Slower Phase-In Caps after phase-in

Alternative Triggers

I. Gephardt -- Delayed One-time Mandate Trigger

All in 99

- No employer or individual mandates until 1999. 45% st

- no premium caps until 1999, subsidies tied to premium caps in interim to protect government: currently uninsured

  (let you re-bid)

  -- bidding assessments + fallback Medicare Part C program to accomplish premium control during interim in under 1000 sector, no constraint on 1000+ sector in interim

- up to 1% payroll assessments on firms with ≤ 1000 workers that do not offer until the mandate (0.5% in 1996, 0.75% in 1997, 1.0% in 1998), 1% assessment on firms with 1000+ workers from 1996 on.

- Pure individual wage caps (5.5%-12%) for firms and HSA-like subsidies for households.

- 5% lower benefit package.

- No benefit expansion in 2001 and no S&L subsidies.

Results:

- $111B deficit increase in 1995-2000 (HSA was $74B).

- $21B deficit reduction over 1995-2004 (HSA was $126 deficit increase).

- Fiscal problems driven by giving subsidies to currently insured, de facto faster phase-in than HSA.

- options considered for closing short run deficit problem:

  -- reducing benefit package another 5% ($16B)
  -- reduce employer subsidies by 1/2 until 1999 ($57B)
  -- delay start of program ($55B)

Hard trigger
Spends a lot of $
but you get full
coverage by 2000.

II. Mitchell-Breaux -- Sequential Mandate Triggers

85%, 80 75

- Firms with 100+ triggered in 1998, 26-99 in 1999, 2-25 and individuals mandated in 2000.
- HSA Premium caps assumed. of currently uninsured
- 2% payroll assessment on 26-1000 until they offer, 1% on 1000+ that do offer from 1996, 3% on 1000+ until they offer.
- Mitchell (2.8-12%) individual wage caps for firms and HSA-like subsidies for households.
- 5% lower benefit package.
- No benefit expansion in 2001 and no S&L subsidies.

Results:

- $88B deficit increase in 1995-2000 (HSA was $74B).
- $36B deficit reduction over 1995-2004 (HSA was $126 deficit increase).
- Fiscal problems driven by giving subsidies to currently insured, de facto faster phase-in than HSA.
- options considered for closing short run deficit problem:
  - -- reducing benefit package another 5% ($22B)
  - -- reduce employer subsidies by 1/2 until 2000 ($67B)
  - -- 1/2 employer subsidies until mandate ($48)
  - -- no subsidies to currently offering firms ($60B)
  - -- delay start of program ($55B)

III. Mitchell-Breaux-Bradley-Finance

- Combines Mitchell-Breaux with Bradley's alternative to premium caps and some elements of Moynihan's mark.
- 100+, 26-99, 2-25 and individuals triggered as in Mitchell-Breaux (1998, 1999, 2000, etc.) [although we are considering a variant that triggers in 1999-2001].
- No hard premium caps, but plans are taxed for bids above the target. This serves to constrain bids somewhat, and works like a tax cap for consumers at the same time. Tax rate set to keep government whole for higher household subsidies and revenue loss from higher business spending.
- Employer subsidies indexed to shift risk of higher premiums to firms from government.
- 8% lower benefit package.
- Less generous household subsidies (5% instead of 3.9% on the 20% share, only up to $30,000 instead of $40,000).
- No long term care, no Medicare drug, no early retiree subsidy, and lower Medicare program savings.

Results:

- Not estimated yet. Very complicated set of interlocking assumptions. Good numbers not possible in less than a week.
- Given reduction in overall benefits, numbers may appear to work, but they will always have more inherent uncertainty than those derived from assumptions about complete mandates with premium caps.

