural)	—	—	—	—	—	—	123	281	463	677	1,544
MB-2 98-00 & =MB-1 urban	—	—	—	583	1,335 N/A LV 4,020	2,226	2,474	2832 11,103 354 11,449	3101	3396	15,947 479 15,469
MB-1 98-00 &=0 rural	—	—	—	0	0	0	0	0	0	0	0
				583	1335	2226	4247	6889	9765	13128	38,173
				17	40	67	127	207	293	394	1,145
				566	1295	2159	4120	6682	9472	12,734	37,028
					4020				33,008		

07-24-94 03:15 PM FROM ULP PU1

	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
MB-2 01-04 (urbans)	—	—	—	—	—	—	1,650	3,776	6,201	9,055	20,682
MB-1 01-04 (rurals)	—	—	—	—	—	—	123	281	463	677	1,544
MB-2 99-00 (Δ = MB-1) (urban)	—	—	—	—	667	1484 2151 45 2081	1650	1888	2067 7564 736 7633	2264	10,020
[illegible] 99-00 (Δ = [illegible]) (rural)	—	—	—	—	0	0	0	0	0	0	0
H.E. Subtotals					667 20 647	1484 45 1439	3423 103 3320	5,945 178 5,767	8,731 262 8,469	11,996 360 11,636	32,246 967 31,279
					2,086			29,192			

MB-2 (01-04) all
MB-2 (00) urbans

95-00	01-04	95-04
720	26,875	27,596



	FY95	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY95-FY04
MB-2 01-04 (all)	—	—	—	—	—	—	1896	5490	7128	10,408	23,772
MB-2 00 (Δ=MB-1 (urbans)	—	—	—	—	—	742	825	404	1034	1132	4677
						742	2721	5284	8162	11,540	28,449
						22	82	159	245	346	853
						720	2639	5125	7917	11,194	27,596

07-24-04 03:15 PM FROM OLP PUY

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

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

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

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

a Under 1 million.

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

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

Net Effect on Level of Average Private Health Insurance Premiums

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

Net Total Additions

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

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

Working Household Payments as Percent of AGI

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

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

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

Working Household Payments as Percent of AGI

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

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

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

Working Household Payments as Percent of AGI

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

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

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

Working Household Payments as Percent of AGI

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

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

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

Working Household Payments as Percent of AGI

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

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

Full (unsubsidized) Employer Payment for Standard Benefit Package

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

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

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

ANALYSIS

NOTE: ASSUME TRIGGER IN 2000

1) Premium impact over time: 1997, 2000, 2004, looking at:

- Firms currently insuring
- Firms not currently insuring
- Firms <500
- Firms >500
- Individuals - low / middle / upper income

A) Total premium + assessments
B) Break-out of specific components:

- ~~Net~~: Medicaid/~~risk adjustment~~ with adjustment cost shift
- High-cost plan assessment
- Uncompensated care reduction
- Impact of <25 carveout
- 1.75% AHC/research assessment
- Impact of Medicare savings
- Early retiree benefit from community rating
- Administrative load
- Cafeteria plan (plus: #s people with plans, #businesses with plans, $ involved)

2) Post-2000: options for increasing protections for families

3) Options for increasing coverage before 1997

4) Administrative structure for delivering subsidy programs

5) Cost containment - projected impact on NHE growth

6) Benefits package update

7) Coverage - breakout of newly insured: workers v. nonworkers by program

Chris — This is
the thing we
did for
Christy Ferguson.

Wendy

Memorandum

From: Len Nichols, Linda Blumberg, and Ken Thorpe

Re: Premiums for the Moderate Coalition Estimation exercise for 6/27

Date: 6/30/94

The top part of the attached page compares premiums (in current dollars) through time under the Moderate Coalition's proposal (circa 6/24) with premiums under the HSA. Only the single premium is shown: the others would be simple multiples of this number. The underlying growth rate of 7% (managed competition, baseline minus 1%) drives the paths for the Moderate Coalition, while HSA premiums are constrained to grow at HSA rates. For the purposes of the estimation exercise over the weekend, we assumed that the average premium inside the community rating pool would be 8% higher than the overall average due to selection and demographic factors, that the average premium in the experience rating pool would be 3% below the overall average, and that the distribution of each pool would be ± 10% around it's average.

Premium estimation for any given year under tight time constraints is done by a series of adjustments to the CBO's estimate of the basic HSA premium. This process is illustrated for 1997 in the lower part of the attached page. A similar process was applied to each year's base premium, and then it was grown appropriately to reach the numbers displayed.

- **Benefit package**: We assumed the standard package has a generic actuarial value equal to 8% below the HSA, equal to the current BCBS standard policy offered through FEHBP.

- **Uncompensated Care**: Since universal coverage would not be obtained in 1997, a substantial portion of uncompensated (about 70%) care would remain embedded in private sector premiums. This add-on declines through time as a larger fraction of the population becomes insured.

- **S&L/DSH**: CBO included spending by state and local (S&L) governments and Federal Medicaid disproportionate share (DSH) payments in their premium estimate, on the theory that these payments are on behalf of the uninsured and would evaporate with universal coverage. For S&L spending, we subtracted the proportion of this spending that should not go into the premium base until coverage is expanded. This subtraction declines as coverage expands through time. The Moderate Coalition proposal had a specific DSH phase-out rate which we applied.

- **Adverse selection**: In a voluntary purchase environment, especially with community rating, individuals with lower health status can be expected to purchase insurance more readily. Based on National Medical Expenditure Survey data and existing high risk pools' actuarial values, we estimated that the newly insured in the first two years would cost 1.5 times the average. In addition, the base against which this selection is

taken is limited to currently insured workers in firms with fewer than 100 employees and the poor who would take advantage of the free premium. In future years, as this base expands and as the newly insured are expected to be healthier and healthier, this adverse selection add-on declines.

- **Academic Health Centers**: The HSA added 1.5% to the premium for this funding stream. The Moderate Coalition does not.

- **Medicaid non-cash**: The HSA put these individuals into the community rate. The Moderate Coalition does not.

- **NET premium vs. HSA**: This is the fraction of the HSA premium that the Moderate Coalition average premium would be in 1997 if the underlying growth rates from 1994 had been the same.

Single Premiums Through Time

	1997	1998	1999	2000	2001	2002	2003	2004
Moderate Coalition Average	2,491	2,625	2,813	3,029	3,252	3,484	3,735	3,998
General Access Pool	2,691	2,835	3,038	3,271	3,512	3,763	4,034	4,318
Experience rated pool	2,417	2,546	2,729	2,938	3,155	3,380	3,623	3,878
HSA	2,452	2,539	2,615	2,788	2,909	3,037	3,170	3,310

Adjusting Moderate Coalition's Premium from the HSA's (1997)

Benefit Package	-0.08
Uncompensated Care	0.051
S&L/DSH	-0.048
Adverse Selection	0.06
no AHC premium tap	-0.015
no MCD non-cash in pool	-0.03
NET premium vs. HSA	0.938

DEPARTMENT OF THE TREASURY
OFFICE OF TAX ANALYSIS
1500 PENNSYLVANIA AVENUE, NW
WASHINGTON, DC 20220

Number of Pages: C+1 Date: June 20

TO: Chris Jenning | 456-7431 |
Name FAX number Confirmation No.

FROM: Janet Holtzblatt | 622-1327
Name Phone No.

Sender's FAX Number: (202) 622-0236 Location: Room 4112 MT

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002/002
TAX ANALYSIS
202 622 0236
16:13
07/20/94

Congressional Tobacco Tax Estimates
($ Billions; FY)

	Effective Date	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	FY 1994 – FY 1999	FY 1994 – FY 2004
Administration Proposal													
Health Security Act: $.75 increase in cigarette tax													
Treasury	10/1/94	12.0	11.3	11.2	11.1	11.0	10.9	10.8	10.7	10.6	10.5	56.6	110.1
Congressional Proposals													
Ways and Means Committee: Phase-in $.45 increase in cigarette tax: $.15 -- 6/1/95; $.25 -- 1/1/97; $.35 -- 1/1/98; $.45 -- 1/1/99													
Treasury	6/1/95	0.4	2.4	3.5	4.9	6.2	6.6	6.5	6.5	6.4	6.4	17.5	49.9
Joint Committee on Taxation	6/1/95	0.7	2.7	4.5	6.1	7.5	7.3	7.0	6.9	6.8	6.5	21.5	58.1
Variation on Ways and Means: $.45 increase effective 6/1/95													
Treasury	6/1/95	1.2	6.8	6.7	6.7	6.6	6.6	6.5	6.5	6.4	6.4	28.0	60.4
Senate Finance Committee: $1.00 increase in cigarette tax													
Treasury	1/1/95	10.8	13.7	13.6	13.5	13.4	13.3	13.3	13.2	13.0	12.9	65.0	130.7
Senate Labor and Human Resources: $1.49 increase in cigarette tax 1/													
Treasury	1/1/95	13.4	17.0	16.9	16.8	16.6	16.5	16.4	16.3	16.2	15.0	80.7	162.1

1/ This does not include revenues from other tobacco products.

