Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To POTUS Re: Meeting with Senator Robb (2 pages)	8/1/94	P5
002. memo	Chris Jennings, Steve Edelstein to Secretary Bentsen, Erskine Bowles, Alice Rivlin, Robert Rubin, Laura D'Andrea Tyson RE: Profiles of Senators attending Economic Team Lunch Today (3 pages)	7/28/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [11]

gf63

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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

PHONE: (202) 690-7450 FAX: (202) 690-84

TO: **FROM:**

NAME: Chris Jennings / Judy Mays NAME: Bridget Taylor

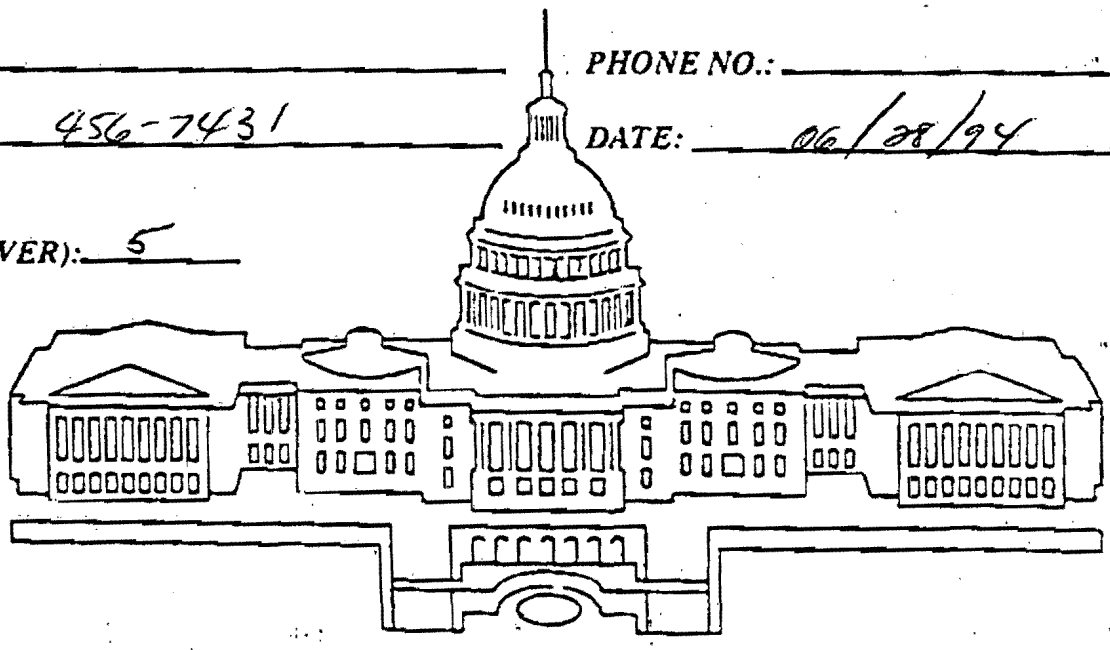
OFFICE: OFFICE:

ROOM NO.: ROOM NO.:

PHONE NO.: PHONE NO.:

FAX NO.: 456-7431 DATE: 06/28/94

TOTAL PAGES
(INCLUDING COVER): 5



REMARKS:

Thanks

B.T.

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: Bridget Taylor

DATE: 6/28

PRIORITY:

SAME OR NEXT DAY: X
2 TO 3 DAYS: _____
WITHIN 1 WEEK: _____
WITHIN 2 WEEKS: _____
OTHER: _____

REQUEST FROM: Jane Horvath

COMMITTEE: SFC

PHONE: 224-4515 **FAX:** 2285568

REQUEST: See attached

ASSIGNMENT:

TO: _____

DATE: _____

DUE DATE: _____

STATUS:

ASSIGNED _____ **OMB REVIEW** _____ **COMPLETED** _____

NOTE: _____

June 23, 1994

NOTE TO: Chris Jennings
Judy Whang
Ken Thorpe

FROM: Bridgett Taylor

SUBJECT: Two requests from Jane Horvath

Request # 1 - Attached is a copy of a document which you prepared for Jane Horvath on premium changes by alliance size and on subsidy and revenue effects on pool size changes. This paper was done with a premium cap. Jane said she also asked Chris for this without premiums constraints. She would like this before they begin markup on Wednesday.

Request #2 - Jane would also like for us to run numbers so that she can compare what the current (national average) per recipient Medicaid spending for non-cash and AFCD would be versus how much the premium amount (average AFDC family) would be increased if you put this same population in the CR pool. She is assuming the pool size to be 500 with no self-insurance under the threshold in a voluntary market for at least the first 5 years.

Thanks for your help.

cc: Karen Pollitz
Jerry Klepner

Subsidy and Revenue Effects of Pool Size Changes*
(Assumes Administration Best Guess of Pool Size Effect on Premiums)
dollars in billions

	1000	500	100
5 YEAR			
Subsidies	360	370	400
Select Other Revenue**	40	40	50
Corporate Assessment	40	50	60
Net Deficit Effect	(10)	(10)	(0)
10 YEAR			
Subsidies	960	990	1,070
Select Other Revenue**	70	80	100
Corporate Assessment	80	90	120
Net Deficit Effect	(90)	(80)	(50)

only slide to here and

* Plan used for calculations is structured as follows:
- premium = HSA-5%
- individual wage cap; all firm sizes eligible
- Prior to 1999, employer mandate on firms of 20+ and individuals. 1999 and beyond, full employer mandate plus individual mandate.

** "Select Other Revenue" includes only those changes in revenue that will differ from the HSA. However, those revenue changes that are identical to the HSA are taken into account in the "Net Deficit Effect" estimates.