Trigger Model 6.1.94

	1996	1997	1998	1999	2000	1996-2000	1996-2004
Subsidy cost:							
HSA	11	37	98	122	128	396	1082
Trigger	58	64	72	74	114	382	948
Assessment Revenues:							
HSA	1	2	2	2	1	8	12
Trigger	12	13	14	14	15	68	128
Number uninsured							
HSA	33	23	0	0	0		
Trigger	34	31	25	20	0		

Subsidy cost of Trigger assumes: No benefit package expansion in 2001, 8% growth in subsidies after 2000, 25% of the HSA level of outsourcing after 2000, no subsidies for state and local governments

Assessments: 2% of payroll on firms with 26-999 workers that don't offer health insurance, 1.5% for firms with 1000+ workers that do offer, 3% for firms with 1000+ workers that don't offer.

6/6/94
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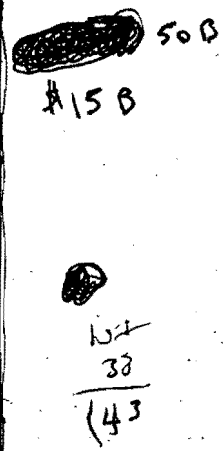
Elements of Trigger Model 6.1.94 to Keep in Mind

	1996	1997	1998	1999	2000	96-00
Premiums, vs. HSA	+5%	+5%	+2%	-1%	-5%	
Cap Growth rates	4.5%	4.0%	3.5%	3.0%	3.0%	
Potential Savings losses						
Medicaid	2	5	15	22	26	70
Medicare	1	2	6	8	8	25
Other Federal Programs	1	2	9	11	15	38
Cafeteria plans restrictions	0	1	2	3	4	10
Potential Revenue gains						
Revenue from the Mandate, Cost Containment, and Subsidies	?	?	?	?	?	?



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DRAFT

Trigger Model 6.1.94

	1996	1997	1998	1999	2000	1996-2000	1996-2004
Subsidy cost:							
HSA	11	37	98	122	128	396	1082
Trigger	58	64	72	74	114	382	948
Assessment Revenues:							
HSA	1	2	2	2	1	8	12
Trigger	12	13	14	14	15	68	128
Number uninsured							
HSA	33	23	0	0	0		
Trigger	34	31	25	20	0		

Subsidy cost of Trigger assumes: No benefit package expansion in 2001, 8% growth in subsidies after 2000, 25% of the HSA level of outsourcing after 2000, no subsidies for state and local governments

Assessments: 2% of payroll on firms with 26-999 workers that don't offer health insurance, 1.5% for firms with 1000+ workers that do offer, 3% for firms with 1000+ workers that don't offer.

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SUBSIDY COSTS (BILLIONS)

	1996-2000	1996-2004
Mitchell Carve Out with HSA-5%	$370	$980
Mitchell Carve Out With HSA-10%	$340	$890
Mitchell Carve Out With HSA-15%	$310	$810
Mitchell Carve Out With HSA-5% and reverse trigger; hsa growth through 1998 then managed competition; no 2001 benefit increase and no s/l subsidies	$400	$1115
Mitchell Carve Out with HSA-5% and reverse trigger; hsa growth through 1999 then managed competition; no 2001 benefit increase and no s/l subsidies	$380	$1030
HSA	$396	$1082

ALL ESTIMATES ARE PRELIMINARY AND NOT OFFICIAL

6/6/94

TABLE 2
OPTION PACKAGES FOR 5% and 10% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE

5% Reduction

Option 1: Raise coinsurance from .2 to .25

Option 2: Raise cost-sharing maximum from $1,500 per person to $2,500

Option 3: Raise deductible from $200 per person to $325

10% Reduction

Option 1: Out-of-pocket maximum $2,500/$3,000, .25 coinsurance; $250 hospital deductible

Option 2: Out-of-pocket maximum $2,500/$3,000, .25 coinsurance; deductible $350/$700

Option 3: Out-of-pocket maximum $2,500/$3,000, .25 coinsurance; deductible $275/$550; eliminate dental and vision

Option 4: Out-of-pocket maximum $2,500/$3,000; deductible $500/$1000; eliminate dental and vision

Option 5: Raise out-of-pocket maximum $2,000/$3000, raise deductible to $325, and cut mental health benefit to Blue Cross Standard Option level.

