Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. notes	Notes from Bentsen "Economic Team" Lunch (5 pages)	7/28/94	P5

COLLECTION:

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

FOLDER TITLE:

Analysis [14]

gf64

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]

MEMBERS:
Dick Armey, TX
Jim Saxton, NJ
Christopher Cox, CA
Jim Ramstad, MN

HOUSE REPUBLICAN CAUCUS
JOINT ECONOMIC COMMITTEE

359 Ford House Office Building
Washington, DC 20515
(202) 226-4066

July 26, 1994

MIDDLE CLASS LOSES UNDER CLINTON'S MANDATED UNIVERSAL HEALTH COVERAGE

Dear Colleague:

The President is making a last-ditch attempt to rally public opinion behind his government-run health care proposal. His latest pitch contends that the middle class would benefit from mandated universal coverage.

Nothing could be further from the truth.

The middle class stands to be hurt the most by the Clinton health scheme. Wealthy Americans will feel less of a pinch from the regressive payroll taxes financing the plan, and they will find ways around health spending caps designed to ration care. Lower income Americans will be protected with huge government subsidies. Stuck in between, middle class Americans will bear the burden of the President's health reform plan.

- The insurance market reforms in the President's plan will increase premiums for more than 65 percent of Americans. Younger Americans with lower incomes will subsidize older Americans at their earnings peak.

- The employer mandate, administered as a 7.9 percent payroll tax, will cost the Nation between 600,000 and 2.6 million jobs. And, a substantial number of these workers who do not lose their jobs will experience pay cuts on the order of $2,268 per affected worker.

- The proposed limits on health care spending would force Americans to give up $149 billion in medical spending in the year 2000. The typical household would have to give up $451 worth of medical services. Which doctor visits would middle class families forego?

- The Congressional Budget Office and many others have found that the Clinton health plan will increase the deficit, leading to bigger debts and higher future taxes for middle class Americans.

Republicans have put forward health reforms that address middle class America's concerns—affordability and portability—without endangering jobs and rationing care. Middle class Americans want and need health reform—and Republicans, not the President, are solidly in their corner.

Sincerely,

Chris Cox (R-CA)
Member, House Republican Caucus

Jim Ramstad (R-
Member, House Republican

Economic Policy Update

MIDDLE CLASS LOSES UNDER CLINTON'S MANDATED UNIVERSAL HEALTH COVERAGE

Prepared by the
Joint Economic Committee Republican Staff

at the request of

Representative Chris Cox (R-CA)

and

Representative Jim Ramstad (R-MN)

Members of the Joint Economic Committee
House Republican Caucus

July 1994

Middle Class Loses Under Clinton's Mandated Universal Health Coverage

High cost and restricted access to health insurance have been widely identified as serious problems currently besetting the health care industry. Issues like affordability, portability, pre-existing condition restrictions, and other aspects of the current health insurance market, are components of these cost and coverage problems. Under the Clinton Plan and its congressional counterparts, all of these problems would get worse.

Quality of care, innovation, access to care, bureaucracy, and income redistribution and class warfare surrounding the present health care system do not seem to be problems now. Under the Clinton Plan, they would become problems.

President Clinton's health care plan would force middle class families to pay more for less health care. The Clinton Plan will raise the cost of health insurance and lower the quality of medical care available to families. Congressional committees now have passed four versions of the President's mandated universal health proposal.[1] For middle class American families, the Clinton health plan and its congressional counterparts will translate into higher costs, lost jobs and rationed care.

Paying More for Less

The Administration's mandated universal coverage proposal would make health insurance more expensive for many middle class families. In her testimony before the Senate Finance Committee, Secretary of Health and Human Services Donna Shalala estimated that 40 percent of all Americans would pay more for health insurance.[2]

First, President Clinton's plan adopts a one-size-fits-all approach. Everyone would be forced to buy an expensive insurance package designed by the Federal government, paying for coverage of services they may not want or need. The White House estimated that its mandated insurance package would cost $1,932 for individual coverage and $4,360 for family coverage. The Wyatt Company, an economic research firm, estimated that the Administration's premium estimates were off by 18 percent; individuals would pay $2,285 for coverage and families would pay $5,155.[3] Hewitt Associates, an employee benefits consulting firm, concluded that

---

[1]House Education and Labor Committee - Health Security Act, H.R. 3600; House Education and Labor Committee - American Health Security Act of 1994 - H.R. 3960; Senate Labor/Human Resources Committee - Health Security Act, S. 2296; and House Ways and Means Committee - Health Security Act, H.R. 3600.

[2]Clymer, Adam, "White House Drops Talk of Capping U.S. Health Spending," *The New York Times*, October 29, 1993, p. A19.

[3]The Wyatt Company, *The Business Council on National Health Policy*, (Washington, DC, 1994).

premiums would be 26 percent higher than the Administration estimates for individual coverage, and 59 percent higher than Administration estimates for family coverage.[4]

Table 1—Mandated Premium Costs Under Clinton Health Plan

	Administration Estimates	Wyatt Company	Hewitt Associates
Single Coverage	$1,932	$2,285	$2,337
Family Coverage	$4,360	$5,155	$6,662

Second, the insurance regulations—community rating and guaranteed issue—would mean higher premiums for most middle class families, especially those younger Americans just entering the work force and just starting families. The American Academy of Actuaries has estimated that pure community rating would increase premiums for 65 percent of the privately insured, non-elderly population (19 percent would face premium increases of more than 20 percent). Among small employers (less than 25 employees), 63 percent would pay higher premiums.[5] The higher premiums on younger, healthier workers would subsidize the health care costs of other workers leading less healthy lifestyles.

Guaranteed issue requirements and limits on pre-existing condition exclusions are designed to provide access to insurance for those who have been denied coverage or priced out of the market due to an illness or medical condition. According to the Department of Health and Human Services, approximately one million of the uninsured lack coverage because illness has priced them out of the market.[6] Regulating the entire insurance market proves to be an expensive means of assisting this relatively small population. In order to make insurance available to these one million consumers, guaranteed issue regulations would raise premiums for nearly all policyholders. According to the Council for Affordable Health Insurance, requiring insurers to take all applicants and cover all health risks raises the cost of insurance for small groups by as much as 50 percent.[7]

[4]Yamamoto, Dale, F.S.A., Testimony before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment, Washington, D.C., November 22, 1993.

[5]American Academy of Actuaries, *An Analysis of Mandated Community Rating*, Washington, D.C., March 1993.

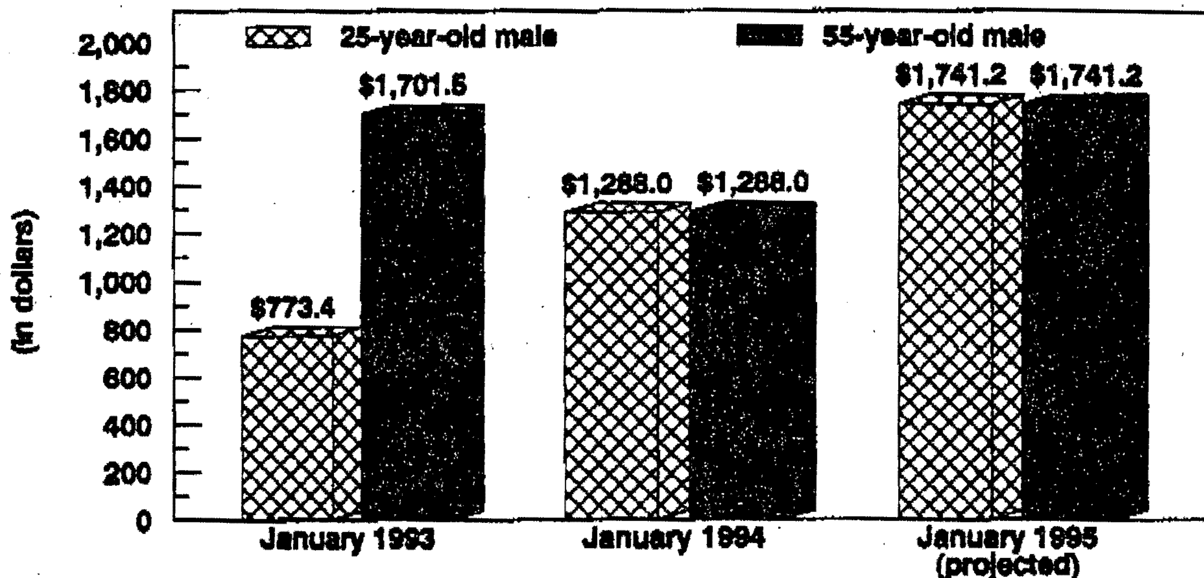
[6]Based on 1987 NMES survey, which found that approximately 2.5 percent of the uninsured under age 65 "had been denied health insurance coverage or offered limited coverage because of their health."