All numbers rounded to the nearest $10 billion.

w/o premium caps & constraints

- No constraints

6/20/94--5:30 p.m.

ESTIMATE OF PREMIUM CHANGES BY ALLIANCE SIZE

(ASSUMING UNIVERSAL COVERAGE AND MANDATORY ALLIANCES)

ALLIANCE SIZE	BEST ESTIMATE (relative to CBO's HSA estimate)*	RANGE
All	-	-
5000	0%	0 - 10%
1000	0.5%	0 - 10%
500	2%	0 - 10%
100	6%	0 - 15%
50	10%	0 - 20%

only 91% these

* Note:
Includes AFDC-and-Non-cash in pool.
All workers in split families follow higher wage earner.

* Increasing Medicare DSH savings by reducing DSH payments by two-thirds is a new item that I believe will add to their already significant Medicare savings.

* Modifying and downsizing the Chairman's Medicaid long-term care provision that disproportionately reallocates money to New York apparently saves $40 billion.

* Eliminating the deduction for individuals apparently saves $70 billion.

* Adding the cafeteria plan savings that we have increases revenues by tens(?) of billions of dollars.

* Delaying the start-up of the academic health center pool money helps.

* Cutting some PHS dollars helps.

* Although they appear to believe that they are covering more people, reducing the premium and more efficiently targeting the subsidies only costs $10 billion more (at least according to Bob).

There may be other savings, but I think these are the ones that are most significant. I hope to have their total summary of the bill sometime tomorrow and that may fill in the rest of the void of information you need to fill. I hope that this helps some. See you later this monring....

MEMORANDUM

TO: Ira M.
FR: Chris J.
RE: Latest Budget Table
Date: August 1, 1994 -- 12:40 am

Ira, Bob just faxed over his budget table for the non-mandate table. For some reason, the mandate table did not come over. I called back and couldn't reach him, but will try first thing in the morning. My understanding, however, is that he is between $100 and $200 billion more in the hole. (One important point, Bob said he is asking CBO/Jt. Tax to do the free rider assessment -- I think at 2 percent for the carved out firms; I will follow that one closely.)

As you will note, there are still some revenue holes. The most notable are: the high cost plan assessment figure and the cafeteria plan savings. These figures are due to come out tomorrow. Other than the subsidies for welfare to work, and perhaps the firm subsidy scheme we discussed earlier, I believe the subsidies are the same as we have discussed with them -- with the exception of giving full funding of the subsidies all the way to 100% -- not 75%.

During my latest conversation with Bob, I received a bit more info from him on where the savings is coming from in their runs relative to Finance. I believe the following are the big ticket items:

* Keeping the community rated pool at 500 reduces premiums and associated subsidies.

* Adding the risk adjustment mechanism also apparently reduces the cost of the premium and thus subsidies. Bob could not give me specific premiums, but he indicated that these two provisions produced significant savings. (He thought he could give me more specific info on premiums and savings tomorrow when he had more time to calculate and to ask CBO.)

* Increasing Medicare cuts to the tune of $278 billion vs. $199 billion helped. Although as you pointed out, the savings must be (if not more than) eaten up by the cost of the new Medicare drug benefit (even if it is delayed.)

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

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(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

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(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**

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(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

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(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

TRIGGERED AFFORDABILITY TARGETS

AFFORDABILITY TARGET TRIGGER FOR COMMUNITY-RATED PLANS

- Premium constraints related to affordability targets would be triggered for community-rated health plans in a state (*Alternative: HCCA*) if conditions related to affordability were not met:

  - **For an area where employers are not required to contribute towards coverage:** Constraints would be triggered if less than 35% of those eligible to enroll in a community-rated health plan are able to enroll in a plan with a premium at or below the reference premium for the area.

  - **For an area where employers are required to contribute towards coverage:** Constraints would be triggered if people generally cannot obtain coverage for X% or less of their income for their 50% share of the premium.

  The relevant federal agency could develop proxy measures to determine whether the above conditions were met.

- The first year in which affordability targets would be triggered would be 2000, based on measurement of affordability for 1999.

- Prior to 2000, a Commission would report each year on the affordability of coverage for families and employers and on the success of market incentives in achieving cost containment. If the Commission finds that coverage is unaffordable or that cost containment efforts are unsuccessful, it would be required to make recommendations for improvements.

AFFORDABILITY TARGETS FOR COMMUNITY-RATED PLANS

- If affordability targets are triggered in an HCCA, the targets would be established as follows:

  - The target in the first year after the trigger would be based on the actual weighted average premiums in the HCCA in the previous three years (inflated forward at the target growth rates for the reference premium).

  - After the first year, the target would rise at wage growth plus one percentage point each year (*Alternative: wage growth*) until the target reaches the reference premium for the HCCA. After that, the target would rise at the same rate as the reference premium. (*Alternative: The reference premium could increase based on wage growth also.*)

- Application of affordability targets would be similar to the Senate Labor Bill (including use of a state-established fee schedule for fee-for-service plans).

COST CONTAINMENT FOR EXPERIENCE-RATED PLANS

OPTION 1:

Experience-rated plans operating in an area where affordability targets have been triggered would have access to the fee schedule used for the affordability targets for community-rated plans. Providers would not be permitted to balance bill if paid on the basis of the fee schedule.

OPTION 2:

- Experience-rated plans operating in an area where affordability targets have been triggered would have access to the fee schedule used for the affordability targets for community-rated plans, as in OPTION 1. Providers would not be permitted to balance bill if paid on the basis of the fee schedule.

- One year following when affordability targets are triggered in an area, an experience-rated employer could choose to purchase coverage from community-rated plans in that area.