Option 6: Raise out-of-pocket maximum to $2,000/$3000, raise deductible to $325, eliminate special preventive services package

Option 7: Eliminate prescription drug coverage.

Option 8: Eliminate mental health coverage.

Add to #28

5/25/94

TABLE 1
OPTION PACKAGES FOR 15% REDUCTIONS (HSA BASE)
FOR FEE-FOR-SERVICE*

Each option contains a set of changes all of which must be done to obtain 15%.

Option I

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $2500
Raise deductible to $400
Add a $250 per hospital admission deductible

Option II

Raise Cost Sharing .20 to .25
Raise Out of Pocket $1500 to $3000
Cut Mental Health benefit to Blue Cross Standard
Change Prescription Drug cost sharing (.2 to .6 in higher)

Option III

Raise Out of Pocket $1500 to $2500
Eliminate Prescription Drug or Mental Health

Option IV

Raise Out of Pocket $1500 to $2,000
Raise deductible to $250
Eliminate preventive services package
Cut mental health benefit to Blue Cross Standard

*To get full 15% will need comparable reductions in HMO benefits. See Table 2 for HMO package.

5/25/94

TABLE 2
OPTION PACKAGE FOR 10% and 15% HMO REDUCTIONS (HSA BASE)

In order to get a 10% or 15% reduction all of the following would be needed:

Change	HSA	-10%	-15%
Hosptial or specialized facilities admission deductible	0	$250	$400
Emergency Room Use (includes physician charges	$10	$100	$150
Inpatient Surgery (in addition to hospital deductible)	$10	$100	$150
Delivery (in addition to hospital deductible)	$10	$100	$150
Outpatient Surgery (includes facility charge):			
Outpatient hospital	$10	$50	$75
Freestanding facility	$10	$25	$35
Office Surgery	$10	$15	$20
Physician, dental visits, Other practioners (other than prevention, ADM, and vision)	$10	$15	$20
ADM residential or outpatient	$25	$35	$45
Routine vision exams	$10	$25	$35
Home Health Care	$10	$15	$20
Ambulance	0	$50	$75
DME	0	20%	30%
Prescription Drugs	$5	$10	$15

Low 1000 – 1% current vs cost of premium

6/7/94 Policy Atte MBB2

DRAFT

Trigger Model 6.1.94

	1996	1997	1998	1999	2000	1996-2000	1996-2004
Subsidy cost:							
HSA	11 (15% slightly subsidies)	37	98 (100% in firms >100)	122	128	396	1082
Trigger	58 – open to all people	64	72	74	114	382	948
Assessment Revenues:							
HSA	1	2	2	2	1	8	12
Trigger	12	13	14	14	15	68	128
Number uninsured							
HSA	33	23	0	0	0		
Trigger	34	31	25	20	0		

HB comes for firms >100 in 1998

Subsidy cost of Trigger assumes: No benefit package expansion in 2001, 8% growth in subsidies after 2000, 25% of the HSA level of outsourcing after 2000, no subsidies for state and local governments

Assessments: 2% of payroll on firms with 26-999 workers that don't offer health insurance, 1.5% for firms with 1000+ workers that do offer, 3% for firms with 1000+ workers that don't offer.

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Medicaid, M'Care worker + other federal program savings which would be lost.

Assumes growth @ HSA rates

SUBSIDY COSTS (BILLIONS)

	1996-2000	1996-2004
Mitchell Carve Out with HSA-5%	$370	$980
Mitchell Carve Out With HSA-10%	$340	$890
Mitchell Carve Out With HSA-15%	$310	$810
Mitchell Carve Out With HSA-5% and reverse trigger; hsa growth through 1998 then managed competition; no 2001 benefit increase and no s/l subsidies	$400	$1115
Mitchell Carve Out with HSA-5% and reverse trigger; hsa growth through 1999 then managed competition; no 2001 benefit increase and no s/l subsidies	$380	$1030
HSA	$396	$1082

ALL ESTIMATES ARE PRELIMINARY AND NOT OFFICIAL

MEMORANDUM FOR THE RECORD

FROM: Len Nichols 2h

RE: Derivation of Estimates Provided to Nexon 5/26/94

DATE: 5/26/94

1. Overall subsidy savings of Kennedy mark: 21

   Urbanesque AHCPR 5 year subsidy total: 375.3
   CBO's HSA: 396

   This is $10b greater than previous savings estimates, delivered prior to the re-calibration to Urban.

