DRAFT

THE SENATE COMPROMISE:
A GRADUAL APPROACH TO ACHIEVING UNIVERSAL COVERAGE

Universal coverage is achieved in two stages. First, market incentives, insurance reforms and assistance for low and middle-income families are provided. These market-based reforms and incentives are allowed to work until the year 2000. Second, if the market reforms do not provide coverage for 95% of Americans by the year 2000, a commission would be required to submit recommendations to the Congress on how to achieve coverage for every American. If the Congress did not then act to achieve universal coverage, employers and employees would be required to contribute evenly to the cost of health coverage. Small employers with fewer than 25 employees would not be required to contribute.

Here are the central elements of the Senate compromise bill:

Affordable Insurance For Working Families. Insurance companies will be forced to compete for business, lowering prices through market forces. There will be a limit on what families and businesses pay for insurance. And if you're in between jobs or living paycheck to paycheck, you'll get a discount.

Coverage That Can't Be Taken Away. It will be illegal for insurance companies to drop people from coverage if they get sick, grow old or change jobs. People with insurance will know that they can never lose it.

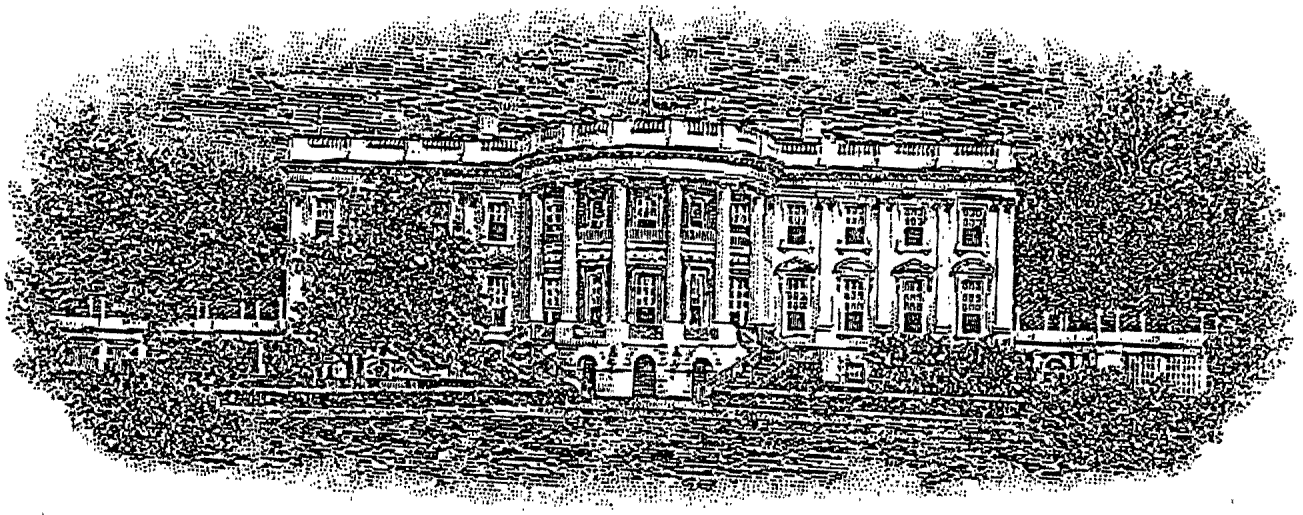
Choice of Doctor and Insurance Plan. Families will be able to keep their doctor and insurance, or choose a new plan. No one-size-fits-all approach -- people will be able to choose the benefits and plan that best fits their needs.

Preserve and Strengthen Medicare. Medicare will be protected and strengthened. Older Americans have a right to count on Medicare and choose their doctor. Prescription drug coverage will be added to Medicare, and there will be additional help with home- and community-based care.

Help For Small Businesses. Small business owners will receive special discounts on insurance for their families and employees. And they'll be protected from the insurance company abuses that hurt small businesses today.

Ensure High-Quality Care. The guaranteed benefits emphasize primary and preventive care. And part of each insurance premium will go to medical research -- to make sure that American medical care remains the finest in the world.

THE WHITE HOUSE
WASHINGTON, DC 20500



FAX COVER SHEET

DATE: 7-22 TIME: 5:40 pm

TO: Judy Feder

PHONE: _____ FAX #: 690-7383

FROM: Chris Jennings

PHONE: (202) 456-5585 PAGES AFTER COVER: 1

COMMENTS:

Tell Ken to get NOR ESI insurance & Survey

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 w/ w/o plan caps

Len

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

- ~~Net~~: Medicaid/~~risk adjustment~~ risk adjustment cost to FFP
- 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)

Larry & Gary do offsets & coord w/ Treas

2) Post-2000: options for increasing protection$ for families Ross

Ken 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

w/ Mitchell staff

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

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

	1995-1999	1995-2004
Subsidies	300	1,077
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(546)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	92
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(97)
Net Other Revenues	(39)	(169)
Net Deficit Effect	**10**	**(116)**

All estimates preliminary and unofficial.

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

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

CR pool 500, Exemption 25, Hard Trigger in 2000, WITH premium cap

	1995-1999	1995-2004
Subsidies	300	1,077
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(546)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	92
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(65)
Net Other Revenues	(39)	(185)
Net Deficit Effect	10	(100)

All estimates preliminary and unofficial.

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

Fiscal Analysis of 7.18.94 Plan

07/20/94

01:07 PM

CR pool 500, NO MANDATE, no premium caps

	1995-1999	1995-2004
Subsidies	300	885
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(518)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	91
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(88)
Net Other Revenues	(39)	(151)
Net Deficit Effect	10	(254)

All estimates preliminary and unofficial.

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

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

TO: Chris Jennings

FROM: Lou Nichols

Fax Destination X67431
Organization:
Phone Number:

Number of Attached Pages: 1

Notes:

HD Fax Number: *202/395-3910*
Voice Confirmation: *202/395-4922*
202/395-4926
202/395-3844

DRAFT DRAFT

Request for Cost-Sharing Estimate, July 21, 1994

Please estimate the cost-sharing subsidy obligation of the Federal government under the following policy.

1. Use as a reference point the Senate Finance bill's base:

   - NO mandates or premium caps
   - non-SSI acute care Medicaid integrated into regular health plans, AFDC and non-cash in the community rate
   - Not necessarily achieving universal coverage.

2. Assume the generic "HSA-8%" benefit package, i.e., with the cost-sharing raised to keep the actuarial value equal to the FEHBP's BCBS standard policy, given whatever extra special services are added at zero or reduced cost sharing. For estimation purposes, assume current BCBS standard levels of cost-sharing.