  - The experience-rated employer would pay demographically-adjusted premiums to the community-rated plans. Plans would be required to offer coverage to any experience-rated employer making this election.

  - An experience-rated employer electing to purchase from community-rated plans would be required to make such an election in all areas where the employer operates and affordability targets are triggered.

  - An employer could make the election to purchase from community-rated plans any time after one year following when affordability targets are triggered, but the election is permanent.

July 28, 1994
1:44 pm

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

URGENT

July 29, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-3478

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: JANET R. FORSGREN (for) B Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: HHS Drafting Service RE: S 1757, Health Security Act

DEADLINE: 5:30 P.M. July 29, 1994

COMMENTS: SEN. MITCHELL REQUEST FOR DRAFT LANGUAGE TO REPEAL THE MEDICARE AND MEDICAID COVERAGE DATA BANK

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew
Lynn Margherio
Barry Clendenin (2)
Mike Dost
Shannah Koss
Janet Forsgren

LRM #I-3478

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Drafting Service RE: S 1757, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

July 29, 1994

NOTE TO: Chris Jennings
Bob Pellicci

FROM: Bridgett Taylor

SUBJECT: Two requests from Senator Mitchell's office - 1) regarding the provision to correct the MVPS upward bias. 2) draft language to repeal the Medicare and Medicaid coverage data bank.

Senator Mitchell's office requested numbers to show the difference between the original physician update provisions in the MSA and the new provision to correct the MVPS upward bias. Attached are these numbers.

Senator Mitchell's office also requested draft language to repeal the Medicare and Medicaid coverage data bank. This language is also attached.

Senator Mitchell is on a very tight time frame so we need to get this ASAP, as in some time this p.m., Friday, July 29.

Thanks.

cc: Jerry Klepner
Karen Pollitz

attachments

DRAFT

SEC. __. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) REPEAL OF DATA BANK.--Section 1144 of the Social Security Act (42 U.S.C. 1320b-14), as added by section 13581 of the Omnibus Budget Reconciliation Act of 1993, is repealed.

(b) CONFORMING AMENDMENTS.--

(1) Medicare.--Section 1862(b)(5) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended --

(A) in subparagraph (B), by striking "the information received under" and all that follows and inserting instead "the information received under subparagraph (A) for the purposes of carrying out this subsection.", and

(B) in subparagraph (C)(i), by striking "subparagraph (B)(i)" and inserting instead "subparagraph (B)".

(2) Medicaid.--Section 1902(a)(25)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking "(including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1144 and any additional measures as specified" and inserting instead "(as specified".

(3) Conforming Amendment Related to Data Matches.--Subsection (a)(8)(B) of section 552a of title 5, United States Code, is amended --

(A) in clause (v), by striking the semicolon at the end and inserting instead "; or";

(B) in clause (vi), by striking "; or" and inserting instead a semicolon; and

(C) by striking clause (vii).

(4) Conforming Amendment to ERISA.--

(A) Section 101 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021) is amended --

(i) by striking subsection (f); and

(ii) by redesignating subsection (g) as subsection (f).

(B) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended --

(i) in paragraph (6), by striking the semicolon at the end and inserting instead "; or";

(ii) in paragraph (7), by striking "; or" and inserting instead a period; and

(iii) by striking paragraph (8).

(C) Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by striking paragraph (4).

(D) Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended by striking "fiduciary, or any person referred to in section 101(f)(1)" and inserting instead "or fiduciary".

4:30
Leg Mtg.

5:30
Briefing POTUS

> We faxed high cost plan assessment stuff to him a few minutes ago

NO RISK ASSESSMENT

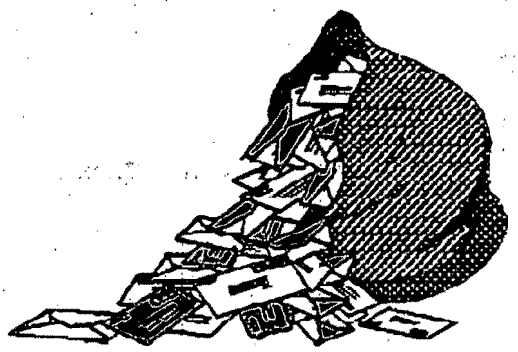
>

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet



URGENT

FROM: Bob Pellicci -- 395-4871

DATE: 7/29 **TIME:** 4:45 p.m.

Pages sent (including transmittal sheet): 3

COMMENTS:

Please see comments. These questions should be addressed before paper is released.

TO: STACY / CHRIS

Transferred.

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To POTUS Re: Meeting with Senator Robb (2 pages)	8/1/94	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [11]

gf63

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

July 31, 1994

MEETING WITH SENATOR GRAHAM

Date: August 1, 1994
Location: Oval Office
Time: 6:00 – 6:30 PM
From: Patrick J. Griffin

I. PURPOSE

- To underscore the importance of health care reform to your Presidency and to the Democratic Party and to seek his support for a bill that achieves universal coverage.

- To illustrate your flexibility and willingness to compromise for a universal coverage bill and to underscore your shared commitment to provide for adequate state flexibility.

II. BACKGROUND

As Chairman of the Senate Democratic Campaign Committee, he would like to be a player in the health care debate. Senator Graham is a Health Security Act cosponsor. He supports universal coverage and is comfortable with the employer mandate and will work with Senator Mitchell to achieve those goals.

Of late, Graham has become concerned that, with the leadership is focusing all energies on drafting a bill with a mandate to achieve universal coverage, not enough attention is being paid to what will happen if such a provision fails. He believes that a fallback position should be developed that is more ambitious than the "rump group" proposal rather than permitting their proposal to succeed by default. To this end, he has been exploring an amendment which would provide flexibility for states to pursue their own universal coverage initiatives in the absence of a federal universal coverage law. Ira Magaziner has met with Senator Graham and other White House staff has met with the Senator's staff to discuss this issue. The Senator and his staff have promised to coordinate with the Majority Leader's office. We have offered to provide additional technical assistance as needed.