DEPARTMENT OF THE TREASURY
WASHINGTON

July 20, 1994

MEMORANDUM FOR NANCY-ANN MIN
ASSOCIATE DIRECTOR FOR HEALTH
OFFICE OF MANAGEMENT AND BUDGET

FROM: ERIC TODER
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: **Estimates of July 18 Options**

At Sunday's meeting with Senate staff, the Administration was asked to prepare estimates of two variants to the July 7 option. Under each variant, health insurance reforms would be implemented nationally by January 1, 1997. Firms with fewer than 500 employees and non-workers would be required to purchase community-rated insurance. Employers with 500 or more employees could purchase only experience-rated insurance. The options vary in the following ways:

Option 1: This option includes a hard trigger for an employer mandate. The Administration is assuming that the trigger would be pulled in the year 2000, and both an employer and individual mandate would become effective. Employers would be required to pay 50 percent of the costs of the standard benefit package. However, small firms (those with fewer than 25 employees) would be exempt from the mandate.

Option 2: There would be no employer mandate under this option, but low-income families and some employers would be eligible to receive subsidies for health insurance costs.

To reduce the costs of the plan, the following four modifications were requested:

- Household and employer subsidies would be delayed until January 1, 1998. (In the options presented over the weekend, subsidies were available in 1997.)
- Subsidies for employers and households would be indexed to pre-determined targets rather than growing at the same rate as the average cost plan.
- The high cost plan assessment rate would be increased from 25 percent to 35 percent.
- Premium caps would become effective in 2000 (assuming a mandate as well in 2000).

In addition, we were also requested to estimate the effects of a 45 cent increase in the cigarette

tax, assuming both immediate implementation and the Ways and Means committee proposed phase-in schedule.

Since last weekend, OTA has modified its estimates of the initial proposal containing a hard trigger. With a hard trigger, the proposal would raise $382.8 billion between FY 1994 and 2004 instead of $386.7 billion. (If the revenues from the risk assessment on experience rated plans, which are entirely spent to reduce premiums on community rated plans, are not counted, the current revenue estimate would be $337.9 billion instead of $348.3 billion.) In reviewing the estimates, OTA staff determined that the earlier estimates had underestimated the degree to which employees would shelter their required employee contribution for health insurance through cafeteria plans. If employers are required to provide only 50 percent of the costs of the standard benefit package (instead of 80 percent), newly covered employees must pay for a greater share of the costs of the benefit package. Absent other reforms, these employees will increase utilization of cafeteria plans in order to reduce the after-tax costs of health insurance. By revising its estimates of the increased utilization of cafeteria plans, OTA's estimates of the effect of the mandate on payroll and income taxes are reduced by $35 billion, while the estimates of the repeal of the cafeteria plan are increased by $22 billion.

In combination, the modifications listed above generally increase revenues by between $46 and $60 billion above last week's proposal if a mandate is still assumed. Assuming an employer mandate in 2000, a high cost plan assessment rate of 35 percent increases revenues by $96.8 billion, or about $50 billion more than the previous estimate of the 25 percent assessment rate. However, part of the revenue difference can be explained by changes in the underlying methodologies used by both OMB and OTA. For example, the higher estimate of the high cost plan assessment may reflect changes since last week in the methodology used by OMB to calculate the growth in premiums between 1994 and 2004. With the increase in the high cost premium assessment, average premium costs also decline, causing employer contributions to increase (even as subsidies are reduced due to indexing). As a consequence, individual income and payroll taxes increase by $16.4 billion over the ten year period relative to the initial option.

If a high cost assessment is combined with HSA premium caps (which lower average premium costs) and an employer mandate, the assessment raises $64.5 billion between FY 1994 and 2004. However, the HSA premium caps further reduce employer costs, raising individual income and payroll taxes by $34 billion relative to the initial option.

Without a mandate, the 35 percent high plan cost assessment raises $87.9 billion instead of $96.7 billion because the volume of plans subject to the assessment declines. If there is no mandate, however, the change in average premium costs for the standard benefit package has little effect on the allocation between taxable wages and non-taxable compensation.

Under the July 7 option, the cigarette tax would have been increased by 75 cents (as under HSA), raising $110 billion between FY 1995 and 2004. If, instead, the cigarette tax is increased by 45 cents, the proposal would raise $60.4 billion over the same period. Assuming the slower phase-in schedule contained in the Ways and Means committee bill lowers the tobacco revenue pick-up by $10.5 billion to $49.9 billion. However, we believe that JCT would estimate this provision (with the Ways and Means phase-in schedule) as raising an additional $6 billion.

Relative to OTA, JCT appears to assume a smaller behavioral change in response to increases in the cigarette tax below 75 cents.[1]

cc: Nichols
Blumberg

[1] Unfortunately, the converse also seems to be true. Relative to OTA, JCT assumes a larger induced change in behavior resulting from a larger increase in the tobacco tax. Hence, JCT's estimates of the revenue gain from more sizable increases in the tobacco tax are generally lower than OTA's estimates.

Variations for Health Security Act

The Proposals of July 18, 1994 (OTA 045)
Experience Rated Pool Starts With Firms of Greater Than 500 Employees

(Fiscal Years, $ Billions)
Changes From Current Law

Estimates Use CBO Premiums
Estimates Out to The Year 2004

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total 1994-2000	Total 1994-2004
The Proposal of July 7, 1994, Revised (OTA 044, OTA 045-1) Hard trigger in 2000													
Effect of Mandate, Subsidies and Other Health Reforms	-	-	-	0.1	0.7	1.0	-2.3	-3.4	-2.4	-2.1	-1.4	-0.5	-9.8
Cafeteria Plan Limitation With Grandfathering	-	-	-	3.5	5.5	6.7	13.0	16.4	17.4	18.7	20.1	28.7	101.3
Self-Employment Deduction	-0.1	-0.5	-0.7	-1.2	-1.3	-1.4	-1.5	-1.3	-1.4	-1.5	-1.6	-6.7	-12.5
The 1.75% Premium Assessment	-	-	-	5.3	8.0	8.8	10.2	11.2	12.1	12.9	13.9	32.3	82.4
The Risk Assessment On Experience Rated Pools 1/	-	-	-	4.2	6.3	6.9	5.4	4.9	5.3	5.7	6.2	22.8	44.9
The 25% High Cost Plan Assessment	-	-	-	0.1	0.4	1.0	3.3	5.9	8.2	11.6	15.8	4.8	46.3
Cap On Out of Scope Benefits	-	-	-	-	-	-	-	-	-	-	3.1	0.0	3.1
Total	-0.1	-0.5	-0.7	12.0	19.6	23.0	28.1	33.7	39.2	45.3	56.1	81.4	255.7
The Proposals of July 18, 1994, (OTA 045-2) Hard trigger in 2000 tied to targeted premiums													
Effect of Mandate, Subsidies and Other Health Reforms	-	-	-	1.7	3.3	4.1	0.6	-1.0	-0.5	-0.8	-0.8	9.7	6.6
Cafeteria Plan Limitation With Grandfathering	-	-	-	3.5	5.5	6.7	12.6	15.9	17.0	18.4	19.9	28.3	99.5
Self-Employment Deduction	-0.1	-0.5	-0.7	-1.2	-1.3	-1.4	-1.5	-1.3	-1.4	-1.5	-1.6	-6.7	-12.5
The 1.75% Premium Assessment	-	-	-	5.1	7.7	8.6	9.9	10.8	11.6	12.5	13.4	31.3	79.6
The Risk Assessment On Experience Rated Pools 1/	-	-	-	4.1	6.1	6.6	5.2	4.7	5.1	5.5	5.9	22.0	43.2
The 35% High Cost Plan Assessment	-	-	-	0.6	1.3	2.4	8.2	13.1	17.2	23.4	30.6	12.5	96.8
Cap On Out of Scope Benefits	-	-	-	-	-	-	-	-	-	-	3.1	0.0	3.1
Total	-0.1	-0.5	-0.7	13.8	22.6	27.0	35.0	42.2	49.0	57.5	70.5	97.1	316.3

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Note: An * denotes values of less than $50 million.
A -- denotes that no estimate is provided because the provision isn't applicable to that year or that proposal.

1/ The risk assessment is 2.295% in years 1997 - 1999 and 1.5% in years 2000- 2004.