3. Cost-sharing policy under variant requested:

   - logic is similar to HSA. Where an HMO is available, most get no cost-sharing subsidy. Where an HMO is not available, some poor (defincd below) get the difference between the ffs cost-sharing and the HMO level of cost sharing (note the HMO level of cost-sharing will be higher with the BCBS ffs package than it was with the HSA benefit package).

   - All those insurcd under 76% of poverty, regardless of prior Medicaid status, have to pay only 20% of HMO level cost-sharing. The Federal government subsidizes the rest.

   - Those between 76% and 150% of poverty, regardless of prior Medicaid status, get the regular cost-sharing subsidy, i.e., nothing if there is an HMO available, and the difference between the ffs cost-sharing and the HMO level of cost sharing if there is no HMO available.

4. Please do the cost estimate under two scenarios, attached. One has a mandate and reaches universal coverage in 2000. The other does not, and reaches the "percent insureds" listed.

DRAFT

IME 5.2 gravis v&L

CPB

214-1316 Oliver Fein

Durability

All of Option D (53) (253)

Home health to 200% Yes

home health copay NO

Lower Medicare Elder FMC 100 to 20

timed payment thing

90 [illegible]

Medicare repealed date back

99

prohibition of balance billing for part B

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + 3

DATE: _____

TO: Barry

Fax: _____

Phone: _____

FROM: Debbie Chang

Fax: (202) 690 - 8168

Phone: _____

REMARKS:

The attached is for OMB Review and Clearance

↓ JR
AM
DB

Fa Assessment
on 7/22.

BC

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

Additional Medicare Savings Proposals (C) 7/21/94

- Lower Threshold from 100 to 20 Disabled Employees for MSP: Effective 1/1/98, lower the threshold from 100 to 20 employees for disabled persons for application of the Medicare secondary payor provisions.

- Extend ESRD Secondary Payor to 24 Months: Increase requirement for non-Medicare insurers to be the primary payor for ESRD patients from 18 to 24 months before Medicare becomes the primary payor, effective 1/1/96.

- Reduce 1995 Physician Update: Reduce the Medicare fee schedule conversion factor by 3 percent in 1995, except for primary care services.

- Correct MVPS Upward Bias: Correct the upward bias in factor four of the MVPS by treating savings and expansion proposals consistently.

  If Medicare is expanded, or if fees are raised (such as for an MVPS adjustment), the full amount of the increase is passed through in the MVPS. However, savings proposals are not treated in the same way. When savings proposals are enacted, for budget purposes, scoring assumes a volume response. Those savings estimates (net of the volume offset) are incorporated into factor 4 of the MVPS. Because scored savings are lower due to the assumed volume response, use of scored savings raises the MVPS.

  While appropriate for budget purposes, building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings is not keeping with the spirit or intent of the MVPS and leads to an upward bias. It is inconsistent to have a system which provides for reducing the update to recoup for when a prior target was exceeded, but to increase the next year's target because of a volume offset to this reduced update.

  This proposal would eliminate building in anticipated volume responses to legislative reductions in payment (or reductions due to exceeding the MVPS) in the scored savings. Effective for MVPS beginning with FY 1995.

* 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 (who 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.

202-307-
7461

Jen

Alan
Reuther

dropping

- mental health
parents

A. LOW-INCOME VOUCHER PROGRAM

1. **Eligibility.** Families with income under 200% of the poverty level are eligible for premium subsidies.

2. **Amount of subsidy.**

   a. For families with family income at or below 75% of the poverty level, the subsidy is equal to the full premium (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA).

   b. For families with family income greater than 75% of the poverty level but less than 200% of the poverty level, the subsidy is determined on a sliding scale basis (phasing out linearly to zero at 200% of poverty).

   c. The subsidy is reduced (but not below zero) by an employer contribution. To receive a subsidy, a family is required to take advantage of an employer contribution towards the standard benefits (and, if multiple employer contributions are available, to take advantage of the contribution that results in the lowest possible contribution by the family).

3. **Use of subsidy.** A voucher may be used toward the purchase of any health plan available to a family.

4. **Dual eligibility.** In general, families eligible for multiple subsidies may receive the subsidy (or combination of subsidies) that results in the greatest assistance to the family.

5. **AFDC recipients.**

   a. In general, AFDC recipients are eligible for a full premium subsidy (i.e., they are treated as if they had income at or below 75% of the poverty level).

   b. Families that include individuals who are AFDC recipients and individuals who are not AFDC recipients are treated as separate families.

6. **Non-cash Medicaid recipients.** People receiving non-cash Medicaid as of December 1996 are treated as follows:

   a. They recieve a full premium subsidy for a period of six months (i.e., they are treated as if they had income at or below 75% of the poverty level).

   b. After six months, they are treated like other people for the purposes of subsidies.

c. Families that include indivdiuals who are non-cash Medicaid recipients and individuals who are not are treated as separate families.

B. ADDITIONAL SUBSIDIES FOR UNINSURED KIDS

1. **Eligibility.** In general, children up to age 19 who have not been covered by health insurance for at least six months (!could be a year if dropping of employer coverage is an issue!) and who are in families with incomes up to 240% of poverty would be eligible for a voucher toward insurance coverage.

   a. Children in a family would not be eligible for this program if the children are eligible for coverage under an employer's plan where the employer offers to contribute at least 80% (!could make lower level if there would be an assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a single-parent or two-parent family policy.

   b. To be eligible for the program, families would be required to enroll all eligible dependent children.

   c. Children who were covered under a State's Medicaid program (cash or noncash) as of December 1996 would not be required to meet the six month previously-uninsured test.

2. **Amount of subsidy.**

   a. Eligible children in families with income up to 185% of poverty would receive a voucher for the full premium for the appropriate children's policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA).

   b. Eligible children in families with incomes between 185% and 240% of poverty would receive a voucher for a portion (calculated on a sliding scale, phasing out at 240% of poverty) of the premium for the appropriate children's policy (limited as above).

3. **Use of subsidies.** Community-rated health plans would accept vouchers toward payment for coverage.

   a. Community-rated health plans would create two categories of children's coverage: single child and multiple child.

      These categories would be tied to the premiums charged for two-parent family coverage. The National Board (?or HCFA?) would determine the average cost of insuring children and would express it as a national percentage for family coverage. For example, the single child policy might be one-third of the premium for the two-parent family policy and the multiple child

policy might be one-half of the two-parent family premium.

b. Eligible children with a parent covered by a community-rated or experience-rated plan could use their voucher to be covered under the parent's policy.