[7]Council for Affordable Health Insurance, "Guaranteed Issue: Guaranteed to Make the Problems in the Small Group Market Worse," Alexandria, VA, November 1992.

As the insurance regulations increase premiums paid by employers, employers will pass those costs on to employees. Based on a review of the literature,[8] economists June and Dave O'Neill assume that employers pass on to employees 70 percent of the costs of the higher premiums by reducing employee wages.[9] Economists Jonathan Gruber and Alan Kreuger assume that firms would pass on to workers approximately 85 percent of the increase in health insurance by lowering wages within a few years.[10]

State experience shows that these regulations fail to achieve their twin goals of lower premiums and increased health insurance coverage. New York enacted community rating, guaranteed issue, and a ban on pre-existing condition exclusions in 1993. For some younger state residents, premiums increased by as much as 79 percent in one year.[11] And despite the huge new costs for younger policyholders, premiums for 55-year-old New Yorkers today are above 1992 rates.

Annual Premiums in New York State
(Mutual of Omaha individual premiums)



---

[8]See, for example, Barrera, Heather, *Tax Incidence: A Selected Bibliography* (Chicago: CPL Bibliographies, 1993).

[9]O'Neill, June E, and Dave M. O'Neill, "The Employment and Distributional Effects of Mandated Benefits," (Washington, D.C.: American Enterprise Institute), 1994.

[10]Klerman, Jacob Alex and Dana Goldman, RAND Corporation, "Job Loss Due to Health Care Reform," written testimony to the United States Senate, Committee on Labor and Human Resources, October 1993.

[11]Sciam, Leslie, "New York Finds Fewer People Have Health Insurance a Year After Reform," *Wall Street Journal*, May 27, 1994.

Not surprisingly, many young consumers dropped their insurance coverage. Some New York insurers report the average age of policyholders has increased three years or more, as young, relatively healthy consumers are priced out of the market. The number of New Yorkers buying individual and small group health insurance policies fell by 25,000 in less than one year, and likely will continue to fall as insured New Yorkers face premium increases of 25 to 35 percent this year.[12] The New York Insurance Department reports that 43,666 individual policy-holders have canceled their policies since the law was passed.[13]

Health economists David Bradford and Derrick Max estimate that community rating under the Clinton Plan would overcharge young people by about $650 per year and subsidize older people by about $2,000. In other words, the Clinton Plan would tax people ages 25 to 43 about $26 billion each year, while providing an annual subsidy of $33 billion to those aged 55 to 64.[14]

The Kennedy bill in the Senate and the Williams and Gibbons bills in the House mirror the President's proposal for insurance reforms. Middle class Americans would pay more for health insurance to subsidize those at their earnings peak.

Even groups supporting these health reform bills have criticized the new insurance regulations in them. Families USA, a group strongly committed to advancing government-run health care, commissioned an actuarial study of insurance reforms proposed in 1992.[15] The study examines the impact of the health insurance reforms included in the Senate version of the 1992 tax bill: modified community rating, limits on pre-existing condition exclusions, and guaranteed issue of insurance. The author, Gorden Trapnell Consulting Actuaries Limited, concludes that "there would be three to four times as many 'losers'—who would pay considerably higher premiums—as there would be 'winners.'"

Even the so-called "moderate" Senate Finance Committee bill[16] includes "modified" community rating that will dramatically increase the cost of insurance for the middle class. Modified community rating allows rate adjustments for age, sex, and geography, but still increases premiums for most Americans. The American Academy of Actuaries calculates that

---

[12] *Ibid.*

[13] "Community Rating A Cure Worse than the Disease," Brief Analysis No. 114, National Center for Policy Analysis, Dallas, TX, July 6, 1994.

[14] Bradford, David, and Derrick Max, "Health Reform's Rating Roundelay," *Washington Times*, February 8, 1994.

[15] Families USA, "The Senate's Small Group Insurance Reform: A Catastrophic Health Care Debacle in the Making?" Washington, D.C., May 1992.

[16] Senate Finance Committee — Health Security Act.

under modified community rating, 79 percent of the privately insured, non-elderly population would pay higher premiums, and 76 percent of small employers would pay more. The average increase under modified community rating would be smaller than under pure community rating but would affect more people.

Losing Good Jobs at Good Wages

The Clinton mandate requiring employers to pay for health insurance amounts to a 7.9 percent payroll tax on most employers. Several econometric studies have estimated massive job loss as a result of the mandate and the other taxes in the Clinton health plan.[17] DRI/McGraw-Hill puts the cost at 709,000 jobs.[18] CONSAD research estimated job losses of 850,000, with potential job losses of 3.8 million.[19]

Table 2—Estimated Employment Effects of An Employer Health Care Mandate

Study Author/Organization	Probable Job Loss
Office of Planning & Research/State of California	2.6 million
DRI/McGraw-Hill/CSE Foundation	709,000
O'Neill & O'Neill/EPI	780,000 - 890,000
JEC/GOP Staff	710,000
Klerman & Goldman/RAND	600,000
CONSAD Research Corp./NFIB	850,000
Fiscal Associates/NCPA	677,000
Vedder & Gallaway/ALEC	1.0 million

Source: JEC/GOP staff study, *Mandate for Destruction*, prepared at the request of Congressman Jim Saxton (R-NJ), Member, Joint Economic Committee, House Republican Caucus, June 1994.

This destruction of jobs would affect low wage workers the most. Middle wage workers, on the other hand, face another prospect—substantial wage reductions. Economists Richard Vedder and Lowell Gallaway estimate that the Clinton health plan would reduce wages by $93

[17]See JEC/GOP staff study, *A Mandate for Destruction*, prepared at the request of Representative Jim Saxton (R-NJ), Member, Joint Economic Committee, June 1994.

[18]DRI/McGraw-Hill, *The Administration's Health Care Reform Plan: National Macroeconomic Effects*, (Washington, D.C., Citizens for a Sound Economy Foundation) February 1994.

[19]National Federation of Independent Business and the Healthcare Equity Action League, *Employment and Related Economic Effects of Health Care Reform*, (Pittsburgh, PA, prepared by CONSAD Research Corporation) April 1994.

SENT BY:Xerox Telecopier 7021 ; 7-28-94 ; 5:18PM ; → 94565383;# 9

billion in 1998.[20] That would amount to $2,268 per affected worker. Workers earning between $14,000 and $30,000 per year stand to suffer most of the wage reductions, losing between $660 and $2,300 per year in wages. Lewin/VHI found that when depressed wages are factored in, more than half of all working age households (53.4 percent) would experience a net decrease in income in the first year of the Clinton health plan.[21]

The Williams and Gibbons bills in the House contain virtually identical employer mandate provisions and additional taxes on tobacco and on large employers that threaten the job security of millions of working middle class Americans. The Kennedy bill in the Senate has an even more destructive mandate than the Clinton proposal. The Kennedy bill calls for a payroll tax of up to 12 percent for employers and an additional 3.9 percent for employees. According to CONSAD Research, this larger tax could cost up to 1.7 million jobs.