2. Better targeting (individual wage cap vs. firm payroll cap) 35

   This is the pure effect of moving to the individual wage cap. I used HSA - Mitchell model 1 (UI) (396-360). I subtracted 1 to make the whole thing add to 21.

3. More generous household subsidies: 27

   Urbanesque AHCPR 5 year HH subsidy total: 243.8
   CBO's HSA: 217

4. Employer subsidy savings from the ≤ 5 worker exemption: 13

   I took employer subsidies to firms ≤ 10 from AHCPR's HSA (#239) model and subtracted ER subsidies to firms ≤ 10 from AHCPR's 241b (Kennedy Mark), multiplied by the UI/AHCPR adj. factor, 40/51.2. Then, I multiplied by the ratio of payroll for firms with ≤ 5 to payroll for firms with 5-10 from UI.

5. Imbedded in each of these estimates is the effect of a 2% lower premium.

6. Business savings:

   I took Ken's memo from Jim Mays who had calculated busines savings from the HSA consistent with CBO's analysis and baseline. From our earlier assumption that the revenue effects of Kennedy are roughly similar to those estimated for UI model 141, I inferred that business savings must be greater under Kennedy. How much more is the fundamental and unknowable answer. In mindlessly assigning

Model 141's revenue estimates to Kennedy's bottom line under extreme time pressure during the evening of 5/9, I had "given" Kennedy $15b in "other revenue" vis a vis the HSA. This would require, given Treasury's usual 1/3 rule of thumb, an additional $45b in business savings. Given that the HSA only had a total savings of $30b according to Jim, this didn't seem credible. In addition, AHCPR's model output showed virtually identical total employer spending between Kennedy and the HSA, excluding corporate assessments. So, I decided to lower the estimate of other revenue gains originally given to Kennedy by about 1/2. This is consistent with the revenue estimate for UI Model 132 (Mitchell Model #2), and Kennedy's model ought to generate something close to or greater than that. **[Clearly we should now ask Treasury to estimate the revenue effects of the Kennedy model and the Bingaman alternative].** This meant I had to get enough extra business savings to pay for $8b in revenue, or about $24b. I then multiplied each year of Jim's business savings between 1996-2000 by 1/[30/(30+24)]=1.8. For the 10 year estimate, I needed $14b in revenue which requires $42b in extra business savings. I had already generated $24b for 1996-2000, so I allocated the next $18b as simple additions of 4-4-4-6 during 2001-2004. I then added the cautionary footnote and called Lowell Solomon and told him just how rough these numbers are.

5 year Subsidy Savings Decomposed

Overall 5 year subsidy savings of Kennedy Mark vs. HSA	**21**
Better Targeting (individual wage cap vs. firm payroll caps)	**35**
More Generous Household subisides	**- 27**
Employer subisidy savings from the ≤ 5 worker exemption	**13**

IMBEDDED IN EACH OF THESE IS THE EFFECT OF A 2% PREMIUM REDUCTION.

PRELIMINARY UNOFFICIAL STAFF ESTIMATES AFTER CONSULTATION WITH CBO AND THE ADMINISTRATION.

Business Savings Per the Kennedy Mark

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Business savings	1	1.5	1	16	36	40	62	88	120

THESE ESTIMATES ARE EXTREMELY ROUGH. THEY ARE DERIVED FROM A CBO BASELINE AND STAFF ESTIMATES OF THE EFFECTS OF THE HSA AND THE KENNEDY MARK. THEY SHOULD ONLY BE USED FOR ILLUSTRATIVE PURPOSES AND DO NOT REPRESENT OFFICIAL ESTIMATES.