4. **Nondiscrimination.** To protect the subsidy program from the incentives for employers to drop coverage (and/or contributions) for dependent children, nondiscrimination rules would apply to employer's decisions to offer coverage and the amount they contribute for dependent children. Nondiscrimination rules would apply by class of employee (i.e., full-time or part-time).

5. **Dual eligibility.** For families that are eligible for a subsidy under the kids program and under the low-income or unemployed voucher program:

   a. The family receives the sum of: The voucher amount for the kids and the applicable low-income (or unemployed) voucher amount for the family.

   b. The voucher for the low-income voucher program is calculated using the poverty level based on the entire family, but the premium is the applicable premium for the entire family minus the premium applicable for the kids alone.

   c. A family may use the children's voucher and the low-income voucher to purchase separate policies or combine their value toward one policy.

      (!**NOTE:** for some single parent families, it may be cheaper for them to purchase a single adult policy and a children's policy with the voucher. This would allow some single parent families above 75% of poverty to receive a full subsidy. This is inevitable as long as the prices for single policies and children's policies do not sum to the price of family policies.!).

C. ADDITIONAL SUBSIDIES FOR PREGNANT WOMEN

1. **Eligibility.** In general, pregnant women who have not been covered by health insurance for at least six months (!could be a year if dropping of employer coverage is an issue!) and who are in families with incomes up to 240% of poverty would be eligible for a voucher toward insurance coverage.

   a. Pregnant women would not be eligible for this subsidy if they have available an employer's plan where the employer offers to contribute at least 80% (!could make lower level if there would be an assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a policy covering the woman.

   b. Pregnant women who were covered under a State's Medicaid program (cash or noncash) as of December 1996 would not be required to meet the six month previously-uninsured test.

   c. Eligibility would continue for three months after delivery.

   d. Pregnancy would not be treated as a pre-existing condition.

2. **Amount of subsidy.**

   a. Eligible women in families with income up to 185% of poverty would receive a voucher for the full premium for a single policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA).

   b. Eligible women in families with incomes between 185% and 240% of poverty would receive a voucher for a portion (calculated on a sliding scale, phasing out at 240% of poverty) of the premium for the single policy (limited as above).

3. **Use of subsidies.** Community-rated health plans would accept vouchers toward payment for coverage. A pregnant woman could use the voucher towards the purchase of a single policy or towards the purchase of a couple, single-parent, or two-parent policy, as appropriate.

4. **Dual eligibility.** For families that are eligible for a subsidy under the pregnant women program and under the low-income voucher or unemployed program:

   a. The family receives the sum of: The voucher amount for the pregnant woman and the applicable low-income (or unemployed) voucher amount for the family.

b. The voucher for the low-income voucher program is calculated using the poverty level based on the entire family, but the premium is the applicable premium for the entire family minus the premium applicable for the pregnant woman alone.

c. A family may use the pregnant woman voucher and the low-income voucher to purchase separate policies or combine their value toward one policy.

d. A family eligible for the pregnant women and kids subsidy programs would be treated in the same way as described above, except that the applicable premium for the low-income (or unemployed) voucher program would be the applicable premium for the entire family minus the premiums applicable for the pregnant woman alone and the kids alone.

The applicable premium for the low-income (or unemployed) voucher program could not be less than zero.

D. SUBSIDIES FOR PEOPLE LEAVING WELFARE FOR WORK

1. **Eligibility.** Under current law, welfare recipients who return to work receive extended Medicaid coverage for one year. This period is extended to two years.

2. **Amount of subsidy.** Instead of receiving Medicaid coverage, welfare recipients returning to work would receive a full premium subsidy for the entire family (i.e., the family would receive a low-income voucher as if it had income below 75% of the poverty level).

United States House of Representatives
Office of the Majority Leader

FAX TRANSMISSION

TO: Chris Jennings

FROM: Anne King

FAX #: 456-7431

DATE:

 # OF PAGES TO FOLLOW: 1

MESSAGE: As we discussed

Telephone: (202) 225-0100 Fax: (202) 225-7414/7296

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 1993

"(f) If rebates or marketing incentives are allowed to pharmacies or other dispensing entities providing services or benefits under a health benefit plan, these rebates or marketing incentives shall be offered on an equal basis to all pharmacies and other dispensing entities providing services or benefits under a health benefit plan when pharmacy services, including prescription drugs, are purchased in the same volume and under the same terms of payment. Nothing in this section shall prevent a pharmaceutical manufacturer or wholesale distributor of pharmaceutical products from providing special prices, marketing incentives, rebates, or discounts to different purchasers not prohibited by federal and State antitrust laws."

Bobby Rozen
703-524-1377

Ken 301-365-9587

STATE RESPONSIBILITIES FOR ADMINISTERING HEALTH CARE REFORM UNDER FINANCE COMMITTEE RECOMMENDATIONS

State Responsibilities

-- States will not have to build new administrative infrastructures to determine and administer subsidies. Applications can be taken through the existing structure of State assistance offices. A very large proportion of families who will receive subsidies will have contact with the State assistance structure through AFDC, Medicaid, Food Stamps, Unemployment Compensation, Child Support Enforcement, or State general assistance. In many cases eligibility for health benefits subsidies can be determined as part of the process of obtaining benefits under these existing programs.

-- States would have to train employees to take applications for subsidies. States have shown considerable flexibility in responding to major program changes in the past. In recent years, States have been able to quickly adjust to changing rules in Medicaid eligibility for pregnant women and children, as well as for the elderly.

Payment to Health Plans

-- Those persons who are eligible for subsidies could receive certificates which could be presented to employers or other private plans to help pay their premiums.

-- Private insurance could bill the State to recoup the value of the certificates. States could pay the plans using their existing payment structures.

Reconciliation

-- Reconciliation would be a major, though not impossible, undertaking. States could reconcile subsidies through their existing State tax structure by requiring families receiving subsidies to file a State tax return.

-- Subsidies from different States going to the same family over a tax year could be reconciled in the same way States treat out-of-state earnings in their income tax systems today.

-- States without income tax systems could still ask families to file returns and use existing State revenue offices to perform the reconciliation.

-- Those persons who might otherwise not be required to file a tax form could be required to do so as a condition of obtaining health care subsidies. This would follow the current practice used with EITC at the Federal level.

Plan Enrollment

-- States can use existing structures for outreach and to encourage enrollment in private health plans. Information on available plans can be provided through all State offices that interface with the public. These efforts could be intensified in those offices that provide any form of public assistance.

-- Anticipating a new pool of subsidy recipients, plans themselves will actively market before and during the open season and will target this recipient population much as plans operating in FEHB do today for Federal government employees.