Waiting in Line for Care

At the same time that the Clinton health plan and its congressional counterparts undermine job security and income security for the middle class, they all fail to provide "health security." Instead, they threaten to reduce the level of care now consumed by middle class American families.

The Clinton health plan, as well as the Kennedy, Gibbons and Williams bills, would cap the Nation's spending on health care. The President proposes a cap so tight that it allows zero real growth in health expenditures after the year 2000—not even allowing for a growing population. According to DRI/McGraw-Hill estimates, the Administration price caps would require Americans to give up $149 billion in medical spending in the year 2000.[22] Had these caps been in effect this year, DRI/McGraw-Hill estimates the average household would have to give up $451 worth of the medical services. A reduction in medical spending on this scale would translate into eight fewer trips to the doctor's office annually per family.

Rationing also threatens access to high-tech treatments. A National Health Board would be vested with the authority to decide when certain treatments are "medically necessary." Bureaucrats in Washington would decide if treatments are worth the expense—without even seeing the patient. Doctors and patients would be forced to endure cook-book

---

[20] Vedder, Richard, and Lowell Gallaway, *Concealed Costs: The Real Impact of the Administration's Health Care Plan on the Economy, A State-by-State Analysis*. (Washington, DC: American Legislative Exchange Council), March 1994.

[21] "The Effects of the Health Security Act on Employee Wages and a Comparison of the Effects of the Health Security Act and the Individual Tax Credit Program on Households and the Individual Tax Credit Program, Estimated Cost and Impact," for the Heritage Foundation, Lewin/VHI, Fairfax, VA, March 9, 1994.

[22] DRI/McGraw-Hill, *The Administration's Health Care Reform Plan: National Macroeconomic Effects*, (Washington, D.C., Citizens for a Sound Economy Foundation) February 1994.

medicine—accepting the procedures allowed by the National Health Board rather than looking for cost-effective treatments and cures that suit each individual case.

In nations that impose spending caps, access to these treatments is often rationed by politicians. The wealthy and the well-connected get care when they need it while middle class families wait in line. In Canada today, nearly 180,000 people are waiting in line for surgery, with 45 percent reporting that they are in pain.[23] For many of these patients, the risk of dying in line is greater than the risk of dying on the operating table. The Clinton health spending cap threatens to force middle class American families onto similar waiting lists.

Layers of bureaucracy would stand between patients and their doctors. The Administration itself estimates that the health reform plan would require 50,000 new bureaucrats to administer it.[24] Dealing with insurers could become as difficult as dealing with the post office or the department of motor vehicles. A series of gatekeepers would decide what insurance coverage a family must buy, what "network" of physicians they would be allowed to see, whether or not they have direct access to specialists and what treatments are allowed when they need care.[25]

Spending limits threaten the development of new treatments, as well. Fewer medical innovations would occur, to improve the quality of life for ill Americans. For example, medical researchers made lifesaving innovations in the 1970s in kidney dialysis, CAT scanning and pacemaker technology. These advances were far more widely available in the United States than in other nations with national health spending limits. The rate of pacemaker implantation in the United States during the mid-1970s was almost 20 times that of Canada, and the treatment of kidney patients was more than 60 percent greater in the United States than in Canada.[26] A government busy trying to restrain spending within strict limits denies its citizens access to lifesaving technologies.

Piling Debt on Us and Our Families

When the Administration released its proposal, it claimed the plan would trim more than $50 billion from the Federal budget deficit. Soon after, the Congressional Budget Office (CBO) exposed this myth, noting that even if the President's spending caps are tightly enforced, the

---

[23]Pipes, Sally, *The Queue Zone*, (San Francisco, CA: Pacific Research Institute), January 1994.

[24]Toner, Robin, "Washington Memo: 'Alliance' to Buy Health Care: Bureaucrat or Public Servant?" *The New York Times*, December 5, 1993, p. A1.

[25]McCaughy, Elizabeth, "No Exit," *New Republic*, February 1994, pp. 21-22.

[26]Walker, Michael, and John Goodman, "What President Clinton Can Learn from Canada About Price Controls and Global Budgets," Policy Backgrounder No. 129, (Dallas, TX: National Center for Policy Analysis), October 5, 1993.

Federal budget deficit would increase by more than $84 billion.[27] KPMG Peat-Marwick calculated that if the spending caps are just 50 percent effective, the deficit would explode by $282 billion over five years.[28]

As the deficit skyrockets, middle class Americans will be faced with new taxes.

Simply put, the Clinton health plan and its congressional counterparts would force middle class Americans to pay more for less care. The Clinton health plan means higher health insurance premiums, fewer jobs, lower quality and reduced availability of care for the middle class.

Real Reform for the Middle Class

The twin problems of excessive cost and restricted access to health insurance can be tackled through a series of prudent changes to the tax code and the creation of government risk pools. The central ingredient in rising costs (higher than overall price inflation) is the third party payment system. In 1960, consumers paid 49 percent out-of-pocket for medical expenses, and by 1993 it was down to 19 percent. CBO predicts direct payment by consumers will fall to 14 percent by the year 2000. The expansion of government programs like Medicare and Medicaid have contributed mightily to the inflation problem, of course, but third-party private insurance produces similar results.

Another major cause of rising prices has been the tax code: most insured people buy their health insurance through their job because they can use pre-tax dollars rather than post-tax dollars, reducing the cost by as much as 50 percent, considering all income and payroll taxes paid by a typical dollar of wages. Locking health insurance into the employment system has produced various problems like "job lock" and pre-existing conditions restrictions.

The Democrat plans all attempt to address these problems by giving the Federal government extraordinary authority to regulate the health care industry and to restrict individual choice. The Democrat plans attempt to solve virtually all of the problems in health care through command and control regulations from Washington: to resolve the pre-existing conditions problem, they would enact a regulation preventing insurance companies from imposing pre-existing conditions restrictions on coverage; to eliminate job-lock, the Democrat plans would mandate that every employer provide health care coverage; to control rising prices, the

---

[27]CBO, *An Analysis of the Administration's Health Proposal*, February 1994.

[28]"An Analysis of H.R. 3600: The Health Security Act of 1993," KPMG Peat Marwick, (Washington, D.C.), March 28, 1994. See also JEC/GOP staff study, *A Billion Dollars a Day: The Financing Shortfall in President Clinton's Health Care Proposal*, prepared at the request of Congressman Jim Saxton (R-NJ), Member, Joint Economic Committee, January 1994.

Democrats would impose a variety of price controls euphemistically called community rating; and to lower the apparent cost of insurance to consumers the Democrats would mandate that employers pay the bulk of the premium and would levy various taxes on insurance premiums. Like King Knut of the 12th Century legend who tried in vain to defy the laws of nature by commanding the waves to stand still, the Administration's approach to health care reform is to command everyone to behave just as the President thinks they should, regardless of the laws of economics. It won't work.

There are sensible reforms that will work to make health care more affordable and more available for middle class Americans without killing jobs and destroying the quality of care. In the Senate, for example, 39 Republicans joined Minority Leader Bob Dole to support the Alternative Health Reform Proposal (AHRP) which puts forth a package of health reforms that would solve many of the problems facing middle class Americans, without imposing new taxes and new bureaucracies, or increasing the deficit.

Universal Affordability

The key to reigning in the rising cost of health care and making it accessible to everyone is to allow every individual the same full tax deduction for health insurance that their employers already enjoy. Combining this tax reform with elimination of state-mandated health insurance benefits, which drive up the price of insurance, and allowing individuals and families to set up Medical Savings Accounts would ensure that market discipline is brought to bear on health industry pricing.