III. PARTICIPANTS

The President
Senator Graham
Patrick Griffin

IV. SEQUENCE OF EVENTS

Closed Meeting with Senator Graham in the Oval Office.

V. PRESS PLAN

Closed Press. (White House photographer will be present.)

Add to Presumptive Eligibility Section:

Under 1b.

* Upon completion of the application, the applicant and family (here limited to those eligible for a 100% (full) premium subsidy) would be eligible for insurance (they would select one immediately). Pre-existing condition limits on those eligible for a 100% premium subsidy would be waived. Any costs of the waiver would be allocated to all community rated plans through the risk adjuster.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

# of pages ►

To CHRIS/LARRY

From KC

Dept./Agency

Phone #

Fax #

Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Cost of Options, 2000-2004

	$ billions
Cost of Employer Subsidies	118.2
Cost of Providing Absolute 6% Income Cap	180.0
Cost of Providing Absolute 8% Income Cap	98.6
Cost of Providing Absolute 10% Income Cap	57.6

λ 26 Bill

These are all in relation to the 50% employer mandate trigger in 2000.

Households already have an 8% cap on their 50% share.

The extra cap would limit the amount paid by those households who do not have at least one full time worker or whose employers are exempt from the mandate.

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Chris Jennings | From Lisa Nichols

Co. | Co. | Phone # | Fax #

Dept. | | | Fax #

TRIGGERED PREMIUM CAPS

PREMIUM CAP TRIGGER FOR COMMUNITY-RATED PLANS

- Premium caps would be triggered for community-rated health plans in a state (*Alternative: HCCA*) if the following condition is met:

  Fewer than 35% of those eligible to enroll in a community-rated health plan in the state are able to enroll in a plan with a premium at or below the reference premium for their area. (*Alternative: The plans below the reference premium must also have the capacity to accept new enrollees.*)

- The first year in which premium caps would be triggered would be 2000, based

ENFORCEMENT OF CAPS FOR COMMUNITY-RATED PLANS

- If premium caps are triggered in an HCCA, the premium targets would be established as follows:

  - The premium target in the first year of premium caps would be based on the actual weighted average premiums in the HCCA in the previous three years (inflated forward at the target growth rates for the reference premium).

  - After the first year of premium caps, the premium target would rise at CPI plus one each year (*Alternative: CPI*) until the target reaches the reference premium for the HCCA. After that, the premium target would rise at CPI plus two each year.

- Enforcement of premium caps would be similar to the HSA (including use of a state-established fee schedule for fee-for-service plans).

COST CONTAINMENT FOR EXPERIENCE-RATED PLANS

OPTION 1:

Experience-rated plans operating in an area where premium caps have been triggered would have access to the fee schedule used for enforcement of premium caps for community-rated plans. Providers would not be permitted to balance bill if paid on the basis of the fee schedule.

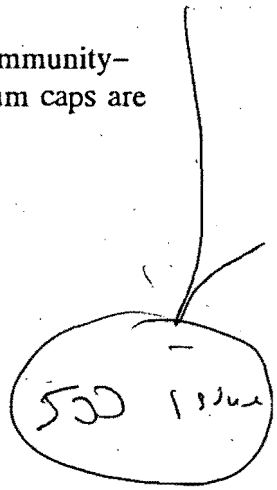
OPTION 2:

- Experience-rated plans operating in an area where premium caps have been triggered would have access to the fee schedule used for enforcement of premium caps for community-rated plans, as in OPTION 1. Providers would

not be permitted to balance bill if paid on the basis of the fee schedule.

- One year following when premium caps are triggered in an area, an experience-rated employer could choose to purchase coverage from community-rated plans in that area.
  - The experience-rated employer would pay demographically-adjusted premiums to the community-rated plans. Plans would be required to offer coverage to any experience-rated employer making this election.
  - An experience-rated employer electing to purchase from community-rated plans would be required to make such an election in all areas where the employer operates and premium caps are triggered.
  - An employer could make the election to purchase from community-rated plans any time after one year following when premium caps are triggered, but the election is permanent.

July 28, 1994
10:38 am



Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Chris Jennings, Steve Edelstein to Secretary Bentsen, Erskine Bowles, Alice Rivlin, Robert Rubin, Laura D'Andrea Tyson RE: Profiles of Senators attending Economic Team Lunch Today (3 pages)	7/28/94	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [11]

gf63

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FAX

DATE: _____ **TIME:** _____

TO:

RECIPIENT: L + G

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: B. Rozan

ORGANIZATION: _____

NUMBER OF PAGES: _____
(including this one)

COMMENTS: Larry + Gary,

please call me

about this

Intended for internal discussion only.

DRAFT -- July 27, 1994

The High Cost Plan Assessment (HCPA) in the Mitchell Bill would impose a nondeductible 25-percent excise tax on premiums in excess of predetermined targets (or growth rates, in the case of self-insured plans). The tax applies to insurance premiums for the basic health plans, but not for cost-sharing supplements or for supplemental policies. As explained in my earlier note on the Senate Finance Committee version of the tax, the effective tax rates would exceed 25 percent for almost all insurance providers, and would be much higher for taxable insurers (62.5 percent) than for employers who self-insure (38.5 percent).

- The tax would not apply to cost-sharing supplements. It would thus encourage consumers to acquire health coverage with low or zero deductibles and copayments. Evidence from the RAND health insurance experiment suggests that this would substantially increase expenditures on health care.