Business Savings From the HSA

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Business savings	**0.7**	**0.9**	**0.7**	**8.8**	**20**	**34.9**	**58.1**	**84.4**	**113.60**

SOURCE: Jim Mays of ARC via Ken Thorpe, using CBO baselines and HSA trajectories.

To: Chris Jennings
From: Jason Goldberg

U.S. DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY
WASHINGTON, D.C.
20210

May 19, 1994

MEMORANDUM TO DANA HYDE
CABINET AFFAIRS

FROM: KATHRYN HIGGINS
CHIEF OF STAFF

SUBJECT: Health Care Reform

On Tuesday, May 17 the Secretary made three phone calls to members of Congress to discuss health care reform. The following is a report on these discussions.

LYNN SCHENK (D-CA)
House Energy and Commerce Committee

* Rep. Schenk told Reich that "Dingell knows that if he can get the other "swing" votes, I'll be with him."

* She mentioned the fact that Dingell has promised her that he will oppose HSA's establishment of a panel to push for lower prices on new drugs. Ira Magaziner reassured her that "there would be no backroom deals by the White House to back off on [this deal]."

* She's pro-choice; she's asked the President, Dingell, and Waxman on several occasions that "there be no backroom deals" on abortion. She wants to make sure the White House goes to the mat on this.

* She thinks we made a big mistake on the alliances by making them so big, bureaucratic, and "incomprehensible," but she will support the voluntary ones in the Dingell mark.

* She suggested that the House postpone the August district work period until they pass a bill.

* We've got to do better job of countering NFIB on small business.

WILLIAM COYNE (D-PA)
House Ways and Means Committee

* Rep. Coyne mentioned that he was happy to see that the President will be meeting with the Committee chairs and Congressional leadership. He wants to see some direction among all the competing bills.

* He supports single payer but knows that there aren't enough votes to pass the measure.

* Thinks that individuals should have the option to choose a medical professional.

* Feels strongly about the need for cost containment. Believes we have a real problem with escalating health care costs.

TIM ROEMER (D-IN)
House Education and Labor

* Thinks the President did a good job of getting the debate started and hopes that he can vote with the President.

* Concerned about treatment of children, especially for immunizations, inoculations, and preventive care. He said he plans on presenting an amendment at full committee to strengthen and clarify the HSA provisions in these areas. He did not say exactly what he had in mind but we will follow up.

* He said that many businesses in his state support an employer mandate, but he expects to see more flexibility than what already exists.

* On premium caps: he likes the idea of a trigger mechanism.

* He mentioned that he is not a co-sponsor of HSA and does not support Cooper or any Republican proposal. He said he's closer to HSA than any other proposal but wants to see some modifications made before he signs on.

* He wants to help the President and First Lady but he feels that getting bipartisan support will be necessary.

* He has concerns about several issues but hopes he can vote with the President in the end.

Health Care Contact : Monica Healy - 219-6141

5/25/94
JB

NO EMPLOYER MANDATE, BUT ALL EMPLOYERS SUBJECT TO HARD TRIGGER

FIRMS WITH 100 OR MORE EMPLOYEES: three years after enactment, if market reforms in a voluntary system do not result in 85% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...11%
# of uninsured employees in this category.....7.4 million
(85% of 7.4 million = 6.3 million)

% of all firms.....1.6%
% of all employees.....60.8%

FIRMS WITH 25 TO 99 EMPLOYEES: four years after enactment, if market reforms in a voluntary system do not result in 80% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...21%
# of uninsured employees in this category.....3.3 million
(80% of 3.3 million = 2.6 million)

% of all firms.....6.5%
% of all employees.....15.9%

FIRMS WITH FEWER THAN 25 EMPLOYEES: five years after enactment, if market reforms in a voluntary system do not result in 75% of the currently uninsured employees of firms in this category gaining coverage, a mandate would go into effect.