Variations for Health Security Act

The Proposals of July 18, 1994 (OTA 045)
Experience Rated Pool Starts With Firms of Greater Than 500 Employees

(Fiscal Years, $ Billions)
Changes From Current Law

Estimates Use CBO Premiums
Estimates Out to The Year 2004

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total 1994-2000	Total 1994-2004
The Proposal of July 7, 1994, Revised (OTA 044, OTA 045-3)													
No hard trigger													
Effect of Mandate, Subsidies and Other Health Reforms	-	-	-	1.7	3.4	4.2	1.7	0.7	1.3	1.5	1.9	11.0	16.4
Cafeteria Plan Limitation With Grandfathering	-	-	-	3.5	5.5	6.7	10.3	12.3	13.2	13.8	14.6	26.0	79.9
Self-Employment Deduction	-0.1	-0.5	-0.7	-1.2	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.8	-6.7	-13.6
The 1.75% Premium Assessment	-	-	-	5.1	7.7	8.6	9.3	10.0	10.8	11.6	12.5	30.7	75.6
The Risk Assessment On Experience Rated Pools 1/	-	-	-	4.1	6.1	6.6	6.4	6.6	7.1	7.7	8.4	23.2	53.0
The 35% High Cost Plan Assessment	-	-	-	0.6	1.3	2.4	7.4	11.8	15.5	21.2	27.7	11.7	87.9
Cap On Out of Scope Benefits	-	-	-	-	-	-	-	-	-	-	3.1	0.0	3.1
Total	-0.1	-0.5	-0.7	13.8	22.7	27.1	33.6	39.8	46.2	54.0	66.4	95.9	302.3
The Proposals of July 18, 1994, (OTA 045-4)													
No hard trigger, Subsidies Tied to Targeted Premiums													
Effect of Mandate, Subsidies and Other Health Reforms	-	-	-	1.7	3.4	4.2	1.6	0.4	0.8	0.7	0.9	10.9	13.7
Cafeteria Plan Limitation With Grandfathering	-	-	-	3.5	5.5	6.7	10.3	12.3	13.2	13.8	14.6	26.0	79.9
Self-Employment Deduction	-0.1	-0.5	-0.7	-1.2	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.8	-6.7	-13.6
The 1.75% Premium Assessment	-	-	-	5.1	7.7	8.6	9.3	10.0	10.8	11.6	12.5	30.7	75.6
The Risk Assessment On Experience Rated Pools 1/	-	-	-	4.1	6.1	6.6	6.4	6.6	7.1	7.7	8.4	23.2	53.0
The 35% High Cost Plan Assessment	-	-	-	0.6	1.3	2.4	7.4	11.8	15.5	21.2	27.7	11.7	87.9
Cap On Out of Scope Benefits	-	-	-	-	-	-	-	-	-	-	3.1	0.0	3.1
Total	-0.1	-0.5	-0.7	13.8	22.7	27.1	33.5	39.5	45.7	53.2	65.4	95.8	299.6

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Note: An * denotes values of less than $50 million.
A – denotes that no estimate is provided because the provision isn't applicable to that year or that proposal.

1/ The risk assessment is 2.295% in years 1997 - 1999 and 1.5% in years 2000- 2004.

Variations for Health Security Act

The Proposals of July 18, 1994 (OTA 045)
Experience Rated Pool Starts With Firms of Greater Than 500 Employees

(Fiscal Years, $ Billions)
Changes From Current Law

Estimates Use CBO Premiums
Estimates Out to The Year 2004

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total 1994-2000	Total 1994-2004
The Proposals of July 18, 1994, (OTA 045-5)													
Hard Trigger in 2000, HSA Caps For 2000 and Beyond, Subsidies are Tied to Targeted Premiums													
Effect of Mandate, Subsidies and Other Health Reforms	-	-	-	1.7	3.3	4.1	2.5	1.9	2.8	3.8	4.5	11.6	24.6
Cafeteria Plan Limitation With Grandfathering	-	-	-	3.5	5.5	6.7	12.2	15.3	16.3	17.5	18.8	27.9	95.8
Self-Employment Deduction	-0.1	-0.5	-0.7	-1.2	-1.3	-1.4	-1.5	-1.3	-1.4	-1.4	-1.5	-6.7	-12.3
The 1.75% Premium Assessment	-	-	-	5.1	7.7	8.6	10.1	11.2	12.1	12.9	13.9	31.5	81.6
The Risk Assessment On Experience Rated Pools 1/	-	-	-	4.1	6.1	6.6	5.3	4.9	5.3	5.7	6.2	22.1	44.2
The 35% High Cost Plan Assessment	-	-	-	0.6	1.3	2.4	5.2	8.4	11.5	15.0	20.2	9.5	64.6
Cap On Out of Scope Benefits	-	-	-	-	-	-	-	-	-	-	3.1	0.0	3.1
Total	-0.1	-0.5	-0.7	13.8	22.6	27.0	33.8	40.4	46.6	53.5	65.2	95.9	301.6

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Note: An * denotes values of less than $50 million.
A -- denotes that no estimate is provided because the provision isn't applicable to that year or that proposal.

1/ The risk assessment is 2.295% in years 1997 - 1999 and 1.5% in years 2000- 2004.

Selected Revenue Provisions in July 18 Proposal

($ Billions; FY)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	FY 1994 – FY 2000	FY 1994 – FY 2004
Increase tobacco tax ($.45 increase on cigs) 1/	0	1.2	6.8	6.7	6.7	6.6	6.6	6.5	6.5	6.4	6.4	34.5	60.4
Medicare revenue provisions with mandate 2/	0	0	1.9	3.1	2.8	2.9	2.7	2.7	2.7	2.8	3.0	13.4	24.6
Other revenue provisions 3/	0	0	−0.2	−0.6	−0.7	−0.7	−0.7	−0.9	−1.2	−1.2	−1.3	−2.9	−7.5
Total	0.0	1.2	8.5	9.2	8.8	8.8	8.6	8.3	8.0	8.0	8.1	45.0	77.5

Department of the Treasury
Office of Tax Analysis

July 19, 1994

1/ Assumes August 1, 1995 effective date (as in Ways and Means bill). No phase–in schedule.

2/ Includes (1) recapture of Medicare Part B subsidies; and (2) extension of HI tax to all state and local government employees.

3/ Includes (1) tax incentives for providers in underserved areas; (2) S–corp and SECA provisions; (3) tax treatment of accelerated death benefits; (4) tax credit for disabled workers; (5) removal of $150 million bond cap on non–hospital 501(c)(5) bonds; and (6) long–term care tax provisions.

Addendum

Increase tobacco tax ($.45 increase on cigs) with Ways and Means phase–in schedule		0.4	2.4	3.5	4.9	6.2	6.6	6.5	6.5	6.4	6.4	24.1	49.9
Medicare revenue provisions with no mandate	0	0	1.9	3.1	2.8	2.9	3.0	3.2	3.3	3.5	3.8	13.7	27.5

July 19, 1994

NOTE FOR: NANCY-ANN MIN
BARRY CLENDENIN
BOB PELLICCI

FROM: ANNE MUTTI
DANIEL BLUME
JOHN RICHARDSON

SUBJECT: Medicare Savings Packages for Judy Whang

Attached are four options for an $80 billion (FY 1995-2000) package of Medicare savings that we were asked to clear. The tables show changes from the July 15th $80 billion package (copy attached):

Option A: splits the difference between the IME cuts in the HSA and Senate Finance packages and cuts Disproportionate Share Payments by 50% off the CBO original DSH baseline. Note that the IME reduction shown in the table does not achieve the anticipated $8.3 billion in 1995-2000 savings. The total of $7.3 billion results from following the base year and growth rate specifications accompanying the outline received this morning.

We are concerned that this approach fails to establish a coherent policy for the IME cut and also reduces DSH payments 50% each year (including the first year).

Option B: reduces IME payments compared to current law using a 5.2% increase in payments for every 10% increase in the ratio of residents to beds. Because the original $80 billion package included only a 3.0% increase, lost savings are offset by increasing the DSH cut to 55% (from 20% in July 15 package), calculated off of CBO's pricing of the HSA proposal.

Option C: reduces IME payments using the 5.2 factor and offsets lost savings by increasing the copayment for home health services by 20%.

Option D: eliminates IME cut and offsets lost savings by increasing the hospital update cut, imposing lab coinsurance, reducing the 1995 physician update by 3%, and eliminating the thirty day window for the home health copay.

We do not yet have available year-by-year breakouts for the four packages of cuts beyond the $80 billion package. We expect to have this information tomorrow. In the meantime, we do not have any objections to clearing the ten-year (FY 1995-2004) savings amounts that are included with these four packages.

cc: Len Nichols

Attachments

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$80 billion package from July 15th.

MEDICARE SAVINGS PACKAGE OPTION

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

	PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
	PART A													
1	Hospital Update at MB-0.5 (1997-2000)	0	0	0	-587	-1,050	-1,600	-1,776	-2,035	-2,228	-2,440	-1,637	-3,237	-11,716
2	Reduce Indirect Medical Education Payments	0	-1,812	-2,479	-2,885	-3,274	-3,693	-4,154	-4,663	-5,222	-5,836	-10,450	-14,143	-34,018
3	Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
4	Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
5	Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
6	Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,856
7	Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
8	Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	647	2,349
9	Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
	Part A Sub-total	-20	-4,491	-5,702	-7,549	-8,884	-10,359	-11,246	-12,393	-13,439	-14,587	-26,646	-37,007	-88,670
	PART B													
10	Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
11	Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
12	Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
13	Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
14	Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
15	Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
16	Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
18	Extend Part B Premium at 25% of Costs	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
	Part B Sub-total	-843	-753	-2,057	-3,676	-6,742	-9,363	-13,387	-18,282	-24,133	-30,206	-14,071	-23,434	-109,442
	PARTS A and B													
19	10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
20	Extend OBRA93 Medicare Secondary Payer	0	0	0	-176	-1,455	-2,091	-2,248	-2,397	-2,555	-2,723	-1,631	-3,722	-13,645
21	HMO Payment Improvments	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
22	Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
23	Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
	Parts A and B Sub-total	-134	-1,346	-1,942	-2,617	-4,228	-5,098	-5,487	-5,909	-6,368	-6,880	-10,267	-15,365	-40,009
	Medicare Total	-997	-6,590	-9,701	-13,842	-19,854	-24,820	-30,120	-36,584	-43,940	-51,673	-50,984	-75,806	-238,121
	Memo - Possible Part B additions to raise 1995-2000 total to $80 billion:													
	Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
	Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
	Medicare Total including Memo Items	-1,249	-7,006	-10,159	-14,865	-21,198	-26,166	-31,569	-38,201	-45,646	-53,419	-54,477	-80,645	-249,478