States currently mandate that insurance cover a variety of treatments—including *in vitro* fertilization and hairpieces—that force middle class Americans to pay for coverage they may never want or need. The AHRP eliminates these mandates, so that families can buy only the coverage they want to buy—allowing them to reduce health insurance premiums by as much as 20 percent.[29]

Extending the current tax deduction for employer provided insurance to consumers who purchase insurance outside the workplace will reduce the price of such health insurance to the middle class by almost 40 percent.[30] In addition, allowing Americans to select high-deductible insurance and deposit the premium savings tax-free into a Medical Savings Account (MSA) (the AHRP permits up to $2,000 for an individual and $4,000 for a family) would be a powerful restraint on rising prices. Funds in the MSA would cover all routine medical

---

[29]Blue Cross Blue Shield Association, *Impact of State Basic Benefit Laws on the Uninsured*, Washington, DC, December 1992.

[30]According to JEC/GOP staff calculations. Middle-class consumers currently buying health insurance with after-tax income must earn $5,000 to pay for a $3,000 insurance policy, given a 28 percent Federal income tax rate, a 7.9 percent FICA tax, and an average state income tax of 4 percent. Allowing them to use pre-tax income would thus reduce the required earnings by $2,000, a 40 percent decrease.

services—including check-ups and other services often not covered today by traditional insurance. Money not spent each year on health care would earn interest in a special account, and would belong to the individual or family setting up the MSA. Since 80 percent of American families spend less than $3,000 on medical care in any one year, most families would have substantial funds left over at the end of the year.

According to an actuarial study conducted by Milliman and Robertson for the Council for Affordable Health Insurance, widespread use of Medical Savings Accounts would reduce health spending by almost $588 billion over five years.[31]

Total Portability

The best way to make health insurance portable and guaranteed renewable at standard rates is to make subsidized insurance available through high-risk pools to people who can't purchase conventional coverage for a reasonable price. Middle class families no longer would have to worry about insurance companies canceling their policies or pricing them out of the market when a family member gets sick. And middle class Americans could change jobs without losing their health insurance. According to the National Center for Policy Analysis, solving the problem of pre-existing conditions through risk pools would cost less than 1/10 of 1 percent of our annual health care bill.[32]

CONCLUSION

The kinds of reforms discussed here, and in large part contained in the AHRP, address the real needs of middle class Americans making health care and health insurance more affordable and ensuring that coverage is never taken away due to illness or a change in jobs. As consumers take control over their own medical spending, health care costs will come down—without the need for a new health-care bureaucracy to ration care and police individual behavior.

This study was prepared by JEC/GOP staff economist, Michelle Davis.

[31]Litow, Mark, *The Financial Impact of Medical Savings Account on Health Care Spending and the Federal Budget*, (Alexandria, VA: Council for Affordable Health Insurance), October 1993.

[32]National Center for Policy Analysis, "Risk Pools: A Better Solution for Preexisting Conditions," *Brief Analysis*, No. 112, Dallas, TX, June 30, 1994.

To; Greg Lawler, Laura Quinn, Christine Heenan, SBA
From: Walter Zelman
RE: New data on small businesses and the purchase of insurance

RWJ funded two researchers who recently conducted a poll on health benefits (1993) and small businesses (under 50 employees). Some of this data was published in a journal. Some has not been published.

We should consider how to use this. Testimony before House Small Business? Press?

OVERVIEW

1. 85% of employers of 25-50 employees offer insurance plans
   70% of employers of 10-24 employees offer insurance plans

2. Small employers (1-50 employees) are **evenly divided** on the mandate issue. Employers of 25-49 individuals, **support** a mandate.

   • The numbers of small employers supporting a mandate are increasing.

3. **Small businesses can afford insurance in a reformed market.** The great majority of small employers who don't insure say they would insure if doing so were less costly. Subsidy schemes proposed would bring costs **below** what they say they would be willing to pay.

4. 66% of small employers support overall limits or budgets on health care spending.

5. Most small employers who offer insurance offer only one plan. Their employees have no choice.

NUMBERS OF SMALL EMPLOYERS WHO INSURE EMPLOYEES

1. 51% of small businesses offer some coverage, often comparable to that offered by large firms.

2. 44% of firms with 1-9 employees offer insurance.

3. 70% of firms with 10-25 employees offer insurance

3. 85% of firms with 25-50 employees offer insurance.

Analysis: Most small businesses offer insurance. If a mandate were not imposed on the smallest (as likely to emerge in Congressional bills), a mandate might not be a great additional burden on small business. This would be

especially true if discounts are offered. With such discounts many small employers would save.

SMALL EMPLOYERS AND MANDATES

1. Among small employers who offer insurance:

   - 51% support a mandate
   - 38% oppose
   - 15% neutral or don't know

   (i.e., only 38% oppose --others support or have no opinion)

2. Among all small employers --those who offer and don't offer

   - 42% support a mandate
   - 46% oppose a mandate
   - 13% neutral/don't know

3. Among all employers 25-49 employees

   - 56% support a mandate
   - 36% oppose
   - 8% neutral/don't know

4. Among small employers who do not offer insurance

   - 29% support a mandate
   - 56% oppose
   - 15% neutral/don't know

5. Among employers of 25-49 employees who offer insurance

   - 62% support a mandate
   - 30% oppose
   - 8% neutral/don't know

6. Among employers of 1-4 individuals who do not insure

   - 25% support a mandate
   - 54% oppose
   - 20% neutral/don't know

Analysis:

- It can't be said that small employers support a mandate: but it can hardly be said they oppose it. Those in the 25-49 category clearly support it, and those that insure support it. Even where opposition should be greatest (6) only 54% oppose a mandate.

- Support for mandates among small employers may be growing: NFIB survey in 1989 showed that 24% supported a mandate, 67% opposed.

WHY SMALL BUSINESSES DON'T OFFER COVERAGE AND AT WHAT COST WOULD THEY DO SO

1. Main reason small employers don't buy insurance is cost: I.e, they want to buy it. (90% say that one reason they don't buy it is cost --including volatility of price.

   - While data is not available, it is likely that those very small employers not offering insurance face higher costs due to underwriting, experience rating, administrative costs, etc..

2. 61% listed "profits too uncertain" as a reason for not insuring. (Reform may not address this concern)

3. 52% listed "premium increases too uncertain." (Reform can address this one.

4. 40% of those who don't offer insurance say they would if the cost was $175 a month ($2,102).

5. 75% of those who don't offer insurance say they would buy it if the cost were half that, or $85-90 a month.

Analysis:

- The vast majority of small businesses want to insure their employees: they just cannot afford to.

- Given that the employers least likely to insure are the smallest, lowest wage firms, any reasonable subsidy scheme would get most of them to what **they** say are affordable numbers. (I.e., about $1,000/year). This might be especially true if the employer share drops from 80%.

CLASSIFYING SMALL EMPLOYERS

Researchers classified small employers surveyed according to their views on reform. They concluded that:

- 53% were "reformers": favored a number of reforms
- 17% were "defenders" of the present system:
- 30% were "betwixt;" favored "reform" but not specific reforms.

OTHER RELEVANT DATA

COST CONTROL

- 66% of small employers approve of overall limits or budgets on health care spending

INCREMENTAL REFORM

The study reports that the great problem is cost --not access to insurance sellers or even pre-existing conditions or employee health conditions.

They conclude that **incremental reform won't help that much --because it won't reduce costs that much.** The things it will do won't help that much.

Researcher also argues that voluntary efforts by states to increase purchase of insurance by small employers are not having much success. (information coming).

CHOICE

- A solid majority of small firms offering insurance offer only one plan, usually a traditional plan.
- I.e., small employees are not getting access to lower cost plans --or at least plans that entail lower out-of-pocket costs.
- Small employers are buying the most expensive form of insurance. They may be paying more than they need to.