- The tax would not apply to supplemental coverage for such services as routine dental exams and eyeglasses. Most such coverage is not true insurance (the covered expenditures are highly predictable) and have the least rationale for a subsidy.

- Because HMOs would have low or no cost-sharing by design, their premiums implicitly reflect the basic coverage and cost-sharing rates plus an integral cost-sharing supplement. Thus, for HMOs, cost-sharing is subject to tax. This would place HMOs at a disadvantage relative to fee-for-service plans. The HCPA could thus discourage use of HMOs and their potential to constrain health care costs.

- Without accurate risk adjustments, the HCPA would have perverse effects. For example, an insurer with low premiums might become subject to the tax because it is erroneously judged to have below average risk. Since nobody knows how to do accurate risk adjustments, they would lead to random tax liability.

- The effective tax rates would vary by the type and tax status of insurance provider, which is inequitable and inefficient (see next bullet).

- The HCPA would be hard, if not impossible, for the tax authorities to administer. Self-insured firms would be able to easily limit their exposure to the tax by allocating costs to the untaxed cost-sharing supplements rather than the taxable basic coverage. Combined with the much lower effective tax rate on firms that self-insure, virtually all firms in the experience-rated pool would probably choose to self-insure rather than purchasing insurance from commercial insurers. This would exacerbate the compliance problems, and would also be inefficient.

July 28, 1994

SUBJECT: EASING THE INDIVIDUAL CONTRIBUTION OF A 50-50 MANDATE

Currently, there is a serious political problem with the individual mandate portion of universal coverage under a 50-50 mandate. Under a 50-50 mandate, we must take more seriously the impact of the mandate on the individual -- a matter that was less of an issue in the 80-20 scenario.

To see the problem consider a family of our making about $30,000. If in the year 2000 the cost of a family premium is $6000, the working uninsured would be required to pay $3000 or $2,400 with a 8% household cap. That would be likely 12% of the family's after tax income. Furthermore, the family is likely to suffer a wage loss over time of another $3000 as the employer gradually passed back the costs of wages in the form of lower wages -- or less raises.

In one sense we may feel this is fair, as the worker was previously free-riding on others. Yet from the perspective of these families, they may feel that health reform has made them worse off. The family may feel they were previously scraping by, in need of health insurance, but feeling that it was better to take the chance of uncompensated emergency room care than to take away a few thousand dollars of money going to the mortgage or expenses. For this family that likely saves virtually no money to be told to now cough up a few thousand dollars *under the force of federal law* is no small matter.

Below I would like to run through three options. The first two are what is being worked on now -- a 8% or 6% cap. My fear is that we will not be able to afford lowering the cap enough to make this palatable to uninsured families in the $30,000-$45,000 range. I would like to propose a third option that gives employees a choice of catastrophic or comprehensive plan in a 50-50 mandate world.

OPTIONS:

A 8% CAP: We are seeing whether we can afford to impose an 8% option. Yet this would assure the family of $30,000 only that they would only pay $2,400 -- at least 10% of their after tax income -- a substantial hit, while only providing a $600 subsidy.

A 6% CAP: This would lower the family contribution to $1,800, and increase the subsidy to $1,200 if you could have a 6% cap. The problem, however, is a 6% ceiling on payments as a percentage of household income becomes very expensive when one starts applying it to the vast amount of families in the $30,000-$40,000 range.

EMPLOYEE CHOICE OPTION: An option that we may want to consider is how a 50–50% mandate would work where the **employee had the option to choose a more catastrophic plan or a basic comprehensive benefit plan.**

Imagine that the basic package was $6,000 and the catastrophic plan was $4,000. One way to do a 50–50 would be to make the family making $30,000 pay either $3000 (50% of the comprehensive package $6,000) or $2,000 (50% of the catastrophic $4,000). In this world, we would put less financial burden on the $30,000 family, but the new law would still be compelling the family making $30,000 to pay $2,000 just to get catastrophic.

Yet, the idea I would like to suggest is that the 50–50 plan could work by allowing requiring the employer to pay 50% of the comprehensive plan and then give the household the choice of buying a comprehensive or a catastrophic plan. In that case, a household who would feel that they could not afford the comprehensive plan, could pay $1000, that along with the employer's $3000 contribution would allow the family to get catastrophic plan for less than 4% of after tax income. In other words, the household would have the choice of paying 50% of a comprehensive plan or 25% of a catastrophic plan.

This is not nearly as preferable as a comprehensive plan with a 80–20 employer mandate. Yet, if we are going to be in a 50–50 world, we should consider this option. I will point out, however, that to the degree that the mandate does not trigger in for a few years there would be time to try to fix this later -- in the hope that it would be easier once we have established universal coverage. Even still, however, without the employee's choice, we may have to deal with our reply to the 50% individual mandate without a lower cap or some employees' choice like mentioned above.

NOTE ON CHILDREN COVERAGE

Currently, there are 67 million young people under 18 and 8.5 million or 12.7%.

It is worth noting that if we were to cover 7.5 million of these uninsured children -- leaving only 1 million uncovered who are upper income, that would mean we were covering 98.5% of children.

COMPARISON OF EMPLOYER BEHAVIOR WITH AND WITHOUT EQUAL CONTRIBUTION RULES

EMPLOYER SUBSIDY GENERALLY NOT AVAILABLE[3]

Current	Without Equal Contribution Rules	With Equal Contribution Rules
1. Employer covers all employees.	May drop low-wage employees.	a. May drop all employees; or b. May outsource low-wage employees.
2. Employer covers only high-wage employees.	Continues current coverage.	a. May add coverage for low-wage employees; or b. May drop high-wage employees; or c. May outsource.
3. Employer does not cover employees.	If employer subsidy, may add coverage for low-wage employees (and possibly add some high-wage employees).	If employer subsidy, may add coverage for all employees.