(DRAFT - 7/22/94)

THE MITCHELL PLAN:
Responding to the Concerns fo the American People

Senator Mitchell's health care plan is a moderate and reasonable approach that will move this country toward universal health coverage in a defined time frame. And it does so without a mandate or a government takeover of our health care system. It addresses the criticism of the Presidents plan by building in a deliberate way on the best elements of our current system and targeting resources to maximize their impact in extending coverage as quickly as possible to those who currently lack protection. The Mitchell plan preserves the right for more businesses to self insure, allowing their employees to continue with the plans that are satisfied with today. It builds in extra protections for small businesses and working Americans to ensure that insurance is available. It strengthens coverage for seniors by including a prescription drug benefit under Medicare and establishing a new home and community based long-term care program. It is fiscally sound with built in protections for the federal budget.

CUTS BUREAUCRACY AND REGULATION:

- Replaces large mandatory government alliances with voluntary purchasing pools to help small businesses and individuals get affordable insurance coverage.

- Eliminates intrusive government cost containment mechanism relying on more market-oriented approach.

MINIMIZES DISRUPTION TO CURRENT SYSTEM:

- All firms with more than 500 employees are allowed to self insure rather than firms with more than 5,000 employees under the President's plan. Many more firms that sponsor their own high-quality plans and are effective at controlling costs will have the opportunity to continue to do so.

- Eliminating mandatory alliances gives people and businesses more choices in how they purchase insurance coverage including the opportunity to stick with plans they are satisfied with today..

(DRAFT - 7/22/94)

PROVIDES EXTRA PROTECTION FOR SMALL BUSINESSES:

- By eliminating the employer mandate, the Mitchell bill addresses one of the major concerns about the President's plan -- namely that such a mandate would hurt small businesses imposing a financial burden they could not handle and costing numerous jobs.

- It provides new targeted subsidies to help the most vulnerable small businesses afford private insurance coverage.

- Should voluntary efforts not achieve universal coverage, the fall-back trigger mechanism would exempt firms with fewer than 25 employees, protecting those businesses least able to handle the burden of providing insurance coverage to their workers. Even for those businesses with more than 25 employees, the Mitchell plan dramatically scales back how much they would be asked to contribute. Under the plan, employers and employees would split the cost of insurance evenly, a significant reduction from the 80/20 requirement of the President's plan.

FISCALLY SOUND WITH ADDED PROTECTION TO THE FEDERAL BUDGET:

- The plan pays for itself through realistic savings to the Medicare and Medicaid programs, an assessment on high cost insurance plans and an increase in the tobacco tax by 45 cents per pack.

- To provide ironclad protection to the federal budget, the plan provides a fail-safe mechanism to ensure that the cost of reform does not exceed the savings and revenues in hand.

RELIES ON MARKET ORIENTED COST CONTAINMENT:

- Rather than an intrusive government sytem for controlling costs by regulating insurance premium increases, it fosters market forces and harnesses them to keep costs down. By placing an assessment on high cost plans, it encourages plans to lower their premiums and employers and individuals to choose more efficient, better priced plans.

(DRAFT – 7/22/94)

THE MITCHELL PLAN:
Preserves the Best Elements of the President's Plan

Senator Mitchell's plan includes the elements that the American people want most out of health care reform. While any of these features were included in the President's plan, the Mitchell plan acomplishes these goals in a volunatry way, with less government involvement, building gradually but deliberately on our current system, with the least disruption possible. It provides affordable insurance for working families with security of coverage that can never be taken away. It expands choices of doctors and insurance plans and ensures high–quality care. Finally, like the President's plan, it preserves and strenghten coverage for older Americans under Medicare.

ACHIEVES PRESIDENT'S GOAL OF UNIVERSAL COVERAGE:

- It ensures that all hard working American families have the insurance protection that they deserve.

PROVIDES PROTECTION TO THE MIDDLE CLASS:

- By capping household insurance expenses at 8% of income and providing targeted subsidies to middle class families, the Mitchell plan insures that insurance protection is within everyone's reach.

REFORMS INSURANCE MARKET:

- The plan embraces the consensus insurance reforms that enjoy overwhelming support in the Congress. It levels the playing field for small businesses and indviduals by community rating premiums for firms with fewer than 500 employees and individuals.

- It eliminates abusive insurance company practices by guaranteeing issue and enrollment, eliminating preexisting condition exclusions and lifetime limits and open enrollement.

- It establishes voluntary purchasing pools to help small businesses and individuals negotiate rates only large companies can get today.

ENSURES HIGH-QUALITY CARE:

- The core benefits package will emphasize primary and preventive care to help keep people healthy not just treat them once they become sick.

- A portion of each premium will be earmarked for medical research to encourage the technological advancements and improvements that have made American medicine the finest in the world.

PRESERVES AND STRENGTHENS COVERAGE FOR SENIORS:

- The Medicare program is preserved and the benefits seniors enjoy today will be expanded to include coverage for outpatient prescription drugs. Starting in 1998, Medicare will cover the cost of prescription drugs with a $500 deductible, 20% copay and a cap on out-of-pocket expenditures.

- In addition, the Mitchell plan establishes a new home and commuinty-based long-term care program to give older Americans and those with disabilities additional options for care.

DRAFT

How The Senate Compromise Differs From The Clinton Plan

Choice: Individuals Can Keep the Insurance They Have

- People will not be herded into some kind of government plan. Families will have a maximum choice of insurance plans, with different levels of benefits and costs. There will, however, be certain benefits which are guaranteed to everyone.

Added Protection Against Rising Costs For Families and Businesses

- Families will never pay more than 8% of their income for health insurance, and businesses will never pay more than 8% of their payroll. In addition, the most expensive insurance plans will have to pay a penalty for excess profits.

Extra Protection For Small Businesses

- Small businesses will receive special discounts on the price of insurance. And if employers and employees do end up splitting the cost of insurance, businesses with less than 25 employees will be exempted.

Less Bureaucracy and Regulation

- There is no more requirement to join government alliances. Instead, there will be voluntary purchasing cooperatives to allow small businesses and individuals to join together to get high-quality insurance at an affordable rate.

More Businesses Can Self-Insure

- Many more companies which do a good job of controlling costs and providing high-quality care may continue to do so through their own health care plans.

Additional Protection For Federal Budget

- Written into the law will be a guarantee that the cost of health reform does not exceed the savings and revenues earmarked for health reform.

Numbers of Persons Participating in Cafeteria Plans

- Under current law, the Treasury Department estimates that 14 million persons will use cafeteria plans to shelter employer-provided medical benefits from individual income and payroll taxes in 1994. Approximately $15 billion of medical benefits may be sheltered in cafeteria plans in 1994.