% of employees in this category who are uninsured...26%
# of uninsured employees in this category.....9.8 million
(75% of 9.8 million = 7.4 million)

% of all firms.....91.9%
% of all employees.....23.0%

JOHN C. DANFORTH
MISSOURI

COMMITTEES:
COMMERCE, SCIENCE, AND TRANSPORTATION
FINANCE
INTELLIGENCE

United States Senate

WASHINGTON, DC 20510-2502

DATE: 5/26/94

FAX TRANSMISSION SHEET

TO: Chris Jennings

FROM: Peter Lehrfeld

TOTAL NUMBER OF PAGES (INCLUDING THIS COVER SHEET): 3

COMMENTS:

Could we get a copy
from Christine Gibbs?
Let's talk at 4

456-7431

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 2

To Betty Molaet	From Leroy Jackson
Co.	Co.
Dept.	Phone #
Fax #	Fax #

May 26, 1994

Senator John C. Danforth

Mr. Danforth:

I am writing to you in the hope that this letter will be passed on to the appropriate individuals.

This summer marks a significant milestone in my life. In 1984 at the age of 19, I was infected with HIV through tainted blood products. This summer I will be "celebrating" my tenth anniversary of HIV infection. In 1986 I was diagnosed as having AIDS.

Having AIDS has forced me to really experience life, and to attempt to accomplish as much as I can in the time that I have. During this period of time I fought even harder to fullfill personal and professional goals. I completed a two year Radiologic Technology program and subsequently became registered as a Radiologic Technologist. Following that I attended a community college for one year. At that time I chose to subspecialize in diagnostic medical ultrasound. I applied to, and was accepted, into a 12 month hospital based ultrasound training program. Upon graduation I sat for an ultrasound registry examination. I became registered in the Abdominal and Ob/Gyn modalities.

My first full time job was at a community hospital in the Kansas City metropolitan area. I worked there for nearly two years. After much discussion with my new wife I decided to further my career by applying for a position with a manufacturer of ultrasound equipment. In my role as a clinical specialist I was expected to be well versed in all of the clinical applications of ultrasound. My first objective was to become knowledgable in the area of blood flow evaluation. Following a very intense training period I became registered in Vascular Technology. Shortly after that I was approached with a request to learn Cardiac ultrasound. I took the opprotunity and entered into another intense training program, however I have yet to become registered in Cardiology. In my capacity as a clinical specialist I worked with salespeople in sales situations. I trained customers and co-workers in various aspects of ultrasound technology and clinical uses. In doing so I accumulated a significant amount of public speaking experience. I have written several slide presentations for customer education. I have interacted with customers both domestically as well as internationally. In all modesty, I established a reputation among my customers and peers as being exceptional at what I did.

Unfortunately, in Dec. of 1993, after having been on short term disability for some time; my employer, my wife, myself,

and my physicians agreed that the time had come to pursue long term disability. This has been the most difficult decision I have had to make. After ten years of clinical and commercial medical education and experience I find myself at age 28, cast aside as unemployable. The insurance company and Social Security from whom I receive disability benefits both have policies that make it a disadvantage to pursue any efforts at financial self sufficency. To the extent that even buying and selling stocks would jeapordize my disability benefits. I find it frustrating that I would be penalized for any efforts I may take to supplement my disability payments. These policies effectively remove any motivation to attempt to return to a productive, rewarding career.

To say that AIDS has devastated my life would be an understatement. This disease has robbed me of a very rewarding career, my self esteem, the chance to be a parent, and has given me a decade of abject fear. I lived in silence due to the social implications of having AIDS. And that is in addition to fear, bordering on paranoia, that the next infection could be my last. Compounding this, I have seen the pain and frustration that my wife, family, and friends have had to deal with knowing that I am sick and there is nothing they can do to help. I am now confronted with the possibility that when my insurance under the COBRA plan terminates I may not be able to afford insurance. It seems to be particularly needless to die because of bourocratic policies.

My purpose in writing to you is in the hope that I could become involved with the Presidential Council on AIDS. I believe that I have a unique perspective to bring to the table. My experience as an AIDS patient, health care provider, commercial representative, and public speaker have provided me with a full understanding of the ramifications of AIDS. As I am now unemployed this would allow me to give something back to society. I view this a chance to leave a lasting legacy.