Overall, employers are likely to provide more health insurance benefits with equal contribution rules than without equal contribution rules.

***

EMPLOYER SUBSIDY AS GENEROUS AS HOUSEHOLD SUBSIDY

Current	Without Equal Contribution Rules	With Equal Contribution Rules
1. Employer covers all employees.	Continues current coverage.	Continues current coverage.
2. Employer covers only high-wage employees.	Continues current coverage.	a. May add coverage for low-wage employees; or b. May drop high-wage employees; or c. May outsource.
3. Employer does not cover employees.	May add coverage for low-wage employees (and possibly add some high-wage employees).	May add coverage for all employees.

Given existing data, it cannot be determined whether employers would provide more or less health insurance benefits with equal contribution rule than without equal contribution rules, however the difference is not likely to be large.

---

[3] Also applies if employer subsidy not as generous as household subsidy.

Jane Horan

OPTIONAL FEHBP-TYPE OPTION DURING TRANSITION TO UNIVERSAL COVERAGE

PHASE-IN OF UNIVERSAL COVERAGE

- A voluntary insurance market with reforms and subsidies is given an opportunity to achieve universal coverage.
- If universal coverage is not achieved in a voluntary market, Breaux-type triggers phase in requirements for employers to provide coverage.
- Beginning in 1996, employers not providing coverage that meets minimum requirements must pay an assessment equal to 1% of payroll.
- All Americans are covered by 2000.
- Optional enrollment in an FEHBP-type program maintains stability in the insurance market and ensures cost containment. Subsidies are available only through the FEHBP program.

ELIGIBILITY FOR COVERAGE THROUGH THE FEHBP OPTION

- Any individual without coverage available through an employer, or any employer with fewer than 1,000 employees, may obtain coverage through FEHBP (or a similar) program (as described below).
- Employers with 1,000 or more employees who do not now provide coverage may also choose the FEHBP option.
- Uninsured dependents of workers insured through their employers may purchase coverage through the FEHBP option.
- Part-time workers may purchase coverage through the FEHBP option, applying any insurance contributions made by their employers.

INSURANCE MARKET REFORMS

- Basic insurance market reforms apply to employers with fewer than 1,000 employees both in the FEHBP option and in the outside market.

- All insurers are required to guarantee access to coverage for individuals and employers with fewer than 1,000 employees.

- Insurers may vary rates by age for employers with fewer than 1,000 employees, but not by experience. Self-insurance is not permitted for employers with fewer than 1,000 employees.

- Option: Permit some variation for experience -- e.g. plus or minus 15% -- outside of the FEHBP option. Also, permit self-insurance for employers with 500 or more employees (maybe with a "self-insurance risk adjustment assessment" paid to the FEHBP pool).

- Insurers may have different premiums as part of the FEHBP option and in the outside market.

- Pre-existing condition exclusions are permitted, but limited to a defined period of time (e.g. six months).

- Coordination for dual worker families is the same as in the current market.

- Certain non-discrimination rules apply to employer contributions.

BENEFITS

- Insurers are permitted to offer any type of benefits package, but must also offer the package guaranteed under universal coverage.

- Insurance market reforms apply to all benefits packages sold to employers with fewer than 1,000 employees.

- Only the package guaranteed under universal coverage is offered under the FEHBP option.

SUBSIDIES

- The employer and individual subsidies ultimately provided under universal coverage are also available during the transition.

- Subsidies are generally only available for coverage purchased through the FEHBP option. However, low wage workers with coverage through an employer outside of the FEHBP option are eligible for subsidies for their share of the premium (capped at the subsidy that would be available within the FEHBP option).

CHOICE OF PLANS WITHIN THE FEHBP OPTION

- Private health plans submit premium bids the administrator of the FEHBP option. The administrator is not required to accept all bids.

- The availability of a fee for service plan is guaranteed through a Medicare–type plan.

- Health plans offered through the FEHBP option are separate from those available to federal employees.

COST CONTAINMENT

- Guaranteed cost containment is available only through the FEHBP option.

- The guaranteed Medicare–type fee for service plan uses Medicare reimbursement methods and rates. Providers accepting payment from the Medicare program must also accept payment under the FEHBP option fee for service plan, with the same balance billing rules.

- Private insurers may also use payment rates used by the guaranteed Medicare–type fee for service plan.

- Subsidies are provided up to the weighted average premium in the FEHBP option (up to the premium under the guaranteed fee for service plan).

MEDICAID

- All Medicaid recipients (cash and non-cash) receive coverage through the FEHBP option.

- The state and federal governments make per capita payments to the FEHBP program, which are blended with private premiums. The per capita payments rise at constrained growth rates.

- Medicaid eligibility continues for non-cash recipients. Their coverage is financed in the same way as cash recipients (i.e. per capita payments blended with private premiums).

EARLY RETIREES

- Early retirees with employer-sponsored coverage are not eligible to enroll in the FEHBP option.

- Early retirees without employer-sponsored coverage may enroll in the FEHBP option, and are eligible for the same subsidies as others without employer coverage.

STATE FLEXIBILITY

- States may vary the insurance market structure (e.g. create alliances).

- States may use alternative cost containment strategies (e.g. premium caps).

- Federal subsidy payments are capped at what they would be under the FEHBP option, and states are required to make up any extra costs if they use an alternative approach.

Mitchell come out

– Dr. Podboff / Peter Bolotti

– Demo down,

– Organize ... – Rep ... ...

Jane / Van Thorpe

AFRC 1112
&
All for ... 2 categories
1 Adult
2 adults or Rods

– before

FEHBP come it ...

... all Rods ...

– high ... list ...