- Over the past decade, the popularity of cafeteria plans has grown at a very fast pace, and the Treasury Department anticipates that utilization will continue to increase rapidly. Assuming current law, the Treasury Department anticipates that 21 million persons will be using cafeteria plans to shelter about $36 billion of employer-provided medical benefits by the year 2000.

- Both the Health Security Act and Senator Mitchell's plan repeal employer contributions for medical benefits through cafeteria plans in 1997. In both bills, the cafeteria plan restrictions are effective prior to the full implementation of the employer mandate. Under Senator Mitchell's plan, collective bargaining agreements would be exempt from this provision for the duration of the contract.

Background

- Cafeteria plans commonly give employees a choice to reduce their taxable wages in favor of tax-sheltered employer contributions for health insurance premiums, reimbursement for out-of-pocket medical expenses, and/or dependent care benefits. Cafeteria plans are governed by section 125 of the Internal Revenue Code.

- The estimates of the numbers of persons participating and the dollar amounts sheltered are based on a combination of data from the Bureau of Labor Statistics and private benefit consultants.

7025

What time (roughly) will you be in tomorrow?

- Trigger — cost containment
- % contribution
- Tax - Bailey
- diff employer stuff

1130 → Breath path

- no COBRA up to [illegible] [illegible]
- age 24 in policies

COBRA-[illegible]

confirmation policy implications?

1% [illegible]
1.5%
[illegible] parents
2-3 million people

Will come in shortly after.

Good night!

Wofford 10%
Freerider

Current
& speed

Get memo on premium calculation for Clarke

Ken
Tamera

Lasting Reform

DR 498

Rockefeller

12:00

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~~ (risk 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 Var Lang
- Administrative load ~~Low~~ Com
- Cafeteria plan (plus: #s people with plans, #businesses with plans, $ involved)

2) Post-2000: options for increasing protection$ for families ↑↑ Lead

Key — 3) Options for increasing coverage before 1997

4) Administrative structure for delivering subsidy programs → Com + Mulind

5) Cost containment - projected impact on NHE growth

Key 6) Benefits package update

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

Bob

- Bruce Cutler
- Thompson
- state options
- Congressional Meeting

Consider VP's Dog

Kathy Key

Two Parent Family
Income = 75% of Poverty

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%	15.3%	12.6%	20.6%

Two Parent Family
Income = 150% of Poverty

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%	8.0%	16.0%	8.0%	16.0%

Notes: Assumes that no employer coverage is available in the absence of a mandate.
Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 200% of Poverty

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%	8.0%	16.0%	8.0%	16.0%

Notes: Assumes that no employer coverage is available in the absence of a mandate.
Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

Two Parent Family
Income = 300% of Poverty

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%	15.5%	8.0%	16.0%

Notes: Assumes that no employer coverage is available in the absence of a mandate.
Assumes average pay in HSA capped firm is average pay in firms with 100 or more workers.

8/1/94

FAX TO CHRIS JENNINGS

RE: POSSIBLE POLICY FOR THE DEDUCTIBLE UNDER THE DRUG BENEFIT

The deductible amount for 1998 (first year of the benefit) would not be set in statute. Instead, the bill would require that the Secretary determine the deductible consistent with a spending target.

- Before September 30, 1997, the Secretary would determine a deductible that would result in incurred spending for benefits and administrative costs (before rebates and premiums) under the drug benefit that would equal the spending target. All other aspects of the benefit would be specified -- that is, the out of pocket cap, payment methodology and rebate levels (consistent with the current draft).

- The spending target would be specified in statute as $18.3 billion. This target is consistent with a stream of fiscal year outlays that would total $95 billion over ten years (95 - 2004).

- The deductible would be updated for 1999 so as to maintain the same percentage of beneficiaries who met the deductible in 1998.

- In updating the deductible for 2000, the Secretary would look back to the actual experience for 1998 and determine what the deductible should have been in order to have met the target. The Secretary would then determine the percentage of beneficiaries that would have met that deductible in 1998 and would establish the deductible for 2000 and subsequent years so as to maintain that percentage.

I spoke with Scott Harrison at CBO. He indicated that CBO

would have no problem with this deductible policy. He also said that the $18.3 billion target for 1998 would be scored by CBO as generating an outlay stream of $98 billion over ten years. The difference between our $95 billion and CBO's $98 billion is due to higher rate of growth assumptions by CBO. Both our $95 billion and CBO's $98 billion are before any savings from the maintenance of effort provision.

Peter Hickman

SENATE STATUS (7/21/94)
[Democrats & Senator Jeffords Only]

Solid Base 27 (27)	Solid Leaning Yes 6 (33)	Leaning Yes 10 (43)	Hopeful 4 (47)	Swing 4 (51)	Very Tough or Unlikely 6 (57)
Akaka	Bumpers	[redacted]	[redacted]	[redacted]	Boren
Boxer	Byrd	Biden	[redacted]	[redacted]	[redacted]
Bingaman	Feingold	[redacted]	[redacted]	[redacted]	[redacted]
Daschle	J. Kerry	[redacted]	[redacted]	[redacted]	B. Kerrey
Dodd	Sasser	[redacted]			Nunn - cancelled
Glenn	Wellstone	[redacted]			Shelby - Pat ...
Graham		[redacted]			
Harkin		[redacted]			
Inouye		Mathews - doesn't need			
Kennedy		Robb — Monday			
Leahy					
Levin					
Metzenbaum					
Mikulski					
Mitchell					
MoseleyBraun					
Moynihan					
Murray					
Pell					
Pryor					
Reid					
Riegle					
Rockefeller					
Sarbanes					
Simon					
Wofford					
Jeffords					

Graham Fl. Mch —
... less than NHE > 95% ...

What about
— Hatfield
— Cohen
— Jeffords

Dodd
— Sasser
Reid
Bumpers
Hatfield
Cohen
—

↓
- 50-60 Billion — eliminate ...
- 20 Billion —

OFFICE OF PUBLIC LIAISON
THE WHITE HOUSE

MEMORANDUM FOR HAROLD ICKES
ALEXIS HERMAN
BOB RUBIN
IRA MAGAZINER
GREG LAWLER
CHRIS JENNINGS ✓
JACK LEW
MIKE LUX

cc: STEVE HILTON

FROM: CAREN WILCOX

SUBJECT: PREMEDICARE ISSUE

DATE: JULY 29, 1994

PRE MEDICARE: This is the most important issue for the auto companies and other older manufacturers with early retiree populations from downsizing. As you know these companies have been in the forefront of health care reform for many years and were among the earliest supporters of the President's efforts. In addition, other beneficiaries of this will be the many retirees who have seen their benefits lost or cut back due to insolvency of their former companies etc.