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- IME @ "split difference": $3.1 base in 1996; 5.35% growth rate
- DSH @ 50% of CBO Baseline

OPTION A

MEDICARE SAVINGS PACKAGE OPTION

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

7/19/94 7:37 PM

	PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
	PART A													
1	Hospital Update at MB-0.5 (1997-2000)	0	0	0	-587	-1,050	-1,600	-1,776	-2,035	-2,228	-2,440	-1,637	-3,237	-11,716
2	Reduce Indirect Med. Ed. Payments (split diff.)*	0	-1,000	-1,230	-1,360	-1,680	-2,090	-2,490	-2,880	-3,350	-3,910	-5,270	-7,360	-19,990
3	Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
4	Phase Down DSH (50% red. of CBO baseline)**	0	-1,900	-2,050	-2,200	-2,400	-2,650	-2,900	-3,150	-3,450	-3,750	-8,550	-11,200	-24,450
5	Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
6	Extend OBRA93 SNF Update *Freeze*	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
7	Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
8	Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	647	2,349
9	Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
	Part A Sub-total	-20	-5,467	-6,133	-7,218	-8,593	-10,270	-11,178	-12,338	-13,466	-14,719	-27,431	-37,643	-89,342
	PART B													
10	Use Real GDP in MVPS for Physician Services	0	0	-258	-883	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
11	Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
12	Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
13	Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
14	Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
15	Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
16	Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
18	Extend Part B Premium at 25% of Costs	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
	Part B Sub-total	-843	-753	-2,057	-3,676	-6,742	-9,363	-13,387	-18,282	-24,133	-30,206	-14,071	-23,434	-109,442
	PARTS A and B													
19	10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
20	Extend OBRA93 Medicare Secondary Payer	0	0	0	-176	-1,455	-2,091	-2,248	-2,397	-2,555	-2,723	-1,631	-3,722	-13,645
21	HMO Payment Improvments	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
22	Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
23	Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
	Parts A and B Sub-total	-134	-1,346	-1,942	-2,617	-4,228	-5,098	-5,487	-5,909	-6,368	-6,880	-10,267	-15,365	-40,009
	Medicare Total	-997	-7,566	-10,132	-13,511	-19,563	-24,671	-30,052	-36,529	-43,967	-51,805	-51,769	-76,442	-238,793
	Memo - Possible Part B additions to raise 1995-2000 total to $80 billion:													
	Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
	Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
	Medicare Total including Memo Items	-1,249	-7,982	-10,590	-14,534	-20,907	-26,017	-31,501	-38,146	-45,673	-53,551	-55,262	-81,281	-250,150

*assumes IME payments in 1996 total $3.1 billion and grow at a rate of 5.35%.

**uses CBO Disproportionate Share Payment baseline from 1996-99, projected out to 2004 using HCFA projected rate of growth.

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- IME @ 5.2%, offset by
- DSH @ -55%

OPTION B

MEDICARE SAVINGS PACKAGE OPTION

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

	PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
	PART A													
1	Hospital Update at MB-0.5 (1997-2000)	0	0	0	-587	-1,050	-1,600	-1,776	-2,035	-2,228	-2,440	-1,637	-3,237	-11,716
2	Reduce Indirect Med. Ed. Payments (5.2%)	0	-964	-1,319	-1,535	-1,741	-1,964	-2,210	-2,480	-2,778	-3,104	-5,559	-7,523	-18,095
3	Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
4	Phase Down DSH (55% reduction)	0	-308	-1,018	-2,767	-3,017	-3,289	-3,586	-3,911	-4,266	-4,653	-7,110	-3,781	-26,815
5	Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
6	Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
7	Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
8	Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	647	2,349
9	Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
	Part A Sub-total	-20	-3,839	-5,190	-7,960	-9,271	-10,723	-11,584	-12,699	-13,710	-14,816	-26,280	-30,387	-89,812
	PART B													
10	Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
11	Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
12	Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
13	Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
14	Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
15	Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
16	Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
18	Extend Part B Premium at 25% of Costs	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
	Part B Sub-total	-843	-753	-2,057	-3,676	-6,742	-9,363	-13,387	-18,282	-24,133	-30,206	-14,071	-23,434	-109,442
	PARTS A and B													
19	10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
20	Extend OBRA93 Medicare Secondary Payer	0	0	0	-176	-1,455	-2,091	-2,248	-2,397	-2,555	-2,723	-1,631	-3,722	-13,645
21	HMO Payment Improvments	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
22	Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
23	Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
	Parts A and B Sub-total	-134	-1,346	-1,942	-2,617	-4,228	-5,098	-5,487	-5,909	-6,368	-6,880	-10,267	-15,365	-40,009
	Medicare Total	**-997**	**-5,938**	**-9,189**	**-14,253**	**-20,241**	**-25,184**	**-30,458**	**-36,890**	**-44,211**	**-51,902**	**-50,618**	**-69,186**	**-239,263**
	Memo - Possible Part B additions to raise 1995-2000 total to $80 billion:													
	Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
	Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
	Medicare Total including Memo Items	**-1,249**	**-6,354**	**-9,647**	**-15,276**	**-21,585**	**-26,530**	**-31,907**	**-38,507**	**-45,917**	**-53,648**	**-54,111**	**-74,025**	**-250,620**

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- IME @ 5.2%, offset b
- H.H. copay @ 20%

OPTION C

MEDICARE SAVINGS PACKAGE OPTION

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

	PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
	PART A													
1	Hospital Update at MB-0.5 (1997-2000)	0	0	0	-587	-1,050	-1,600	-1,776	-2,035	-2,228	-2,440	-1,637	-3,237	-11,716
2	Reduce Indirect Med. Ed. Payments (5.2%)	0	-964	-1,319	-1,535	-1,741	-1,964	-2,210	-2,480	-2,778	-3,104	-5,559	-7,523	-18,095
3	Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
4	Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
5	Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
6	Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
7	Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
8	Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	647	2,349
9	Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
	Part A Sub-total	-20	-3,643	-4,542	-6,199	-7,351	-8,630	-9,302	-10,210	-10,995	-11,855	-21,755	-30,387	-72,747
	PART B													
10	Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
11	Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
12	Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
13	Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
14	Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
15	Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
16	Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
18	Extend Part B Premium at 25% of Costs	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
	Part B Sub-total	-843	-753	-2,057	-3,676	-6,742	-9,363	-13,387	-18,282	-24,133	-30,206	-14,071	-23,434	-109,442
	PARTS A and B													
19	20% Copayment for Home Health Services	-201	-2,237	-2,661	-3,000	-3,240	-3,513	-3,820	-4,144	-4,495	-4,875	-11,339	-14,852	-32,186
20	Extend OBRA93 Medicare Secondary Payer	0	0	0	-176	-1,455	-2,091	-2,248	-2,397	-2,555	-2,723	-1,631	-3,722	-13,645
21	HMO Payment Improvments	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
22	Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
23	Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
	Parts A and B Sub-total	-231	-2,427	-3,228	-4,067	-5,794	-6,796	-7,338	-7,917	-8,546	-9,242	-15,747	-22,543	-55,586
	Medicare Total	-1,094	-6,823	-9,827	-13,942	-19,887	-24,789	-30,027	-36,409	-43,674	-51,303	-51,573	-76,364	-237,775
	Memo - Possible Part B additions to raise 1995-2000 total to $80 billion:													
	Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
	Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
	Medicare Total including Memo Items	-1,346	-7,239	-10,285	-14,965	-21,231	-26,135	-31,476	-38,026	-45,380	-53,049	-55,066	-81,203	-249,132

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- No IME cut
- More savings from Part B and increase in hospital update reduction

OPTION D

MEDICARE SAVINGS PACKAGE OPTION

Estimated CBO scoring

All estimates are preliminary and unofficial

($ millions, by FY)

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	PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
	PART A													
1	Hospital Update at MB-1.0 (1997-2000)	0	0	-277	-1,005	-1,918	-2,986	-3,318	-3,798	-4,158	-4,554	-3,200	-6,186	-22,014
2	Reduce Indirect Medical Education Payments	0	0	0	0	0	0	0	0	0	0	0	0	0
3	Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
4	Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
5	Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
6	Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
7	Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
8	Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	649	2,049
9	Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
	Part A Sub-total	-20	-2,679	-3,500	-5,082	-6,478	-8,052	-8,634	-9,493	-10,147	-10,865	-17,759	-25,811	-65,250
	PART B													
10	Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,306	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
11	Set Cumulative Growth Targets for Phys Svcs	0	0	75	-1,725	-2,325	-1,500	-1,625	-1,850	-1,975	-2,200	-3,975	-5,475	-13,125
12	Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
13	Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
14	Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
15	Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
16	Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
	Lab Coinsurance (MD+OPD)	-411	-687	-761	-866	-970	-1,086	-1,219	-1,358	-1,545	-1,744	-3,695	-4,781	-10,647
	Reduce1995 Physician Update	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
18	Extend Part B Premium at 25% of Costs	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
	Part B Sub-total	-1,506	-1,856	-3,276	-5,041	-8,252	-11,032	-15,235	-20,320	-26,413	-32,744	-19,931	-30,963	-125,675
	PARTS A and B													
19	10% Copayment for Home Health Services	-104	-1,156	-1,375	-1,550	-1,674	-1,815	-1,969	-2,136	-2,317	-2,513	-5,859	-7,674	-16,609
	Home Health Copay - no 30 day window	-52	-578	-688	-775	-837	-908	-985	-1,068	-1,159	-1,257	-2,930	-3,838	-8,307
20	Extend OBRA93 Medicare Secondary Payer	0	0	0	-176	-1,455	-2,091	-2,248	-2,397	-2,555	-2,723	-1,631	-3,722	-13,645
21	HMO Payment Improvments	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
22	Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
23	Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
	Parts A and B Sub-total	-186	-1,924	-2,630	-3,392	-5,065	-6,006	-6,472	-6,977	-7,527	-8,137	-13,197	-19,203	-48,316
	Medicare Total	-1,712	-6,459	-9,406	-13,515	-19,795	-25,090	-30,341	-36,790	-44,087	-51,746	-50,887	-75,977	-239,241
	Memo - Possible Part B additions to raise 1995-2000 total to $80 billion:													
	Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
	Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
	Medicare Total including Memo Items	-1,964	-6,875	-9,864	-14,538	-21,139	-26,436	-31,790	-38,407	-45,793	-53,492	-54,380	-80,816	-250,598