– 8 ... 2-10

For river

John Costa
Cell
(610) ... 0753

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Ken Thorpe To: Chris Jennings

Phone: (202) 690- Phone:
(202) 690-6870

FAX: (202) 401-7321 Fax:

Number of Pages (Including Cover):

Comments: Nexon's Request. Never called me (Jeanne) and said this was urgent. Thanks.

State Maintenance of Effort under the Health Security Act, Year 2000

	MOE 2000 (1) ($ millions)	Population 2000 (2) (thousands)	MOE Per Capita 2000	Index to US 2000
UNITED STATES	23,400	276,241	$85	1.00
Alabama	171	4,485	$38	0.45
Alaska	69	699	$99	1.17
Arizona	449	4,437	$101	1.19
Arkansas	101	2,578	$39	0.46
California	3,946	34,888	$113	1.34
Colorado	201	4,059	$49	0.58
Connecticut	537	3,271	$164	1.94
Delaware	33	759	$43	0.51
District of Colum	142	537	$264	3.11
Florida	884	15,313	$58	0.68
Georgia	408	7,637	$53	0.63
Hawaii	98	1,327	$74	0.87
Idaho	53	1,290	$41	0.48
Illinois	857	12,168	$70	0.83
Indiana	427	6,045	$71	0.83
Iowa	115	2,930	$39	0.46
Kansas	149	2,722	$55	0.64
Kentucky	186	3,989	$47	0.55
Louisiana	445	4,478	$99	1.17
Maine	118	1,240	$95	1.12
Maryland	486	5,322	$91	1.08
Massachusetts	638	5,950	$107	1.26
Michigan	629	9,759	$64	0.76
Minnesota	256	4,824	$53	0.63
Mississippi	98	2,750	$36	0.42
Missouri	618	5,437	$114	1.34
Montana	28	920	$30	0.36
Nebraska	85	1,704	$50	0.59
Nevada	146	1,691	$86	1.02
New Hampshire	54	1,165	$46	0.54
New Jersey	657	8,135	$81	0.95
New Mexico	43	1,823	$23	0.28
New York	3,656	18,237	$200	2.37
North Carolina	523	7,617	$69	0.81
North Dakota	20	643	$31	0.36
Ohio	950	11,453	$83	0.98
Oklahoma	160	3,382	$47	0.56
Oregon	124	3,404	$36	0.43
Pennsylvania	882	12,296	$72	0.85
Rhode Island	85	998	$85	1.01
South Carolina	268	3,932	$68	0.81
South Dakota	20	770	$26	0.31
Tennessee	465	5,538	$84	0.99
Texas	1,321	20,039	$66	0.78
Utah	71	2,148	$33	0.39
Vermont	30	592	$50	0.59
Virginia	427	7,048	$61	0.71
Washington	297	6,070	$49	0.58
West Virginia	110	1,840	$60	0.71
Wisconsin	148	5,381	$27	0.32
Wyoming	18	522	$34	0.41

(1) HCFA OAct; ASPE; NOTE: State estimates do not sum to U.S. total due to rounding.
(2) CPS State Population Projections (Series A).

EFFECTS OF LOWERING THE THRESHOLD FOR EMPLOYER PARTICIPATION IN THE COMMUNITY RATE

♦ Reducing the threshold for alliance participation from 5,000 to 1,000 and creating a firewall which required firms above 1,000 to pay the 1% assessment achieved signficant deficit reduction for two reasons: first, and most importantly, CBO scoring of the HSA assumed that most firms above 5,000 would join the regional alliance and avoid the 1% assessment. Creating a firewall increased revenues substantially, even if the threshold had been left at 5,000. Second, moving the threshold down to 1,000 gained additional revenue. These estimates assumed that there would be little change in the community rated premium.

♦ As the threshold is reduced below 1,000, however, the revenue gain from additional corporate assessment is more than offset by increased subsidy needs as the community rate increases.

♦ Per capita health expenditures for non-workers are higher, on average, then per capita expenditures for workers (this is true even when Medicaid cash assistance recipients are excluded from consideration). In part this is because non-workers include many older persons who are unemployed or out of the labor force (with relatively high expenditures), and in part because those in poor health are more likely than others to be non-workers.

♦ As the threshold for the size of employer required to participate in the community rate is reduced, the proportion of workers in the community rated pool declines, and the proportion of non-workers increases. As a result, the community rate increases as fewer workers are included in the community.

♦ At a threshold of 100, the community rate would be 10%-14% higher than the CBO estimate for the HSA, and one-year federal subsidy costs would increase substantially. The increase in subsidies would be partially offset by an increase in revenue from the corporate assessment (assuming that the additional firms outside the community rate were required to pay the 1% of payroll assessment), but the net effect would be to increase the deficit substantially.

♦ Some might think that the effects on the community rate from reducing the threshold are due to the treatment of the Medicaid cash assistance population, but this would not be correct. Prohibiting the Medicaid cash assistance population from enrolling in community rated health plans will have no effect on the community rate or on federal subsidy payments. The community rate, both in the HSA and in the Chairman's Mark, is based on the costs of providing health care to people who are not receiving cash assistance. Thus, the treatment of the Medicaid cash assistance recipients will not affect the deficit estimates.