Proponents indicate that there are 5.3 million non-working Americans 55-64, and that 60% of them have no health benefits from former employers. Seventy five percent have incomes below $25,000. They indicate that Medicare Part C would cost a couple $4,400 plus out of pocket of about $2,400 without subsidies.

They have altered their request from our original bill and propose:

> Purpose: To make health care coverage affordable to non-workers between the age of 55 and 64 who are not yet eligible for Medicare. By the year 2000, no one in this group with individual income under $25,000 or couples with income under $35,000 will have to spend more than 4% of income on health insurance premiums.
>
> There are caps on premiums which are phased out for higher income individuals.

The proponents have estimates, based on CBO projections, for a similar proposal in Ways and means Committee bill. They estimate:

no cost in the first year
1995 - 2000 = $8.9 billion
1994 - 2004 = $30.3 billion

There are provisions to require companies to pay back part of the benefit they receive by this relief.

Most of this relief does not go to companies, but goes to unemployed and unemployable older Americans of modest means who cannot buy health care coverage.

Companies affected by this provision include General Motors, Chrysler, Ford and USX and Bethlehem, as well as hundreds of other companies which have preferred to remain less visible. These are the earliest supporters of the Clinton plan, and are from key states for us over time, such as MI, PA, CA etc.

Majority Leader Gephardt's summary indicates a willingness to help current early retirees in some manner. The Senate appears to be more difficult for them.

Reportedly Rep. Stark is their main problem, but I believe that others such as the retailers, "younger work force companies" and others are lobbying many members against this provision as a "give away" to the older large companies and the unions.

Without some signal that pre-medicare relief has a chance to be discussed in Conference, we risk losing active support of bills by these companies and possible outright opposition.

If some of the taxes in the bill were more evenly spread there could be some mitigation here for these companies. But they are increasingly worried about little cost containment, putting the cost shift into law which they pay already in practice, and other disincentives to their endorsement of the final bills. I am working to hold on to them.

MESSAGE TO COMPANIES: We have to argue that they should stay until Conference, in the hope that we can get a fair spread of health care costs and taxes, but GM and others are close to cutting out of the bills altogether, due to their projections that they will pay much more for health care under various plausible scenarios.

They will know almost as soon as we do about any final decisions, and it may be necessary for Bob Rubin to call the Big Three auto CEOs over the weekend to encourage them. He has one home phone number and I have access to Trotman of Ford's number.

Attachments

REVISED
June 29, 1994

To: David Abernethy and Ann LaBelle

From: Paul Cullinan

Option: Limit Premiums for Persons age 55-64 with income below $30,000 (singles) and $40,000 (couples) to 7% of income in 1998, 6% in 1999,5% in 2000, and 4% later

Preliminary Estimate of Federal Budgetary Effects
(by fiscal year, in billions of dollars)

1998	1999	2000	2001	2002	2003	2004
2.0	3.1	3.8	4.5	5.1	5.8	6.2

Premium Effect: Upon further review, we have determined that the CBO estimates for the Chairman's Mark had already incorporated the assumption that employers would choose to enroll their early retirees into Part C because of the benefits from Part C's community rating feature. Therefore, this amendment would have no additional effect on the Part C premium.

PRE-MEDICARE HEALTH SECURITY COALITION

For Immediate Release
July 29, 1994

Contact: Eric Shulman
(202) 452-9470
Lisa Merman
(202) 452-9531

Coalition Labels GAO Report on Retiree Health "Highly Misleading" and "Inaccurate"

Cites CBO and OMB Cost Estimates of $3 billion per year for Pre-Medicare Provision of President's Health Plan

Washington, DC -- Calling a new Government Accounting Office (GAO) "fact sheet" on retiree health coverage for people in the 55 64 age group highly misleading and inaccurate, Letitia Chambers, executive director of the Pre-Medicare Health Security Coalition said today, "Both the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) have agreed that the cost of the President's plan to cover retirees in this age group is about $3 billion per year. We feel this is a necessary price to pay for providing health care to millions of Americans aged 55-64."

"This is far lower than the GAO estimate of $180 billion over ten years and an excellent example of why we should rely on those agencies of Congress and the Executive Branch -- CBO and OMB -- that were set up for the express purpose of making budget estimates.

Chambers cited several problems with the GAO fact sheet. "First, it appears to ignore the fact that more than half of these retirees or their spouses work in other jobs. Under the President's plan, those 'new' employers would be required to pay for health insurance, not the government. This alone could reduce the GAO cost estimate by up to 50 percent."

"Second, the study fails to recognize that the President's plan (as well as others) has low income subsidies for working and non-working people. Such subsidies have no linkage to the pre-Medicare provision and will be part of any health care reform plan. Yet the GAO report appears to include these subsidy costs as costs of the pre-Medicare provision."

"Third, the study fails to recognize that some employer plans are more generous than the President's proposed federal minimum benefit package. These additional benefits would not be taken over by the federal government yet GAO appears to assume the government will pay 80% of these costs as well."

"Finally, the study ignores the likelihood that health care reform will slow the growth in health care costs -- a major objective of all the health reform proposals -- and assumes that neither the companies nor the federal government will make changes to reduce costs. As a result, the study finds that health care estimated to cost $9.9 billion in 1993 (employer share - $7.9 billion) will cost a staggering $38.8 billion by 2007."

"The fact is that universal health insurance cannot be achieved without addressing the needs of this vulnerable population group. We cannot allow non-working Americans to slip through the cracks of health care reform," Chambers concluded.

-more-

Key Facts about the Pre-Medicare Population

- Of the 5.3 million non-working Americans aged 55-64, most – about 60 percent – receive no health benefits from former employers;
- Most people in the group are of modest means – 75% have incomes below $25,000 per year and half have incomes below $20,000 per year;
- Most have difficulty finding affordable health insurance as a result of declining health or pre-existing conditions -- an estimated 2.7 million people aged 55-64 have no health insurance coverage;
- Minorities and women are particularly vulnerable. African-American males, for example, are almost twice as likely as whites to be disabled or unable to work and only half as likely as whites to have health insurance coverage from former employers;
- Many in this group would not be able to afford Medicare Part C coverage without financial assistance. Part C coverage for couples will cost about $4,400 plus out-of-pocket expenses of about $2,400 which represents 30 percent of income for a non-working couple with an annual income of $23,000.

The Pre-Medicare Health Security Coalition is a broad-based coalition of retiree, consumer, labor and industry groups that support affordable health coverage for non-working persons aged 55-64.