Respectfully yours,

Lawrence M. Jakastic RDMS,RVT

P6/b(6)

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).

Model Assumptions:

500 ✓

250 ✓

Langua (how to sell)

—perhaps alternative benefit packages

or one tier for currently uninsured.

PRELIMINARY DRAFT
May 16, 1994 (10:51am)

GENERAL DESCRIPTION	**Benefit Package:** • Two benefit packages, a basic package and a standard package, would be defined. The basic package would be [20%] less than the standard package. • Over a 5-year period, if federal saving are achieved, the value of the basic package would be phased-up to the value of the standard package. ▸ Savings would be assessed annually before benefits are expanded. **Firms with more than 20 employees:** • Employers would be required to pay 80% of the average premium for the basic benefit package. • Employers payments would be capped at a specified percentage of each worker's wage. Smaller firms would receive more generous subsidies. • All firms would be eligible for subsidies. **Firms with 20 or fewer employees ("exempt employers"):** • Exempt employers would not be required to provide coverage. • Exempt employers with fewer than 10 workers pay 1% of payroll. • Exempt employers with 11 to 20 workers pay 2% of payroll. • Employers with 20 or fewer employees that choose to cover their workers pay 80% of the average premium for the basic package and are eligible for subsidies. • The exemption would be eliminated if 90% of currently uninsured workers are not insured by 1998 and 95% insured by 2000.

GENERAL DESCRIPTION (Continued).	**Families:** • Families working for nonexempt employers pay the difference between the 80% of the average premium for the basic package and the premium of the plan they choose. • Families working for exempt employers pay the entire premium. • Families choosing the standard package are responsible for the full difference between the two packages. • Low-income families are capped at a percentage of income for the family share for the basic package. • Families working for exempt employers are capped at percentage of income for the entire premium for the basic package. • Special subsidies for cost-sharing are provided for low-income families during the phase-in period. **Cost Containment:** • Premium caps would be in place for first three years of system. **Subsidies:** • Federal subsidy costs are capped as in HSA. **Community Rating:** • The threshold for community rating is reduced to firms with 1000 or fewer employees. • Firms above the threshold would pay a payroll surcharge of 1%.

DETAILED SPECIFICATIONS	
• **Structure**	• Each health plan would offer two benefit packages, a basic package and a standard package. • Employers would be required to a percentage of the basic package. Employers could pay more (toward the standard package or for supplemental benefits). • Families would be required to have at least basic package. • All families, including families working for exempt employers, could choose either package. Families would pay the difference between the basic and standard package (without subsidies, although employers may contribute).
• **Benefit package; phase-in**	Two benefit packages, a standard package and a basic package. Basic package phases-up to standard package over five years. <u>Standard package</u>: • HSA benefit package (with 5% reduction). ▸ FFS and HMO packages as in HSA, with 5% reduction a in Energy and Commerce Staff Draft. <u>Basic package</u>: • [20%][1] lower value than standard package. ▸ FFS package with higher (e.g., $1500 - $2000) hospital deducible and higher (e.g., 25%) coinsurance; reduce value of other benefits through higher cost sharing or limits. Preserve preventive care (either with minor copayments or put in the wrap package for children). ▸ HMO package would closely resemble FFS package, with copayments rather than coinsurance. • Federal deficit reduction targets would be incorporated into law. Annual reviews would be conducted to determine if targets met. Benefit expansion would occur only if deficit reduction target is met. ▸ Deficit reduction target would be $50-100 B over ten years.
	Issues: • With two different levels of benefits, adverse selection against the standard benefit package is a danger. Risk adjustment across the packages could increase the cost of the basic package.

[1] Three scenarios should be tested, with the value of the basic package 10%, 15% and 20% less than the standard package.