Researcher: Gail Jensen, Wayne State University

Name	Work #	Home #	DOB
Abernethy, David (W&M)	202-225-7787/0111 fax		
Addison, LaVarne (Budget)	202-226-7100/7165 fax		
Adelstein, Jonathan (Aging)	202-224-6857		
Alberghini, Theresa (Leahy)	202-224-2414/3595 fax		
Allen, Barbara			
Altman, David (Rockefeller)	202-224-6472		
Altman, Roger	202-622-0404 fax		
Anderson, John (Wash Post)	202-334-7281		
Apfel, Ken	202-690-6396		
Arons, Bernie	301-443-0001		
Atkins, Larry	202-775-9818		
Atkinson, Leslie (Stokes)	202-225-7032/1339 fax		
Barnett, Pam	202-456-2369		
Barr, Steve (Wash Post)	202-334-7442		
Barstow, Scott (Kopetski)	202-225-5711		
Bennett, Arnold	202-628-3030		
Berenson, Bob			
Berry, Marion	202-720-7095/66586		
Berry, Paul (Global USA)	202-296-2400		
Berry, Roger (Johnston)	202-225-3001		
Benavides, Ellen	612-348-4338		
Bettigole, Kyle			
Bierbauer, Charles (CNN)	202-898-7542		
Bierwirth, Maggie (Gejdensen)	202-225-2076		
Billy, Carrie (Bingaman)	202-224-5521/2852 fax		
Bingaman, Ann	202-514-2410		
Bloom, Felicia (Slaughter)	202-225-3615		
Blount, John (AssocPrivPensPl)	202-289-6700		
Blumberg, Linda	202-395-3844/539-2367 bp		
Bode, Holly (Levin)	202-224-		
Bocchino, Carmella	202-778-3275/773-0569 bp		
Boehm, Jennifer (Long)	202-225-4436		
Bonmartini, Gioia (Roth)	202-224-4491/9603 fax		
Boorstin, Bob	202-456-7151		
Borzi, Phyllis (Ed&Labor)	202-225-5768/3614 fax		
Bowles, Erskine (SBA Admin)	202-205-6690		
Brassier, Ann	304-876-3611		
Bridenbaugh, Tom	202-872-1155		
Brock-Smith, Cynthia (OPM)	202-606-1300/1344 Fax		
Brodbeck, Laura (McCurdy)	202-225-6165		
Broder, David (Wash Post)	202-334-7444		
Brostrom, Molly (Wofford)	202-224-4474		
Bruderle, Tom (ASHP)	301-657-3000x301		
Bruns, Kevin (PO&CivServ)	202-225-2265		
Buckingham, Warren (Buck) (AIDS)	202-632-1090		
Buonora, David (Kennelly)	202-225-2265		
Burke, Sheila (Dole)(Marilyn)	202-224-5311/2105/3163 f		
Burnett, Laird (Breaux)	202-224-4623/4268 fax		
Candelaria, Alma (DOL Cong Aff)	202-219-		
Cassel, Gene	202- - /682-6287 fax		
Cavanaugh, Sean (Cardin)	202-225-4106		
Certner, Cathy (WBGH)	202-408-9320		
Chaffee, Mary Ann (Bumpers)	202-224-4843		
Chambers, Caroline (Cooper)	202-225-6831/4520		
Chang, Debbie (Riegle)	202-224-3612/8834 fax		
Chen, Ed (LA Times)	202-861-9253		
Chi, Judy (Hosp Pharm Report)	201-358-7258		
Chism, Sharon			
Clark, Bill (Bumpers)	202-224-6433		
Claxton, Gary	202-690-5751/668-8728 bp		
Claxton, Isabelle	202-638-4170		
Clemente, Frank (Govt Ops)	202-225-5051		
Cohen, Cathy (Kodak GR)	202-857-3461		
Cohen, Rima (Daschle)	202-224-2131/2321/2047 f		
Cooper, Barbara	202-690-5500/8168 fax		
Corr, Bill	202-690-7694		
Coster, John (Aging)	202-224-5364/1262/9926 f		
Crossfire	202-898-7655		
Crow, Shelly			
Crump, Janice (Clayton)	202-225-3101		
Daschle, Tom (Senator)			

P6/b(6)

Davies, Monica (Bingaman)	202-224-4266
Davidson, Nestor	202-456-7848
Davis, Lori	202-690-5621/7450/8425 f
Deignan, Kathy (Budget)	202-224-9284
DeLeon, Pat (Inouye)	202-224-3934
Delew, Nancy	202-690-7804
Democratic Caucus	202-226-3210
Democratic National Committee	202-863-8000
Denham, Lori (Dooley)	202-225-3341
Denton, Denise	303-692-2479/782-5576 fa
Doneski, Ellen (Rockefeller)	202-224-9837
Drummond, Faye (Finance)	202-224-4515/8-5568 fax
Eckert, Kevin (Wofford)	202-224-4474
Edelstein, Steve	
Edgell, John (Commerce)	202-482-4067/2741 fax
Einhorn, Ted (Deutsh)	202-225-7931
Eisen, Scott (Commerce)	202-482-2708/2-4420
Eisenbrey, Ross (Labor)	202-219-6141/5120 Fax
Elliot, Warren	202-861-1375
Ellwood, David	202-690-7858
Epstein, Arnie	202-456-2696
Evans, Jennifer (Campbell)	202-224-5852
Faletti, Tom (Durbin)	202-225-5271
Falk, Scott (BNA)	202-728-5241
Fariello, Dr.	703-415-0505
Feder, Judy	202-690-7858/7383 fax
Feighan, Ed	216-447-9000
Ferguson, Christy (Chafee)	202-224-6117/2853 fax
Finan, Steve (Labor)	202-219-6001
Finigan, Thomas (Baucus)	202-224-2651
Firshein, Janet (Med & Health)	202-822-1256
Fiske, Mary Beth (Kennedy)	202-224-7675
Flanders, Don (Adelphi)	516-877-3224
Flemming, Arthur	202-624-9552
Foote, Susan (Durenberger)	202-224-4055/9931 fax
Foreman, Ira (OPM Cong Affairs)	202-606-1300/1344 Fax
Forster, Theresa (Aging)	202-224-5364/6018/9926 f
Forsgren, Janet (OMB)	202-395-3925/6148 fax
Frantz, Molly (Pomeroy)	202-225-2611
Fried, Bruce	202-662-3744
Furman, Jim (United Seniors)	202-393-6222
Furst, Kurt (Searle)	202-842-0706
Gale, Joe (Moynihan)	202-224-4515
Gampel, Gwen	202-544-6264
Garamendi, John (CA Ins Comm)	916-955-2353 ?
Caudette, Sylvia (Olver)	202-225-5335
Gaus, Clif	202-401-7736
Gebbie, Kristine	202-632-1090/1096 fax
Gehan, Margery (Mike Andrews)	202-225-7508
Glaze, Steve (Pryor)	202-224-7827
Gobel, Herschel	202-535-8623
Golub, Al	202-682-6270
Gottlieb, Jim (Vets)	202-224-6202
Goldberg, Jason (Cab. Affairs)	202-456-2572/6704
Goldstein, Elaina	
Goldstein, Naomi	202-690-7858
Goldstein, Steve (Phil Inquirer)	202-383-6048
Goldwater, David (Bilbray)	202-225-5965
Goobokar, Ellen (AFSCME)	202-429-1185
Gordon, Greg (Minn Star-Trib)	202-457-5171
Greenberg, George	202-690-7794/6418 fax
Greenstein, Bob	202-408-1080
Grever, Kim	
Gross, Lauren (Pell)	202-224-4673
Grote, Sara	202-456-2922/7560/2317 f
Grunwald, Mandy	202-973-9400
Gurrola, John	202-632-1090/1096 fax
Gust, Steve (Wellstone)	202-224-5641
Gustafson, Tom	202-690-5960/8168 fax
Hancox, Karen	202-456-6620
Harahan, Mary	202-690-6613
Harbage, Peter	
Harkin, Tom (Senator)	202-224-7301
Harrell, Don (Teachers Ins)	212-916-6244
Hart, John	202-456-2896
Hash, Mike (Waxman)	202-225-4954
Hasson, Judy (USA Today)	703-276-6430
Hatton, Mindy (Metzenbaum)	202-224-5701
Havel, Roberta (SOS, Exec Dir)	202-624-9557

Hayes, Mark (Kittman): [illegible]