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

PHONE: (202) 690-7450 **FAX: (202) 690-8425**

TO: Chris Jennings **FROM:** Bridgett Taylor

NAME: **NAME:**

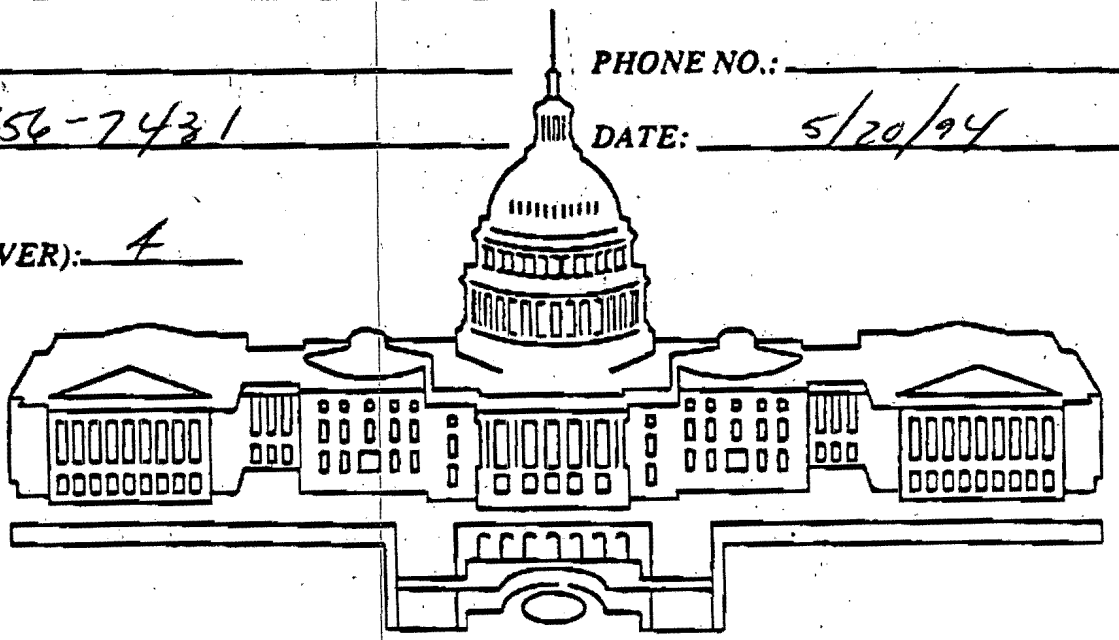
OFFICE: **OFFICE:**

ROOM NO.: **ROOM NO.:**

PHONE NO.: **PHONE NO.:**

FAX NO.: 456-7431 **DATE:** 5/20/94

TOTAL PAGES (INCLUDING COVER): 4



REMARKS:

Chris -

I gave this to Ken Thorpe. Could you call me & let me know what you think? Also I need to discuss Debbie Chang & Stanley Key when you have a chance.

Thanks

Iraq, Nancy Ann, Judy, JMB-PE

May 20, 1994

NOTE TO: Ken Thorpe

FROM: Bridgett Taylor

Attached is a list of questions regarding Medicaid numbers from Jane Horvath, Senate Finance Committee, which she would like for you to run for her, or to answer as best you can. She needs this by early next week if possible. Could you let me know if this is possible?

Thanks.

cc: Jerry Klepner
Karen Pollitz
Chris Jennings

Medicaid Population in Community Rate

1) What happens to the premium, (in percentage terms) when certain Medicaid populations are included in different sized community rated pools? Assume premium caps. Assume state makes 100% ffs equivalence payments for each Medicaid person, therefore payment shortfalls. Assume mandatory purchase for all. Assume no self-insurance for groups covered by community rating (CR).

	CR<5000	CR<1000	CR<500	CR<100
a) Add AFDC to CR:				
b) Add SSI to CR:				
c) Add a) & b) to CR:				
d) Add non-cash to CR:				
e) Add all to pool				

2) What happens to the premium, (in percentage terms) when certain Medicaid populations are included in different sized community rated pools? Assume NO premium caps. Assume state makes 100% ffs equivalence payments for each Medicaid person, therefore payment shortfalls. Assume mandatory purchase for all. Assume no self-insurance for groups covered by community rating (CR).

	CR<5000	CR<1000	CR<500	CR<100
a) Add AFDC to CR:				
b) Add SSI to CR:				
c) Add a) & b) to CR:				
d) Add non-cash to CR:				
e) Add all to pool				

3) What happens to the premium, (in percentage terms) when certain Medicaid populations are included in different sized community rated pools? Assume NO premium caps. Assume state makes 100% ffs equivalence payments for each Medicaid person, therefore payment shortfalls. Assume mandatory purchase for all. Assume self-insurance can occur in market covered by community rating (CR).

	CR<5000	CR<1000	CR<500	CR<100
a) Add AFDC to CR:				
b) Add SSI to CR:				
c) Add a) & b) to CR:				
d) Add non-cash to CR:				
e) Add all to pool				

4) What happens to the premium, (in percentage terms) when certain Medicaid populations are included in different sized community rated pools? Assume NO premium caps. Assume state makes 100% ffs equivalence payments for each Medicaid person, therefore payment shortfalls. Assume voluntary purchase for all. Assume no self-insurance for groups covered by community rating (CR).

	CR<5000	CR<1000	CR<500	CR<100

a) Add AFDC to CR:
b) Add SSI to CR:
c) Add a) & b) to CR:
d) Add non-cash to CR:
e) Add all to pool

II Premium Comparisons

1) What is private sector family premium compared to XIX MOE per capita AFDC payments for typical AFDC family?
2) What is private sector individual premium compared to what XIX MOE per capita SSI payment would be?

for 1) and 2) assume Clinton bill specifications

III Miscellaneous

What happens under Clinton bill when an unemployed family enrolls in an AHP but child member is also eligible for SSI (but is not on Medicare)? How is subsidy calculated, since whole family is not Medicaid eligible and but Medicaid contributes a per capita for the child?

	Model 1
Government Subsidies:	
1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies:	
5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies:	
10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit *	
(5 Years)	(394)
Net Effect on Deficit *	
(10 Years)	(70,596)
Net Effect on Deficit ***	
adjusted by 50% (5 Years)	(197)
Net Effect on Deficit ***	
adjusted by 50% (10 Years)	(35,298)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

Model 1

Private Sector Payments
In 1 Fully Phased-In Year, 1994

	Family Payments	Employer Payments
Total (in millions)	$60,398	$226,847
Average per Family	$584	$2,192

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 10% to 12.8%, depending upon family type.

	Model 2
Government Subsidies:	
1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies:	
5 Years ($m)	331,567
employer	129,668
household	201,899
Government Subsidies:	
10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit *	
(5 Years)	(31,533)
Net Effect on Deficit *	
(10 Years)	(153,081)
Net Effect on Deficit	
adjusted by 50% (5 Years)***	(15,767)
Net Effect on Deficit *	
adjusted by 50% (10 Years)***	(76,541)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

Model 2

Private Sector Payments
In 1 Fully Phased-In Year, 1994

	Family Payments	Employer Payments
Total (in millions)	$57,430	$218,242
Average per Family	$555	$2,108

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 9.3% to 12.0%, depending upon family type.

Possible Mitchell-Breaux-Boren-Like Compromise

- An 80% employer requirement on firms of more than 20 workers. If after 3 years, 90% of workers and families in firms of 20 or less do not receive employment based coverage, a full employer mandate is triggered.

- Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Employer premium share is determined by firm size and average wage in the firm.

- Firms not covering their workers pay a payroll assessment of 1% if firms has 1-10 workers and 2% if 11-20 workers.

- Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment

- Workers and families not receiving coverage through their employer must pay the full share of the premium, but their contributions are capped at 4 to 6% of their income (cap level determined by family income level); just as in HSA, non-workers receive the same out-of-pocket protections and must pay the full share of their premium.

- Premiums/benefits package are 5% below the CBO scoring of the HSA.