• **Employer Payments**	Firms with more than 20 employees: • Employers generally would be required to pay 80% of the average per worker premium for the basic benefit package. ▸ Employer payment for each worker would be capped at the lower of 80% of the average per worker premium or a specified percentage of the worker's wages (Scenario A schedule). ▸ Large firms (over 1000 threshold) would be eligible for subsidies based on the average per worker premium for community-rated employers in the area. Exempt firms: • Exempt employers would not be required to provide coverage. ▸ Exempt employers with fewer than 10 workers pay 1% of payroll. ▸ Exempt employers with 11 to 20 workers pay 2% of payroll. • Employers with 20 or fewer employees that choose to cover their workers are treated as above. • The exemption would be eliminated if specified percentages of the population are not covered by specified dates: ▸ 90% of the population must be insured by 1998; ▸ 95% of the population must be insured by 2000. Self-employed people: • OPTION 1. Self-employed people with employees are treated as employees of themselves and are eligible for exemption. Self-employed people without employees pay as under the HSA. • OPTION 2. All self-employed people are eligible for exemption. Per worker premiums: The per worker premium calculation would be based on the employer contributions for the basic package; employer contributions above the amount required (including any payment toward the difference between the basic package and the standard package) would be considered to offset family payment responsibility. Firms with fewer than 20 employee that choose to provide coverage are counted in per worker premium calculation.

• **Family Payments**	Families working for nonexempt firms (including exempt firms that choose to provide coverage): • Families pay 20% of the average premium for the basic package. • Low-income families are capped at a percentage of income for the family share for the basic package. (Scenario A subsidies). Families working for exempt employers: • Families working for exempt employers pay the entire premium (a per worker employer share and a family share) for the basic package. • Families working for exempt employers are capped at a percentage of income for the entire premium. ▸ The cap ranges from 4-6% (Kennedy schedule for exempt workers). Nonworking families: • Nonworkers pay toward the employer share as under the HSA. Families choosing standard package: • Families choosing the standard package are responsible for the full difference between the basic and standard packages. • No subsidies apply to the difference. Special rules for dual earners: • Families with a worker in an exempt firm and a worker in a nonexempt firm are treated as a family working for a nonexempt firm.

• **Subsidies**	Federal costs for subsidies are capped as under the HSA. Employers: • Employer payments for an employee for the basic plan are capped at 2.8% to 12% of the employee's wages. (The Scenario A subsidy schedule applies.) • Caps apply to all employers. For experience rated employer, payments are subsidized only up to the level of required employer contributions for the basic plan in the appropriate community rating area. Families: • Family payments for the family share of the basic plan are capped at 3.9% of income. (The Scenario A subsidy schedule applies.) • Families working for exempt employers are capped at 4-6% of income for the entire premium obligation (Kennedy schedule for exempt workers). • Payments for nonworking families for the employer share are based on nonwage income and are capped as under the HSA. • Special subsidies for cost-sharing are provided for low-income families during the benefit phase-in period. ▸ Low income families enroll in HMOs (if available). For those under poverty, the difference between the standard HMO cost-sharing and the basic HMO cost-sharing is fully subsidized. A portion of the difference would be subsidized (on a sliding scale basis for those between 100% and [150 - 200%] of poverty. Self-employed: • OPTION 1. Self-employed people without employees pay as under Scenario A (e.g., self-employed without employees capped at small employer schedule). • OPTION 2. All self-employed people are treated as exempt workers unless they employ more than 20 workers in their firm.

• **Community rating threshold**	Firms with 1000 or fewer employees are part of community rated pools. • Large firms cannot elect to be community rated. • Taft-Hartley trusts and rural electric and telephone cooperatives can elect to be experience rated. • State and local governments with more than 1000 employees can elect to be experience rated. • All experience rated employers (including state and local governments) pay a 1% of payroll surcharge.
• **Cost containment**	• Constrain initial premiums (as under HSA) and growth rates for first three years: ▸ OPTION 1. HSA growth rates through 1998. ▸ OPTION 2. Managed care growth rates through 1998. • Constraints are removed after 1998. If growth exceeds projected rates, constraints are applied in following year. [what are we recapturing? what is permitted rate of growth?]