P6/b(6)

Hayes, Charlotte (VP)	202-456-6277/6231
Heenan, Christine	202-456-2929/2857
Healy, Monica (Labor)	202-219-6141/512
Heldman, Paul (BBN)	202-393-0751
Hennemuth, Kathy (Rowland)	202-225-6531/7719 fax
Hermelin, Bill	202-429-7533
Hickman, Peter	202-690-5950/8168 fax
Hill, Diane (Williams)	202-225-3211/6-0244 fax
Hilly, John (Mitchell)	202-224-
Hoffman, Alan	202-690-6786
Hogue, Bonnie (Aging)	202-224-5364
Honig, Judy	703-902-5225
Hopper, Julie	202-456-7561/7560/2317 f
Horvath, Jane (Finance)	202-224-4515/8-5568 fax
Hosto, Lester	501-324-9200
Howard, Ed (Alliance for HR)	202-466-5626
Huckaby, Michelle (Clement)	202-225-4311
Human, Jeff	301-443-0835
Hunter, Nan (HHS Dep Gen Couns)	202-690-7780
Hutchins, Glenn	202-456-
Ickes, Harold	202-456-2459
Inglee, Bill (Wedensday Group)	202-226-3236
Iskowitz, Michael (Labor&HR)	202-224-6572
Jennings, Chris	
Jennings, Lucile	
Jennings, Tom	703-836-7442
Jodrey, Darrel (Wofford)	202-224-7760
Johnson, Don	202-690-
Johnson, Haynes	202-298-6099 fax
Jones, Marcia (Breaux)	202-224-9741
Jorling, Jim	202-408-7131
Joseph-Fox, Yvette (Inouye)	202-224-2251
Kane, Brad (Energy&Commerce)	202-226-3160
Kattan, Azar (Matsui)	202-225-7163
Kazdin, Robert	202-906-5759/7495 fax
Keene, Judy (USA Today)	703-276-3608
Kehoe, Dani (NALU)	202-331-6029
Kendall, Dave (Mike Andrews)	202-225-7508/4210 fax
Kepner, Colleen (Stenholm)	202-225-6605/2234 fax
Klepner, Jerry (HHS)	202-690-7627/7380 fax
Kerrey, Bob (Senator)	202-224-6551
King, Andie (Gephardt)	202-225-0100/7296/7414 f
King, Kathy (Finance)	202-224-4515
Klepner, Jerry	202-690-7627
Konnor, Del (AMCPA)	703-920-8480
Kosterlitz, Julie (Natl Journal)	202-857-1415
Kronick, Rick	202-456-2709
Lambert, David (NACDS)	703-549-3001
Lavizzo-Mourey, Risa	301-227-6662
Lawler, Greg	202-456-6252/225-6060
Lefkowitz, Bonnie	301-443-7526/6155 fax
Legislative Counsel	202-225-6060
Levario, Andrea (HHS)	202-690-7450/8425 fax
Levine, Debbie	202-462-4092
Levine, Greg (DeLauro)	202-225-3661
Levitt, Larry	202-456-2711/668-0886 bp
Lew, Jack	202-456-2316
Lewin, Larry	703-218-5619
Lewis, John (Richardson)	202-225-6190
Liebold, Pete (Danforth)	202-224-1406/0952 fax
Lifse, Diane (Glenn)	202-224-7985
Linkous, John (Issue Dynamics)	202-408-1400
Lipner, Robyn (Mikulski)	202-224-3239/8858 fax
Lipsen, Linda (Consumers Union)	202-482-6262/265-9548 fa
Lively, Rob	202-463-7372
Lopez, Ed (Finance)	202-224-4515/8-5568 fax
Lovell, Ellen (Leahy)	202-224-4242
Lowrey, Bonnie (Foley)	202-225-8550/3738 fax
Littlefield, Nick (Kennedy)	202-224-5465/6367
Lukomnik, Joanne	212-662-2463
Lusskin, Liz (NYS Office)	202-638-1311
Lux, Mike	202-456-2930/2976
Magaziner, Ira	202-456-6406
Maguire, Dan	202-219-4592
Maher, Wally (Chrysler)	202-862-5431
Mande, Jerry	202-690-7780 205-4102
Manowitz, Michele	206-448-2913
Maples, Monica (DCCC Pol Dir)	202-485-3432
Margherio, Lynn	202-456-2315

P6/b(6)

Markus, Kent (DNC)	202-863-8138
Martinez, Ray	202-690-6625
Mays, Janice (W&M)	202-225-3628/2610 fax
McBride, Anne (Common Cause)	202-736-5749
McFee, Tom	202-690-7284
Means, Kathy	202-690-5974
Michie, Jim	301-656-5278
Miller, Carol	
Miller, Meredith	202-219-8233
Min, Nancy Ann	202-395-5178
Mindy (Boren)	202-224-0152
Mittleman, Portia	202-401-4545
Moe, Kari (Wellstone)	202-224-8447/5641
Monahan, John	202-690-6060
Montgomery, Bob	614-297-5889
Montgomery, Jan	202-512-5484
Moore, Walter (Genentech)	202-296-7272/7290 fax
Mossinghoff, Gerald (Pat)	202-835-3420
Murguia, Janet (Slattery)	202-225-6601/1445 fax
Muse, Don (Radiopharm Ind)	202-737-0100
Nader, Ralph	202-387-8030
Navarro, Vicente	410-955-3280
Nelson, Karen	202-225-0130/7090 fax
Nelson, Trish	202-898-4746
Neuberger, Neal (CtrPubServComm)	703-528-0801/0802 fax
Neuman, Tricia (W&M)	202-225-7785
Nexon, David (Kennedy)	202-224-7675/3533/5400
Nichols, Len	202-395-3844/996-2395 bp
Nix, Sheila (Kerrey)	202-224-0295
Norrell, Judy	202-429-6543/833-2055 fa
Obey, Craig (Conrad)	202-224-2519/7776 fax
O'Brian, Rindy (DPC)	202-224-3232/228-3432 fa
O'Donnell, Laurence (Finance)	202-224-7800/8-5568 fax
Offner, Paul (Finance)	202-224-4515/9293 fax
O'Meara, Janis (Mercer)	202-331-5269/223-5985 f
O'Neill, Kim (WH)	395-4730
Ortmans, Jonathan (ColumbiaInst)	202-547-2470/1893 fax
Parker, Kim (HHS)	202-690-6786
Parmalee, Ken (Rural Let Car)	703-684-5545
Patzman, Andrew (Kassebaum)	202-224-6770/8072 dir
Payne, Mary Ella (Rockefeller)	202-224-7993/6472/f7665
Payton, Sallyanne	
Peck, Jonathan (Inst Alt Fut)	703-684-5880
Pellici, Bob (OMB)	202-395-4871/6148 Fax
Picillo, Theresa	
Pigeon, Steve	202-457-5300
Pitts, Bill	202-225-1234
Podoff, David	202-225-2335/3338
Pollitz, Karen	202-690-7450/8425fax Private fax 6351
Pomeroy, Earl (Congressman)	202-225-2611
Portman, Rob	202-219-6045
Potetz, Lisa (W&M)	202-225-7785/0111 fax
Powden, Mark (Jeffords)	202-224-5141
Priest, Dana (Wash Post)	202-334-6566
Proctor, Kurt (NACDS)	703-549-3001
Prowitt, Nancy	703-841-0626
Puskin, Dena	301-443-0835/2803 fax
Quam, Lois	612-936-3630/0044 fax
Raymond, Victor	202-523-1802/1818 fax
Rector, John (NARD)	703-683-8200/703-347-204
Redlener, Irwin	212-535-9707
Reed, Mike (PMA)	202-835-3480
Regan, Carol (CDF)	202-628-8787
Reinecke, Peter (Harkin)	202-224-7303/8-2923 fax
Reinhardt, Uwe	609-258-4781/4830
Reuter, Jamie (W&M)	202-225-7785/0111 fax
Ricchetti, Jeff (BC/BS)	202-626-4806
Ricchetti, Steve	202-456-7054/2604 fax
Richardson, Sally	410-966-3870 Rm 200 E
Richardson, Mary Ann (Labor)	202-219-6141/512
Rios, Elena	916-654-2827
Rissler, Pat (Ed & Labor)	202-225-4527/9070 fax
Rivlin, Alice	202- -4742
Robbins, Liz	202-544-6093
Robertson, Linda (Treasury)	202-622-1920/0534 fax
Rockefeller, John (Senator)	202-224-6472
Rodriguez, Louise	202-535-7302/7237 fax
Rosen, Bob (Mitchell)	202-224-5344/3840/2151