###

RIEGLE PROPOSAL

Amendment

Purpose: To make health care coverage affordable to non-workers between the age of 55 and 64 who are not yet eligible for Medicare.

This group is uniquely vulnerable. They have trouble finding affordable care, limited financial resources and limited work options. This group has higher health care needs and greater out-of-pocket cost than the general population.

Proposal

This proposal would place a cap on insurance premiums as a percent of income for non-workers between the age of 55 and 64. By the year 2000, no one in this group with individual income under $25,000 or couples with income under $35,000 will have to spend more than 4 percent of income on health insurance premiums.

Subsidies

This amendment caps total premium cost for non-workers between the age of 55 and 64 as a percent of income on a phased down schedule from 7% to 4% over 6 years. In the third year of the program, 1998, a cap of 7% would go into effect. In 1999, a 6% cap would go into effect, in 2000 a 5% cap would go into effect and in 2001 a 4% cap would go into effect. This cap would be maintained at 4% thereafter.

The premium cap would be phased out for individuals with adjusted gross incomes between $25,000 and $35,000 and for couples with incomes between $35,000 and $45,000. These income levels would be indexed annually from the date of enactment.

Costs

No cost in the first year. The cost over five years, from 1995 through 2000 is $8.9 billion. The cost over ten years, 1995 through 2004 is $30.3 billion.

These estimates are based on CBO projections of similar proposal in the Ways and Means Committee bill. Lower subsidies and age adjustments to the community rate in the Chairman's mark would increase the cost above these projections. However, a less generous benefits package compared to Ways and Means and a quicker phase out of subsidies in our proposal would lower these projections. (Ways and means ends benefits at $30,000 for singles and $40,000 for couples.)

Premium Cap and Cost Estimates 1995-2000

Year	Income Cap	Cost
1995	none	0
1996	none	0
1997	none	0
1998	7%	($2.0)
1999	6%	($3.1)
2000	5%	($3.8)
2001	4%	($4.5)
2002	4%	($5.1)
2003	4%	($5.6)
2004	4%	($6.2)
10 year total*		($30.3)

* Numbers in billions

Arguments in support of this provision

- This is a uniquely vulnerable population with great health needs, trouble getting affordable care, limited financial resources, limited work options.

- The term "Early retirees" is a misnomer because the primary cause of early retirement is health problems of the individual or a family member. Many other "early retirees" are simply unemployed and unable to find work. Three-fourths of such unemployment results from job loss or layoffs.

- This age group and non-workers in particular have higher than average health care costs.

  - According to EBRI people between the age of 55 and 64 use an average of 37% more services than people between 45 and 54 and over 50% more services than people between 35 and 44.

  - Non-working people age 55 to 64 have health expenditures 65% higher than the working near elderly.

  - Further their out-of-pocket expenses average $1200-1500 annually - far higher than younger populations.

- Most in this group have low or moderate incomes
  - 34 percent less than 150 percent of poverty
  - 55 percent less than 250 percent of poverty

- In an employer based system, these people do not have an employer. These people will be responsible for the employer share (minus any low income subsidy). As such they will be paying a considerable higher percentage of income for health care than the working population.

- Under a system of community rating with adjustments for age, this group will have higher premium costs and this protection becomes even more important.

- U.S. competitiveness is hurt by retiree health costs; competitors don't have these burdens. Mature industries are particularly hurt.

- Companies continue to cut retiree health benefits by either raising retirees costs or dropping benefit altogether.

- So, if we don't address this issue people will continue to lose benefits.

Response to Opposition

- "Its a bailout for big industry."
  - Only 40 percent of all non-works have health care benefits from former employers. Many of these benefits are limited in scope.
  - Less than 3 percent of the targeted population is from the auto industry
  - People who gain the most are the low and moderate income pre-Medicare population
  - Good policy should not be disregarded because some of the benefit goes to companies who have historically helped meet the health needs of former workers.
  - This will also make these companies more competitive with companies who do not have to bear retiree health costs.
- "Many more people will retire because of this provision. More companies will force people in this age group out."
  - Health insurance is only one factor in making a decision to retire. Income from pensions and savings are much more significant as is the general satisfaction and the other rewards of work.
  - This issue has been blown out of proportion. The administration proposal which had more generous benefits was estimated to induce between 350,000 and 600,000 early retirees, but most of this resulted from the certainty of coverage at community rates - not the special early retiree subsidy.

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FACSIMILE COVER SHEET

DATE: 1/29/94

If you have any problems receiving this FAX, or wish to respond, please call 202/857-0670.

TO: MELISSA MURRAY

COMPANY/LOCATION: WHITE HOUSE

FAX #: 456-6218

FROM: ALLEN MOORE

 # OF PAGES (including this cover): 8

SPECIAL INSTRUCTIONS/MESSAGE: As requested. Note: the Levin amendment provides subsidies up to 30,000 for individuals and 40,000 for couples. The Riegle amendment phases them out -- 25,000 - 35,000 for individuals 35,000 - 45,000 for couples.

Original [ ] will [ ] will not follow by:
1)Mail - 2)Messenger - 3)Federal Express

Net New Federal $ per newly insured person

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline uninsured	38.3	38.8	39.3	39.5	39.9	40.4	41.1	41.9	42.6	43.3	44
Net Newly insured											
HSA	0	0	5.9	15.8	39.9	40.4	41.1	41.9	42.6	43.3	44
7.18.c	0	0	0	17.5	21.5	21.6	22.5	20.8	18	16	12.4
Subsidies											
HSA	0	0	11	37	98	121	128	144	164	181	197
7.18.c	0	0	0	66.2	113.5	119.9	128.0	123.1	117.4	112.2	105.1
Medicaid savings + State MOE											
HSA	0	0	4	16	44	66	74	83	93	104	116
7.18.c	0	0	0	45.7	80.8	89.9	99.9	110	120.5	131.4	143
Net new Federal $ per newly insured persons											
HSA	0	0	1187.45	1329.11	1353.38	1361.39	1313.87	1455.85	1666.67	1778.29	1840.91
7.18.c	0	0	0.00	1170.62	1521.89	1390.56	1247.96	630.02	-170.38	-1201.53	-3059.67