ANALYSIS OF REG
CONSTRAINED
Split Families Follo

SINGLE

Alliance Firmsize	AFDC Only Per Capita	AFDC Only Change from CBO Base	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$2,200			$2,200			$2,200		
All	$2,200	100.0%	$101,577	$2,288	104.0%	$107,283	$2,237	101.7%	$105,850
5000	$2,291	104.1%	$88,743	$2,393	108.8%	$94,448	$2,332	106.0%	$93,015
1000	$2,359	107.2%	$81,289	$2,473	112.4%	$86,994	$2,403	109.2%	$85,561
500	$2,391	108.7%	$78,079	$2,510	114.1%	$83,784	$2,436	110.7%	$82,351
100	$2,506	113.9%	$69,352	$2,643	120.1%	$75,058	$2,554	116.1%	$73,625

COUPLE

Alliance Firmsize	AFDC Only Per Capita	AFDC Only Change from CBO Base	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$2,200			$2,200			$2,200		
All	$2,200	100.0%	$86,195	$2,223	101.0%	$87,541	$2,213	100.6%	$87,571
5000	$2,247	102.1%	$66,937	$2,277	103.5%	$68,283	$2,263	102.9%	$68,313
1000	$2,267	103.0%	$56,393	$2,303	104.7%	$57,739	$2,286	103.9%	$57,769
500	$2,249	102.2%	$51,244	$2,288	104.0%	$52,589	$2,269	103.2%	$52,619
100	$2,311	105.0%	$40,347	$2,361	107.3%	$41,693	$2,336	106.2%	$41,723

ANALYSIS OF RE
CONSTRAINED
Split Families Foll

1 ADULT & KIDS

Alliance Firmsize	AFDC Only Per Capita	AFDC Only % Change	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$1,412			$1,412			$1,412		
All	$1,435	101.6%	$42,446	$1,497	106.0%	$32,743	$1,476	104.5%	$36,548
5000	$1,479	104.7%	$37,566	$1,574	111.5%	$27,864	$1,538	108.9%	$31,669
1000	$1,510	106.9%	$34,791	$1,636	115.8%	$25,088	$1,585	112.2%	$28,893
500	$1,525	108.0%	$33,685	$1,667	118.0%	$23,983	$1,608	113.9%	$27,787
100	$1,568	111.0%	$30,721	$1,768	125.2%	$21,019	$1,679	118.9%	$24,824

2 ADULTS & KIDS

Alliance Firmsize	AFDC Only Per Capita	AFDC Only % Change	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$1,286			$1,288			$1,286		
All	$1,292	100.5%	$144,791	$1,301	101.1%	$142,885	$1,322	102.8%	$151,168
5000	$1,328	103.2%	$113,941	$1,340	104.2%	$112,016	$1,366	106.2%	$120,318
1000	$1,353	105.2%	$98,669	$1,369	106.4%	$94,743	$1,398	108.7%	$103,046
500	$1,368	106.3%	$89,053	$1,386	107.7%	$87,127	$1,416	110.1%	$95,430
100	$1,420	110.3%	$70,340	$1,446	112.4%	$68,415	$1,490	115.1%	$76,718

SOURCE: HCFA.

ANALYSIS OF REG
CONSTRAINED
Split Families Follo

SINGLE

	AFDC & SSI			All		
Alliance Firmsize	Per Capita	% Change	Total Premiums	Per Capita	% Change	Total Premiums
	$2,200			$2,200		
All	$2,288	104.0%	$108,087	$2,321	105.5%	$113,163
5000	$2,392	108.7%	$95,253	$2,427	104.6%	$100,329
1000	$2,470	112.3%	$87,799	$2,507	108.0%	$92,875
500	$2,507	114.0%	$84,588	$2,544	109.6%	$89,665
100	$2,638	119.9%	$75,662	$2,673	115.2%	$80,938

COUPLE

	AFDC & SSI			All		
Alliance Firmsize	Per Capita	% Change	Total Premiums	Per Capita	% Change	Total Premiums
	$2,200			$2,200		
All	$2,223	101.1%	$87,630	$2,235	101.6%	$89,096
5000	$2,277	103.5%	$68,372	$2,292	104.2%	$69,837
1000	$2,302	104.7%	$57,828	$2,320	105.5%	$59,294
500	$2,287	104.0%	$52,679	$2,307	104.9%	$54,144
100	$2,360	107.3%	$41,783	$2,384	108.4%	$43,248

Employer Premium Payments
CBO Premiums, Big Firms Out

		1994	1995	1996	1997	1998	1999	2000	'96-2000
Total	Baseline	192,279	209,391	228,237	248,321	269,181	291,792	316,886	1,354,416
	Reform	225,194	244,493	257,940	270,063	282,216	292,941	304,072	1,407,233
Less than 10	Baseline	11,767	12,814	13,968	15,197	16,473	17,857	19,393	82,888
	Reform	16,927	18,378	19,388	20,300	21,213	22,019	22,856	105,776
10 - 25	Baseline	11,156	12,148	13,242	14,407	15,617	16,929	18,385	78,580
	Reform	17,962	19,501	20,574	21,541	22,510	23,366	24,254	112,244
25 - 99	Baseline	20,649	22,487	24,511	26,668	28,908	31,336	34,031	145,454
	Reform	27,334	29,677	31,309	32,780	34,255	35,557	36,908	170,810
100 - 499	Baseline	31,358	34,148	37,222	40,497	43,899	47,586	51,679	220,883
	Reform	34,859	37,846	39,928	41,805	43,686	45,346	47,069	217,833
500-999	Baseline	14,219	15,485	16,878	18,363	19,906	21,578	23,434	100,160
	Reform	14,712	15,973	16,851	17,643	18,437	19,138	19,865	91,935
1,000-4,999	Baseline	54,305	59,138	64,460	70,133	76,024	82,410	89,497	382,523
	Reform	57471	62,396	65,828	68,922	72,023	74,760	77,601	359,135

Model 139
3-June-1994

CBO said $120 Billion - we have $13 Billion - but very unevenly distributed across firm sizes. Ideas?

FOR NEXON - WANTED DISTRIBUTION OF SAVINGS BY FIRM SIZE -