	Mitchell-Breaux-Boren-Like Compromise
Government Subsidies:	
1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies:	
5 Years ($m)	359,142
employer	131,013
household	228,129
Government Subsidies:	
10 Years ($m)	949,907
employer	401,261
household	548,646
Select Revenue Estimates: *	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates: *	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit * (5 Years)	(17,238)
Net Effect on Deficit * (10 Years)	(102,573)
Net Effect on Deficit, Adjusted by 50% (5 Years) ***	(8,619)
Net Effect on Deficit, Adjusted by 50% (10 Years) ***	(51,287)

Model 3: An 80% employer mandate on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is implemented.

Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

Firms not covering their workers pay a payroll assessment of 1% if firm has 1-10 workers and 2% if 11-20 workers.

Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may underestimate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

**** 1 Year subsidy estimates assume a fully phased-in carve-out year.

Mitchell-Breaux-Boren-Like Compromise

Private Sector Payments
In 1 Fully Phased-In Year, 1994 *

	Family Payments	Employer Payments
Total (In millions)	$63,320	$207,655
Average per Family	$612	$2,006

* Assumes small firm exemption in place.

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 10.5% to 13.4%, depending upon family type.

	HSA
Government Subsidies:	
1 Year (1994) ($m)	88,170
employer	40,082
household	48,088
Government Subsidies:	
5 Years ($m)	396,000
employer	179,000
household	217,000
Government Subsidies:	
10 Years ($m)	1,082,000
employer	521,000
household	561,000
Select Revenue Estimates: *	
Corporate Assessment	7,600
Other Revenue	19,300
Total (5 Years)	26,900
Select Revenue Estimates: *	
Corporate Assessment	15,200
Other Revenue	38,600
Total (10 Years)	53,800
Net Effect on Deficit * (5 Years)	74,000
Net Effect on Deficit * (10 Years)	126,000
Net Effect on Deficit, Adjusted by 50% (5 Years) ***	37,000
Net Effect on Deficit, Adjusted by 50% (10 Years) ***	63,000

HSA: An 80% employer mandate on firms of all sizes.

Regional alliance firms pay the lesser of the employer premium share for each worker in the firm, of 3.5 to 7.9% of total payroll in the firm, whichever is less. Cap is determined by firm size and average wage of the firm.
Firms of 5000 workers or more choosing to form their own corporate alliances are not eligible for subsidies.

Corporate alliance firms are outside of the community rating pool and pay a 1% payroll assessment.

Notes on the estimates:

* Revenue estimates are for those components that differ from the other models presented. Deficit effects are relative to the current system.

** Revenue estimates and multi-year subsidy estimates are consistent with CBO scoring. Revenue estimates include 1995 savings of $10 billion.

ALTERNATIVE COMPROMISE PROPOSAL

This proposal builds on the Mitchell/Breaux/Boren–type model, with the following changes:

- It allows for a voluntary insurance market to achieve universal coverage.

- Employers and families who choose to purchase coverage receive subsidies to make coverage affordable (as in the Mitchell/Breaux/Boren–type model).

- For the working population, coverage objectives are established by size of employer, and are evaluated over a five year period.

  - **For firms with 100 or more employees:** After three years, unless 85% of the currently uninsured families with employees working for these firms are covered by their employers, a mandate goes into effect for these firms.

  - **For firms with 25 to 99 employees:** After four years, unless 80% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for firms with 25 or more employees.

  - **For firms with fewer than 25 employees:** After five years, unless 75% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for all firms.

- After five years, to ensure universal coverage, any family not covered through their employer must purchase coverage.

- Insurance market reforms apply upon enactment (e.g., guaranteed issue of coverage and community rating), but special provisions are made so long as the purchase of insurance is voluntary.

  - Insurers are permitted to apply a waiting period for pre–existing conditions when previously uninsured people purchase coverage.

  - Insurers are permitted to adjust community rates by age, but not by health status or other factors.

- To enhance competition and ensure fair application of fall–back premium caps, uncompensated care pools are formed so that the financial burden of serving the remaining uninsured is spread fairly across all health care providers.

This approach achieves universal coverage while providing a similar amount of deficit reduction as the Mitchell/Breaux/Boren–type model. However, without premium caps, the deficit would be substantially increased, and employers and families would pay much more.

PARTICULAR COMPLEXITIES ASSOCIATED WITH A TRIGGER WITHOUT UNIVERSAL COVERAGE AT THE START

Some proposals for triggered mandates require universal coverage from the start (e.g. an employer requirement above a certain size, with an individual requirement below that size), where the trigger applies only to whether certain employers are required to contribute for employees and their families.

Universal coverage makes it easier to establish a competitive and fair insurance market, because uncompensated care is eliminated and risk selection can be more easily controlled.

A trigger without universal coverage from the start (i.e. with no individual mandate to begin with) makes implementation more complicated in a number of ways, including:

- **UNCOMPENSATED CARE.** Without universal coverage, uncompensated care will continue to distort competition among providers and health plans. Uncompensated are pools are needed to spread the financial burden of serving the remaining uninsured fairly across all health care providers. Accurately measuring uncompensated care can be difficult, and uncompensated care pools require a new (and temporary) administrative structure.

- **PRE-EXISTING CONDITION EXCLUSIONS.** To guard against people delaying the purchase of insurance until they need health services, pre-existing condition exclusions for the previously uninsured are necessary.

- **AGE RATING.** Similarly, until universal coverage is achieved, age adjustments to premiums are necessary to prevent younger/healthier individuals from dropping existing coverage. Age rating is unfair, increases subsidy costs, and is more complicated for employers and families.

- **MEASUREMENT.** Evaluating whether coverage objectives have been met (particularly if the objectives vary by employer size) is more difficult and costly without universal coverage because there would not likely be an enrollment system that includes information about all families.

RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

SUMMARY OF A HIGH COST PLAN ASSESSMENT APPROACH

- There are no premium caps. Health plans may charge whatever price results from a more competitive market.

- If competition fails to moderate premium increases -- leading to higher subsidies and lower federal tax revenues -- an assessment on high cost health plans is used to make up the difference and protect the federal budget.

  - High cost health are those plans with a premium above the "target premium" for a state (or substate area). Health plans with premiums below the target are not subject to an assessment.

  - The target premium for a state (or substate area) is based initially on current health care costs, but with added funding for the uninsured and no windfall for the health industry. The target premium grows from year to year based on reasonable expectations for a more competitive health care marketplace.

WHAT THE ASSESSMENT ACCOMPLISHES

- The high cost plan assessment limits the federal budgetary risk from health care reform.

- Because the assessment is targeted at high cost plans, it encourages plans to lower costs and encourages employers and individuals to choose more efficient health plans.

- The high cost plan assessment is analogous to a tax cap in that it uses financial incentives to encourage high cost health plans to lower costs, but it is different from a tax cap in a number of important respects:

  - The assessment does not in any way alter the tax treatment of employer-sponsored health benefits. Benefits would continue to be fully deductible by employers and excluded from taxable income for employees.

  - A tax cap would apply regardless of whether or not competition is effective. However, a high cost plan assessment would be triggered only if competition fails to moderate premium increases.

    Large employer self-insured or experience rated plans could be subject to the assessment, but only to the extent that costs grow faster than targeted growth rates. In effect, the base for the assessment would be the current spending level in a self-insured or experience rated plan, rather than some arbitrary amount as under a tax cap.

- A primary problem with a tax cap is that it specifically targets employees with generous employer-sponsored health benefits. In contrast, the high cost plan assessment targets all high cost health plans, not just generous employer-sponsored health benefits.

- Tax caps impose higher taxes on employers or employees. A high cost health plan assessment charges *insurers* -- not employers and employees -- who have excessive premium levels. While insurers might pass some of the assessment onto employers or employees, a considerable portion would likely be absorbed by insurers and providers.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

3:00

BIAS

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REMARKS:

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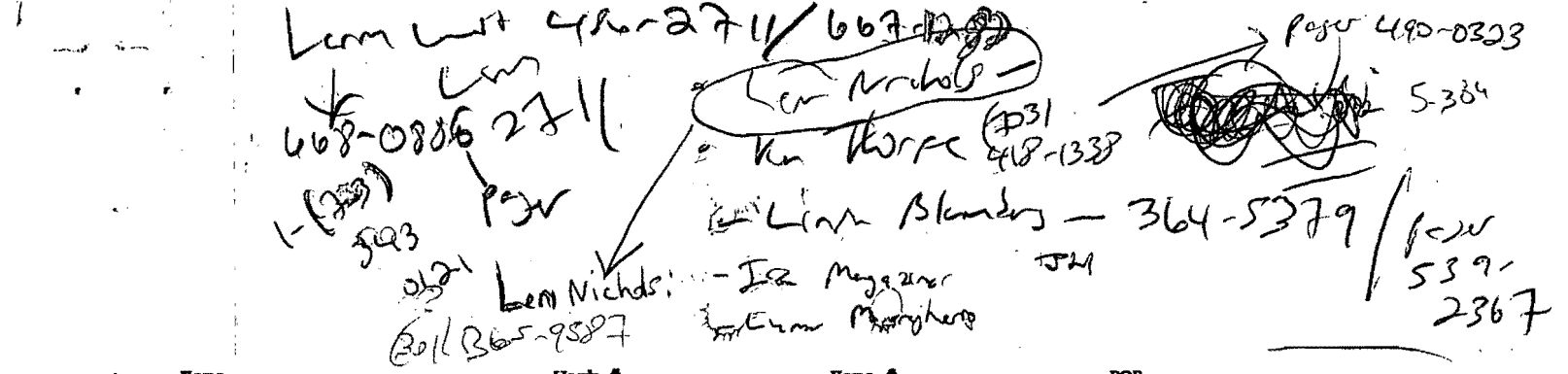