P6/b(6)

Rother, John (AARP)	202-434-3704
Rovin, Lisa	202-690-5512/8168 fax
Rudolph, B.A.	202-659-8320
Rueschemeyer, Simone	202-456-6406
Sagawa, Shirley	
Samuelson, Ellen (Budget)	202-225-4755
Scheppach, Ray (NGA)	202-624-5320/5313 fax
Schroeder, Chris	202-514-2069
Schroeder, Steve (RWJ Fdn)	609-243-5903
Schulke, David (Wyden)	202-225-1058/8941 fax
Schultz, Bill (Waxman)	202-226-7625/5-7092 fax
Shaffer, Ellen (Wellstone)	202-224-8446/8438 fax
Donna Shalala - Scheduling	202-690-6610 Virginia
Shearer, Gail (Consumers Union)	202-482-6262/265-9548 fax
Shriber, Donald (En&Comm)	202-225-3147/2525 fax
Silimeo, Debra (DPC)	202-224-3232/228-3432 f
Silva, John	703-696-2221/2202 fax
Simon, Marsha	202-224-4740/3533 fax
Sklar, Brad	212-536-3320
Smith, Barbara (McDermott)	202-225-3106/9212 fax
Smith, Jennifer	202-690-7850
Solis, Patti	202-456-2468/7560
Solomon, Loel	202-224-6064
Spencer, Susan (Greenwood)	202-225-4276/9511 fax
Stafford, Michael (GRQ)	301-718-0202/2976 fax
Stanton, Tamera (Rockefeller)	202-224-9842
Starr, Paul	609-258-4533
Stevens, Janice	202-690-6033
Stone, Robyn	301-656-7401x256/4-0629f
Stout, Hilary (WSJ)	202-862-9233
Stram, Kenneth (SBA Leg Affairs)	202-205-67007374 fax
Sunderhauf, Steve	
Swedin, Kris (SBA Leg Affairs)	202-205-6700/7374 fax
Sykes, Kathy (Obey)	202-225-3365
Taylor, Bridget	202-690-6273/7450/8425fax
Terry, Donald (LaFalce)	202-225-3231
Testoni, Maureen (Baucus)	202-224-9317/8-3687 fax
Thomas, Tandi (Hastert)	202-225-2976/0697 fax
Thompson, Jake (KS City Star)	202-393-2020
Thorpe, Ken (Joyce Marshall)	202-690-6870/490-0323 bp 401-7321 fax
Thurm, Kevin	202-690-6133
Thursz, Daniel (Nat Coun on Aging)	202-479-6601/1200/0735 f
Tilley, Kim	202-456-2131/7845
Tilson, Hugh	202-690-6250/401-7321 fax
Toohey, Megan	202-690-7858/7383 fax
Torda, Phyllis (Families USA)	202-628-3030
Turk, Barbara (NYC OMB)	212-788-5894
Tyson, Laura (Alice Wms, Sched)	202- -5042
Uhlman, Marian	215-854-2473
Unger, Mike (NY Newsday)	212-251-6600
Vagley, Karen	202-225-4527/9070 fax
Valdez, Bob	310-206-9094/393-0411x743
Varma, Vivek (Synar)	202-225-2701/2796 fax
Varnhagen, Michele (Metzenbaum)	202-224-5546/5474 fax
Velasquez, Joe	202-456-6257
Veloz, Richard	202-456-2302/401-5193
Verveer, Melanne	202-456-6266
Vladeck, Bruce (Rena)	202-690-6726/6262 fax
Volpe, Carl (NGA)	202-624-7729
Wagner, Lynn (Modern Healthcare)	202-662-7215
Waldo, Dan	410-966-7949
Walker, Bill	614-594-8228
Wartzman, Rick (WSJ)	202-862-9284
Waspe, Rob (NACDS)	703-549-3001
Weinstein, Naomi	718-519-2722
Weiss, Gail (PO&CivServ)	202-225-4054
Weiss, Marina	202-622-0090/2633 fax
Werner, Michael	202-393-1650
Westmoreland, Tim (Waxman)	202-225-4952/3043 fax
Whang, Judy	202-690-6797/490-0771 bp
White House Social Office	202-456-7136
Wilkins, Amy (DNC HC)	202-863-7184
Williams, Chris (Mitchell)	202-224-5344/1946 fax
Women's Information Network	202-467-5992
Woo, Michael (En&Comm)	202-225-3147/4014/2525 f
Wood, Susan (Cong Women Caucus)	202-225-6740
Yager, Marilyn	202-456-2930/6683
Yale, Ken	202-638-3535x242

P6/b(6)

Yamamoto, Cora	202-224-7470
Zelman, Walter	202-456-2449
Zettler, Susan (Strickland)	202-225-5705
Ziegler, Ron (NACDS)	703-549-3001
Zubkoff, Jordana (NACDS)	703-549-3001
Zuckerman, Diana (Vets)	202-224-9126

P6/b(6)

The same arguments were made in 1974 when Hawaii passed its comprehensive reform bill. There was the belief that it was unncessary because there would soon be national, comprehensive reform and that Hawaii's bold initiative would frustrate national efforts. Instead, Hawaii and other states have become models for reform.

In addition, the federal government's administrative agencies are not prepared or capable of accepting the mammoth new responsibilities inherent in any unitary, and yet diverse, health care system. The Health Care Financing Administration's dismal performance in monitoring Medicare fraud (a $15-20 billion annual hemorrhage by some estimates) is a harbinger of what a unitary system could inflict upon the nation -- a train wreck with all Americans aboard.

I would further add that Congress has not been successful in recent years in confronting major, complex public problems. The savings and loan debacle, the 1986 Tax Act and catastrophic health care are all examples of how Congress has a greater interest in getting a bill passed than in truly solving problems. We may be at the point in this debate where certain compromise positions will sacrifice effectiveness and reform for a Rose Garden ceremony.

Earlier this week, I listened to one plan being proposed on the Senate floor. The Senator argued for the plan, in part, because it was the result of a series of compromises on contentious components of reform. As I listened to the compromise being discribed as a virtue, I analogized this to two aviation engineers who cannot decide on the wing-span of their plane. One says the wing-span should be 100 feet. The other says the wing-span should be 150 feet. So they compromise -- with disastrous results. They build a plane with one 50 foot wing and one 75 foot wing. Both enginners are happy, but the plane crashes. Unlike the engineers, Congress must come up with a design that works, and not one that compromises principles and threatens the health of all the passengers.

The unitary, centralized path to reform will likely result in ineffective amalgamations and compromises or a highly partisan and closely divided final enactment. The nation would be ill served by either result. A narrowly-based, partisan health care program passed this year would sow the seeds for continued destructive sniping and controversy in the years ahead, and lead to an accelerated erosion of public confidence in the federal government.

We cannot repeat the legislative failures of the eighties. The savings and loan debacle cost us $150-300 billion and was a significant factor in the most serious recession since the 1930's. A health care debacle could put millions of Americans at risk, damage the world's highest quality health care delivery system and establish another unfunded entitlement which would contribute to record deficits by the end of this decade.

<u>Why Federalism?: It Works</u>

There is a second path -- a federal-state partnership toward reform.