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-24.6	-36.7	-41.0	-45.8	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-19.1	-23.4	-25.5	-27.7	-30.1	-32.7	-35.5	-38.6
3 Disproportionate Share Hospital Payments	0	0	-8.8	-10.2	-11.3	-11.6	-18.8	-20.7	-22.9	-25.2
4 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.7	-1.5	-1.7	-1.9	-2.0	-2.2
5 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	0	0	-52.8	-70.8	-79.0	-87.2	-102.5	-112.9	-124.2	-136.5
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.1	-1.4	-1.5	-1.7	-1.8	-2.0	-2.2	-2.5
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Prohibition of Balance Billing	a	a	a	a	a	a	a	a	a	a
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.7	0.8
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.3	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Risk Contracts (Waive 50/50 Rule)	a	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.4	14.8	16.2	17.6	19.2	21.0
Total - Medicare	-2.4	-6.7	-10.3	-14.3	-14.8	-14.2	-19.3	-25.9	-33.4	-41.0
Other Health Programs										
12 Vulnerable Hospital Payments	0	0	0	0	0	1.3	1.3	1.3	1.3	1.3
13 Veterans' programs	0	1.5	4.2	10.8	10.9	11.3	11.7	12.1	12.6	13.0
14 Long Term Care Program										
15 Home and Community Based Care ($48 bil. cap)	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
16 Life Care										
17 Academic Health Centers	0	0	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
18 Graduate Medical and Nursing Education	0	0	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
19 Medicare Transfer - Graduate Medical Education	0	0	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
20 Medicare Transfer - Indirect Medical Education	0	0	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
21 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	0.6	0	0	0
Total - Other Health Programs	0.0	1.8	9.0	19.6	22.5	26.2	28.8	32.4	37.2	42.4
Subsidies										
22 Persons between 0-200% of Poverty	0	0	46.1	66.8	74.6	83.2	93.0	103.6	115.3	127.8
23 Pregnant Women and Kids 0-240% of Poverty	0	0	17.6	24.7	26.4	28.3	30.1	31.7	33.4	35.0
24 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	9.0	9.8	10.6
25 Presumptive Eligibility										
Total - Subsidies	0	0	61.7	94.1	106.0	117.4	129.9	143.3	157.9	173.2

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Public Health Initiative										
26 Biomedical and Behavioral Research Trust Fund										
27 Health Services Research	a	0.2	0.3	0.5	0.6	0.6	0.6	0.6	0.6	0.7
28 PHS Core Functions	0.1	0.2	0.3	0.4	0.5	0.6	0.6	0.7	0.7	0.7
29 Health Promotion/Disease Prevention	0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
30 Development of Community Health Groups	0.1	0.2	0.4	0.5	0.4	0.3	0.2	0.2	0.2	0.2
31 Investment in Infrastructure Development (Loans)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
32 Supplemental Services Grants	a	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
33 Enabling Grants	0	a	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5
34 National Health Service Corps	0	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3
35 Mental Health/Substance Abuse Grants	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
36 School Health Grants	a	0.1	0.2	0.4	0.5	0.6	0.7	0.7	0.7	0.8
37 Occupational Safety/Health Grants	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
38 Indian Health Service	0	0	1.4	1.5	1.6	1.8	1.9	2.1	2.2	2.4
Total - Public Health Initiatives	0.3	1.2	3.6	4.4	4.8	5.2	5.5	5.8	6.0	6.3
MANDATORY OUTLAY CHANGES	**-2.1**	**-3.6**	**11.2**	**33.0**	**39.5**	**47.4**	**42.4**	**42.7**	**43.4**	**44.4**
DISCRETIONARY OUTLAYS										
39 Veterans' programs	1.2	-1.5	-4.2	-15.4	-15.9	-16.6	-17.2	-17.8	-18.5	-19.2
Administrative Expenses										
40 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
41 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	0	0	0
42 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	1.1	1.1	1.2
Studies, Research, & Demonstrations										
41 Department of Labor Programs	a	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
42 Women, Infants, and Children	3.0	3.4	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2
43 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	3.0	3.7	3.8	3.9	3.9	4.0	4.1	4.2	4.3	4.4
DISCRETIONARY OUTLAY CHANGES	**4.8**	**3.5**	**1.2**	**-10.2**	**-11.1**	**-9.6**	**-10.0**	**-12.6**	**-13.1**	**-13.6**
TOTAL OUTLAY CHANGES	**2.7**	**-0.1**	**12.4**	**22.8**	**28.4**	**37.8**	**32.4**	**30.2**	**30.2**	**30.7**

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
44 Increase in Tax on Small Cigarettes	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
45 1.75% Excise Tax on Private Health Ins Premiums										
46 Addl Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
47 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
48 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
49 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
50 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules										
51 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements										
52 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals										
53 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
54 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	a	a	a	a	a	a	a	a	a	a
55 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
56 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
57 Remove $150 million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
58 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2
59 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
60 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
61 Post-Retirement Medical/Life Insurance Reserves			---------- Negligible Revenue Effect ----------							
62 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
63 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
64 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
65 Disclosure of Return Information to State Agencies			---------- No Revenue Effect ----------							
66 Impose Premium Tax with Respect to Certain High Cost Plans										
67 Limit Exclusion for Employer-Paid Health Benefits										
68 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending										
TOTAL RECEIPT CHANGES	0.7	4.2	7.3	8.5	10.3	10.7	10.8	11.2	11.9	13.0
DEFICIT										
MANDATORY CHANGES	-2.8	-7.8	3.9	24.5	29.2	36.7	31.6	31.5	31.5	31.4
TOTAL CHANGES	2.0	-4.3	5.1	14.3	18.1	27.1	21.6	19.0	18.3	17.7
CUMULATIVE DEFICIT EFFECT	2.0	-2.3	2.8	17.1	35.2	62.3	83.8	102.8	121.1	138.9

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

	174	43.5	50.5	94	137.5

SENATE STATUS (7/21/94)
[Democrats & Senator Jeffords Only]

Solid Base 27 (27)	Solid Leaning Yes 6 (33)	Leaning Yes 10 (43)	Hopeful 4 (47)	Swing 4 (51)	Very Tough or Unlikely 6 (57)
Akaka	Bumpers	[redacted]	[redacted]	[redacted]	Boren
Boxer	Byrd	Biden	[redacted]	[redacted]	[redacted]
Bingaman	Feingold	[redacted]	[redacted]	[redacted]	[redacted]
Daschle	J. Kerry	[redacted]	[redacted]	[redacted]	B. Kerrey
Dodd	Sasser	[redacted]			Nunn - cancelled
Glenn	Wellstone	[redacted]			Shelby - Pat Hutch
[redacted]		[redacted]			
Harkin		[redacted]			
Inouye		Mathews - doesn't need			
Kennedy		Robb - Monday			
Leahy					
Levin					
Metzenbaum					
Mikulski					
Mitchell					
MoseleyBraun					
[redacted]					
Murray					
Pell					
Pryor					
Reid					
Riegle					
Rockefeller					
Sarbanes					
Simon					
Wofford					
Jeffords					

What about
- Hatfield
- Cohen
- Jeffords