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Adelstein, Jonathan (Aging)	202-224-6857		
Alberghini, Theresa (Leahy)	202-224-2414/3595 fax		
Allen, Barbara			
Altman, David (Rockefeller)	202-224-6472		
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Democratic National Committee	202-863-8000
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Eisenbrey, Ross (Labor)	202-219-6141/5120 Fax
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Epstein, Arnie	202-456-2696
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Faletti, Tom (Durbin)	202-225-5271
Falk, Scott (BNA)	202-728-5241
Fariello, Dr.	703-415-0505
Feder, Judy	202-690-7858/7383 fax
Feighan, Ed	216-447-9000
Ferguson, Christy (Chafee)	202-224-6117/2853 fax
Finan, Steve (Labor)	202-219-6001
Finigan, Thomas (Baucus)	202-224-2651
Firshein, Janet (Med & Health)	202-822-1256
Fiske, Mary Beth (Kennedy)	202-224-7675
Flanders, Don (Adelphi)	516-877-3224
Flemming, Arthur	202-624-9552
Foote, Susan (Durenberger)	202-224-4055/9931 fax
Foreman, Ira (OPM Cong Affairs)	202-606-1300/1344 Fax
Forster, Theresa (Aging)	202-224-5364/6018/9926 f
Forsgren, Janet (OMB)	202-395-3925/6148 fax
Frantz, Molly (Pomeroy)	202-225-2611
Fried, Bruce	202-662-3744
Furman, Jim (United Seniors)	202-393-6222
Furst, Kurt (Searle)	202-842-0706
Gale, Joe (Moynihan)	202-224-4515
Gampel, Gwen	202-544-6264
Garamendi, John (CA Ins Comm)	916-955-2353 ?
Caudette, Sylvia (Olver)	202-225-5335
Gaus, Clif	202-401-7736
Gebbie, Kristine	202-632-1090/1096 fax
Gehan, Margery (Mike Andrews)	202-225-7508
Glaze, Steve (Pryor)	202-224-7827
Gobel, Herschel	202-535-8623
Golub, Al	202-682-6270
Gottlieb, Jim (Vets)	202-224-6202
Goldberg, Jason (Cab. Affairs)	202-456-2572/6704
Goldstein, Elaina	
Goldstein, Naomi	202-690-7858
Goldstein, Steve (Phil Inquirer)	202-383-6048
Goldwater, David (Bilbray)	202-225-5965
Goobokar, Ellen (AFSCME)	202-429-1185
Gordon, Greg (Minn Star-Trib)	202-457-5171
Greenberg, George	202-690-7794/6418 fax
Greenstein, Bob	202-408-1080
Grever, Kim	
Gross, Lauren (Pell)	202-224-4673
Grote, Sara	202-456-2922/7560/2317 f
Grunwald, Mandy	202-973-9400
Gurrola, John	202-632-1090/1096 fax
Gust, Steve (Wellstone)	202-224-5641
Gustafson, Tom	202-690-5960/8168 fax
Hancox, Karen	202-456-6620
Harahan, Mary	202-690-6613
Harbage, Peter	

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Harkin, Tom (Senator)	202-224-7301
Harrell, Don (Teachers Ins)	212-916-6244
Hart, John	202-456-2896
Hash, Mike (Waxman)	202-225-4954
Hasson, Judy (USA Today)	703-276-6430
Hatton, Mindy (Metzenbaum)	202-224-5701
Havel, Roberta (SOS, Exec Dir)	202-624-9557
Hayes, Charlotte (VP)	202-456-6277/6231
Heenan, Christine	202-456-2929/2857
Healy, Monica (Labor)	202-219-6141/512
Heldman, Paul (BBN)	202-393-0751
Hennemuth, Kathy (Rowland)	202-225-6531/7719 fax
Hermelin, Bill	202-429-7533
Hickman, Peter	202-690-5950/8168 fax
Hill, Diane (Williams)	202-225-3211/6-0244 fax
Hilly, John (Mitchell)	202-224-
Hoffman, Alan	202-690-6786
Hogue, Bonnie (Aging)	202-224-5364
Honig, Judy	703-902-5225
Hopper, Julie	202-456-7561/7560/2317 f
Horvath, Jane (Finance)	202-224-4515/8-5568 fax
Hosto, Lester	501-324-9200
Howard, Ed (Alliance for HR)	202-466-5626
Huckaby, Michelle (Clement)	202-225-4311
Human, Jeff	301-443-0835
Hunter, Nan (HHS Dep Gen Couns)	202-690-7780
Hutchins, Glenn	202-456-
Ickes, Harold	202-456-2459
Inglee, Bill (Wedensday Group)	202-226-3236
Iskowitz, Michael (Labor&HR)	202-224-6572
Jennings, Chris	
Jennings, Lucile	
Jennings, Tom	703-836-7442
Jodrey, Darrel (Wofford)	202-224-7760
Johnson, Don	202-690-
Johnson, Haynes	202-298-6099 fax
Jones, Marcia (Breaux)	202-224-9741
Jorling, Jim	202-408-7131
Joseph-Fox, Yvette (Inouye)	202-224-2251
Kane, Brad (Energy&Commerce)	202-226-3160
Kattan, Azar (Matsui)	202-225-7163
Kazdin, Robert	202-906-5759/7495 fax
Keene, Judy (USA Today)	703-276-3608
Kehoe, Dani (NALU)	202-331-6029
Kendall, Dave (Mike Andrews)	202-225-7508/4210 fax
Kennedy, Eileen	
Kepner, Colleen (Stenholm)	202-225-6605/2234 fax
Klepner, Jerry (HHS)	202-690-7627/7380 fax
Kerrey, Bob (Senator)	202-224-6551
King, Andie (Gephardt)	202-225-0100/7296/7414 f
King, Kathy (Finance)	202-224-4515
Klepner, Jerry	202-690-7627
Konnor, Del (AMCPA)	703-920-8480
Kosterlitz, Julie (Natl Journal)	202-857-1415
Kronick, Rick	202-456-2709
Lambert, David (NACDS)	703-549-3001
Lavizzo-Mourey, Risa	301-227-6662
Lawler, Greg	202-456-6252/225-6060
Lefkowitz, Bonnie	301-443-7526/6155 fax
Legislative Counsel	202-225-6060
Levario, Andrea (HHS)	202-690-7450/8425 fax
Levine, Debbie	202-462-4092
Levine, Greg (DeLauro)	202-225-3661
Levitt, Larry	202-456-2711
Lew, Jack	202-456-2316
Lewin, Larry	703-218-5619
Lewis, John (Richardson)	202-225-6190
Liebold, Pete (Danforth)	202-224-1406/0952 fax
Lifse, Diane (Glenn)	202-224-7985
Linkous, John (Issue Dynamics)	202-408-1400
Lipner, Robyn (Mikulski)	202-224-3239/8858 fax
Lipsen, Linda (Consumers Union)	202-482-6262/265-9548 fa
Lively, Rob	202-463-7372
Lopez, Ed (Finance)	202-224-4515/8-5568 fax
Lovell, Ellen (Leahy)	202-224-4242
Lowrey, Bonnie (Foley)	202-225-8550/3738 fax
Littlefield, Nick (Kennedy)	202-224-5465/6367
Lukomnik, Joanne	212-662-2463
Lusskin, Liz (NYS Office)	202-638-1311

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Lux, Mike	202-456-2930/2976
Magaziner, Ira	202-456-6406
Maguire, Dan	202-219-4592
Maher, Wally (Chrysler)	202-862-5431
Mande, Jerry	~~202-690-7760~~ 205-4102
Manowitz, Michele	206-448-2913
Maples, Monica (DCCC Pol Dir)	202-485-3432
Margherio, Lynn	202-456-2315
Markus, Kent (DNC)	202-863-8138
Martinez, Ray	202-690-6625
Mays, Janice (W&M)	202-225-3628/2610 fax
McBride, Anne (Common Cause)	202-736-5749
McFee, Tom	202-690-7284
Means, Kathy	202-690-5974
Menn, Buddy	202-435-6060
Michie, Jim	301-656-5278
Miller, Carol	
Miller, Meredith	202-219-8233
Min, Nancy Ann	202-395-5178
Mindy (Boren)	202-224-0152
Mittleman, Portia	202-401-4545
Moe, Kari (Wellstone)	202-224-8447/5641
Monahan, John	202-690-6060
Montgomery, Bob	614-297-5889
Montgomery, Jan	202-512-5484
Moore, Walter (Genentech)	202-296-7272/7290 fax
Mossinghoff, Gerald (Pat)	202-835-3420
Murguia, Janet (Slattery)	202-225-6601/1445 fax
Muse, Don (Radiopharm Ind)	202-737-0100
Nader, Ralph	202-387-8030
Navarro, Vicente	410-955-3280
Nelson, Karen	202-225-0130/7090 fax
Nelson, Trish	202-898-4746
Neuberger, Neal (CtrPubServComm)	703-528-0801/0802 fax
Neuman, Tricia (W&M)	202-225-7785
Nexon, David (Kennedy)	202-224-7675/3533/5400
Nix, Sheila (Kerrey)	202-224-0295
Norrell, Judy	202-429-6543/833-2055 fa
Obey, Craig (Conrad)	202-224-2519/7776 fax
O'Brian, Rindy (DPC)	202-224-3232/228-3432 fa
O'Donnell, Laurence (Finance)	202-224-7800/8-5568 fax
Offner, Paul (Finance)	202-224-4515/9293 fax
Oliver, Teal	202-638-4170
O'Meara, Janis (Mercer)	202-331-5269/223-5985 f
O'Neill, Kim (WH)	395-4730
Ortmans, Jonathan (ColumbiaInst)	202-547-2470/1893 fax
Parker, Kim (HHS)	202-690-6786
Parmalee, Ken (Rural Let Car)	703-684-5545
Patzman, Andrew (Kassebaum)	202-224-6770/8072 dir
Payne, Mary Ella (Rockefeller)	202-224-7993/6472/f7665
Payton, Sallyanne	
Peck, Jonathan (Inst Alt Fut)	703-684-5880
Pellici, Bob (OMB)	202-395-4871/6148 Fax
Picillo, Theresa	
Pigeon, Steve	202-457-5300
Pitts, Bill	202-225-1234
Podoff, David	202-225-2335/3338
Pollitz, Karen	202-690-7450/8425fax Private fax 6351
Pomeroy, Earl (Congressman)	202-225-2611
Portman, Rob	202-219-6045
Potetz, Lisa (W&M)	202-225-7785/0111 fax
Powden, Mark (Jeffords)	202-224-5141
Priest, Dana (Wash Post)	202-334-6566
Proctor, Kurt (NACDS)	703-549-3001
Prowitt, Nancy	703-841-0626
Puskin, Dena	301-443-0835/2803 fax
Quam, Lois	612-936-3630/0044 fax
Raymond, Victor	202-523-1802/1818 fax
Rector, John (NARD)	703-683-8200/703-347-204
Redlener, Irwin	212-535-9707
Reed, Mike (PMA)	202-835-3480
Regan, Carol (CDF)	202-628-8787
Reinecke, Peter (Harkin)	202-224-7303/8-2923 fax
Reinhardt, Uwe	609-258-4781/4830
Reuter, Jamie (W&M)	202-225-7785/0111 fax
Ricchetti, Jeff (BC/BS)	202-626-4806
Ricchetti, Steve	202-456-7054/2604 fax
Richardson, Sally	410-966-3870 Rm 200 I

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Richardson, Mary Ann (Labor)	202-219-6141/51
Rios, Elena	916-654-2827
Rissler, Pat (Ed & Labor)	202-225-4527/9070 fax
Rivlin, Alice	202- -4742
Robbins, Liz	202-544-6093
Robertson, Linda (Treasury)	202-622-1920/0534 fax
Rockefeller, John (Senator)	202-224-6472
Rodriguez, Louise	202-535-7302/7237 fax
Rosen, Bob (Mitchell)	202-224-5344/3840/2151
Rother, John (AARP)	202-434-3704
Rovin, Lisa	202-690-5512/8168 fax
Rudolph, B.A.	202-659-8320
Rueschemeyer, Simone	202-456-6406
Sagawa, Shirley	
Samuelson, Ellen (Budget)	202-225-4755
Scheppach, Ray (NGA)	202-624-5320/5313 fax
Schroeder, Chris	202-514-2069
Schroeder, Steve (RWJ Fdn)	609-243-5903
Schulke, David (Wyden)	202-225-1058/8941 fax
Schultz, Bill (Waxman)	202-226-7625/5-7092 fax
Shaffer, Ellen (Wellstone)	202-224-8446/8438 fax
Donna Shalala - Scheduling	202-690-6610 Virginia
Shearer, Gail (Consumers Union)	202-482-6262/265-9548 fa
Shriber, Donald (En&Comm)	202-225-3147/2525 fax
Silimeo, Debra (DPC)	202-224-3232/228-3432 f
Silva, John	703-696-2221/2202 fax
Simon, Marsha	202-224-4740/3533 fax
Sklar, Brad	212-536-3320
Smith, Barbara (McDermott)	202-225-3106/9212 fax
Smith, Jennifer	202-690-7850
Solis, Patti	202-456-2468/7560
Solomon, Loel	202-224-6064
Spencer, Susan (Greenwood)	202-225-4276/9511 fax
Stafford, Michael (GRQ)	301-718-0202/2976 fax
Stanton, Tamera (Rockefeller)	202-224-9842
Starr, Paul	609-258-4533
Stevens, Janice	202-690-6033
Stone, Robyn	301-656-7401x256/4-0629f
Stout, Hilary (WSJ)	202-862-9233
Stram, Kenneth (SBA Leg Affairs)	202-205-67007374 fax
Sunderhauf, Steve	
Swedin, Kris (SBA Leg Affairs)	202-205-6700/7374 fax
Sykes, Kathy (Obey)	202-225-3365
Taylor, Bridget	202-690-6273/7450/8425fa
Terry, Donald (LaFalce)	202-225-3231
Testoni, Maureen (Baucus)	202-224-9317/8-3687 fax
Thomas, Tandi (Hastert)	202-225-2976/0697 fax
Thompson, Jake (KS City Star)	202-393-2020
Thorpe, Ken (Joyce Marshall)	202-690-6870/401-7321 f
Thurm, Kevin	202-690-6133
Thursz, Daniel (Nat Coun on Aging)	202-479-6601/1200/0735
Tilley, Kim	202-456-2131/7845
Tilson, Hugh	202-690-6250/401-7321 fa
Toder, Eric	202-622-0120
Toohey, Megan	202-690-7858/7383 fax
Torda, Phyllis (Families USA)	202-628-3030
Turk, Barbara (NYC OMB)	212-788-5894
Tyson, Laura (Alice Wms, Sched)	202- -5042
Uhlman, Marian	215-854-2473
Unger, Mike (NY Newsday)	212-251-6600
Vagley, Karen	202-225-4527/9070 fax
Valdez, Bob	310-206-9094/393-0411x74
Varma, Vivek (Synar)	202-225-2701/2796 fax
Varnhagen, Michele (Metzenbaum)	202-224-5546/5474 fax
Velasquez, Joe	202-456-6257
Veloz, Richard	202-456-2302/401-5193
Verveer, Melanne	202-456-6266
Vladeck, Bruce (Rena)	202-690-6726/6262 fax
Volpe, Carl (NGA)	202-624-7729
Wagner, Lynn (Modern Healthcare)	202-662-7215
Waldo, Dan	410-966-7949
Walker, Bill	614-594-8228
Wartzman, Rick (WSJ)	202-862-9284
Waspe, Rob (NACDS)	703-549-3001
Weinstein, Naomi	718-519-2722
Weiss, Gail (PO&CivServ)	202-225-4054
Weiss, Marina	202-622-0090/2633 fax
Werner, Michael	202-393-1650
Westmoreland, Tim (Waxman)	202-225-4952/3043 fax

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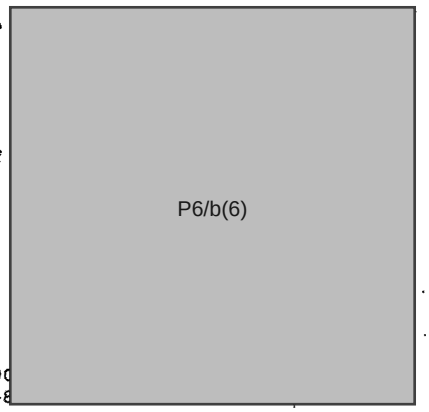
Whang, Judy	202-690-6797/490-0771 bp
Whedin, Chris	202-205-6700
White House Social Office	202-456-7136
Wilkins, Amy (DNC HC)	202-863-7184
Williams, Chris (Mitchell)	202-224-5344/1946 fax
Women's Information Network	202-467-5992
Woo, Michael (En&Comm)	202-225-3147/4014/2525 f
Wood, Susan (Cong Women Caucus)	202-225-6740
Yager, Marilyn	202-456-2930/6683
Yale, Ken	202-638-3535x242
Yamamoto, Cora	202-224-7470
Zelman, Walter	202-456-2449
Zettler, Susan (Strickland)	202-225-5705
Ziegler, Ron (NACDS)	703-549-3001
Zubkoff, Jordana (NACDS)	703-549-3001
Zuckerman, Diana (Vets)	202-224-9126
Ira Magaziner	H 537-8220 CAR 202-494-90
John Hilley	804-253-8220 OR 804-253-8



150% of poverty
[illegible] w/ no asset
single parent

- Karen
- Ann Traina - 11:00 > 757-7657
- David

- Linda - Go for new schedule
- New info on DME from Brad Bailey
- Justice Dept.

- John Hilley - Kennedy - came out
  - mitchell new option - 0.9% vs 35%

- CALL each offices re Q&A's.

- Nancy Sheip - Tryon to Judy w/ 301 469-4997

- Stars list for Nick.

- Last (Goodyear [illegible]
- Boffes > DME
- Bob Rosen re minor changes/Crs

(202) 328-6938

- 45th [illegible] - [illegible]
- [illegible] away [illegible] [illegible]
- not just Medicare, but everyone
- No one comes to vet org.
Nelson - 110% of national avg.

Hatch - national alcohol cont.
phasing [illegible] on
Medicare cont.

< 100,013 - proposal
< 0 | [illegible]