This Jeffersonian model is one that has been utilized time-and-time again. The Interstate Banking Bill, just passed by the

DATE:
TIME:

Executive Office of the President
Office of Management and Budget
Health Policy

725 17th Street, NW, Room 7021
Washington, DC 20503

FAX: (202) 395-3910 Voice: (202) 395-3844

To:	Chris Jennings
FAX #:	6-7431
Voice #:	6-5560

From: Linda Blumberg

Notes:
Chris, I received this today by fax. Please call these people and tell them that it is inappropriate to send me work to do for them. It seems they are confused about who it is that I work for.

Number of Pages (including cover sheet): 5

EDWARD M. KENNEDY, MASSACHUSETTS, CHAIRMAN

CLAIBORNE PELL, RHODE ISLAND
HOWARD M. METZENBAUM, OHIO
CHRISTOPHER J. DODD, CONNECTICUT
PAUL SIMON, ILLINOIS
TOM HARKIN, IOWA
BARBARA A. MIKULSKI, MARYLAND
JEFF BINGAMAN, NEW MEXICO
PAUL D. WELLSTONE, MINNESOTA
HARRIS WOFFORD, PENNSYLVANIA

NANCY LANDON KASSEBAUM, KANSAS
JAMES M. JEFFORDS, VERMONT
DAN COATS, INDIANA
JUDD GREGG, NEW HAMPSHIRE
STROM THURMOND, SOUTH CAROLINA
ORRIN G. HATCH, UTAH
DAVE DURENBERGER, MINNESOTA

NICK LITTLEFIELD, STAFF DIRECTOR AND CHIEF COUNSEL
SUSAN K. HATTAN, MINORITY STAFF DIRECTOR

United States Senate

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

TO: LINDA B.

FAX: 395-3910

FROM: ANTHONY TASSI / DAVID NEXON

DATE AND TIME: ______

NUMBER OF PAGES: COVER + 3

RETURN FAX NUMBER: (202) 224-3533

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

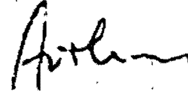
LINDA:

Could you please verify (ie, correct) the following page of payment calculations for the Mitchell Bill.

Bobby sent us a copy of the proposal and when we tried to plug the numbers into a spread sheet using Clinton-like premiums, we came out with very high figures.

Could you please verify the calculations/premium assumptions -- we are supposed to get back to Bobby this afternoon.

As always, much obliged



JUL-29-1994 10:55 FROM TO 93953910 P.03

AFFORDABILITY OF INSURANCE
DUAL PARENT ($5,565)

INCOME $	% POVERTY	WORKING FAMILIES	% OF INCOME	NONWORKERS EMPLOYER	FAMILY	TOTAL	% OF INCOME
7391	50	256	3.5%	274	256	530	7.2%
11086	75	403	3.6%	433	403	836	7.5%
14781	100	551	3.7%	591	551	1142	7.7%
18476	125	994	5.4%	917	994	1912	10.3%
22172	150	1438	6.5%	1244	1438	2681	12.1%
25867	175	1881	7.3%	1570	1881	3451	13.3%
29562	200	2325	7.9%	1896	2325	4221	14.3%
33257	225	2661	8.0%	1896	2661	4557	13.7%
36953	250	2788	7.5%	1896	2788	4684	12.7%
40648	275	2788	6.9%	1896	2788	4684	11.5%
44343	300	2788	6.3%	1896	2788	4684	10.6%

n.b. assumes clinton premiums; for employer share a proportional "per-worker" premium is used -- which may understate the actual cost of repaying the family credit (due to the carve out)

$1896

ID: JUL 29'94 14:24 No.011 P.04

JUL-29-1994 10:56 FROM TO 93953910 P.04

AFFORDABILITY OF INSURANCE: THE MITCHELL BILL
MARGINAL RATES
WORKERS: 4% ($1,000–100%); 12%(100–200%); 8% (>200%)

NONWORKERS/PT: MR1 (4% POVERTY/POVERTY–$1,000) ON (POVERTY–$1000) +
MR2 (REF ADJ REP – 4% POVERTY/POVERTY) ON 100 TO 200%

Reference Adjusted Repayment Amount

ID: JUL 29'94 14:24 No.011 P.05

To Chris Jennings

From Arnie Epstein

Date 7/29/94

Re Comments on potential Mitchell bill vs. Quality Management

Per our discussion I am attaching a copy of the bill language we have received from Oliver Fein. He requested that we get back to him on "what is wrong with the bill." We have a tentative meeting set up for today at 11 AM. I expect that Clif Gaus of OASH and AHCPR, Steve Jencks of HCFA and possibly Lynn will attend.

I am also attaching a copy of comments that we plan to review with Fein (we don't expect to exchange paper). The large majority of them are technical, minor, or identify areas where the language and intent are unclear. The most controversial issue concerns the PROs; I have listed that one and others that should be on the screen below:

1. The PROs The Mitchell bill does not include any mention of the PROs. We think it worthwhile to raise the question of whether this was on purpose and if so suggest that they might consider phasing out the PROs during a transition period after which the PRO functions are assumed by the Quality Improvement Foundations (QIFs). Do you feel comfortable with us doing this? As you remember the HSA eliminated the PROs with enactment. The idea of transition is a response to congressional concern that beneficiaries need protection currently provided by the PROs even though the current system has a number of evident problems.

2. Auditing data There is no clear provision for auditing the measures of quality performance, although there is a reference to having QIFs audit the profiling data. The former is important to ensure validity and reassure patients and providers about accuracy. I suspect this was an error of omission.

3. Funding There are no obvious sources or funding for the consumer survey, the calculation of performance measures by the states and certification of plans by the states.

4. Data Protection and Availability There is: no provision for data to transfer between QIFs for joint projects or between PROs and QIFs; no protection against disclosure for institutions that provide data; and no course of access to data for researchers.

Comments on Mitchell language

Section 5001 National Quality Council

General questions:
- How is Council authority exercised? What is its accountability?
- Will there be a Board? If so, can Council report to Board?
- All quality provisions should apply to all health plans, public and private, fee for service, managed care and self insured plans.
- How are PROs being addressed? Have you thought about how they would be coordinated, etc.

(a) line 7: insert "national program"

re: (c): There is considerable difficulty with the Council performing operational functions such as establishing programs. There is only $4 million for the operation of this council. Therefore, suggest the Council "oversee" functions:

(c) Duties

(3) oversee the design and implementation of a program of national surveys (of plans and) consumers
(4) oversee the design and production of Consumer Report Cards
(5) oversee Quality Improvement Foundations
(6) oversee State based Consumer Information and Advocacy Centers

Section 5002 National Goals and Performance Measures

pg 4
line 25: "shall incorporate goals identified by the Secretary..."

pg 5
line 12: (h)(4): insert: Prevention of disease, disorders, disability, injuries and other health conditions
add (h)(6): Consumer satisfaction

- suggest provision for audit function for measures

Section 5003 Standards and Performance Measures

pg. 5, line 18: Do these standards link to certification? Do states have to certify on quality or not?
line 19: Does the Council establish national standards which may be used to assess access or must be used for health plans?

pg. 6 suggest deleting lines 3-25.

Insert to line 3: Quality measures under this section shall relate at a minimum to:

(1) Access to health care services
(2) Appropriateness of health care services
(3) Consumer satisfaction
(4) Outcomes of care
(5) Disease prevention and health promotion

Quality Standards under this section shall relate at a minimum to:

(1) Health plan compliance with member rights
(2) Quality Improvement and accountability, including demonstrating the plan can monitor and improve the quality of care provided.
(3) Provider credentialing and competency
(4) Management of clinical and administrative and financial information

delete (7)

pg. 7

line 7: (b) which Board? Is this the Benefits Board or The Board?
Does this provision enable the Council to determine *feasibility* of using standards and performance measures for certification? Or does Section 5003 mandate already that standards shall be established?

Section 5004 Plan Data Analysis and Consumer Surveys

-- note: Surveys are unfunded.

pg.7
line 13: do we need to survey plans? If not, delete "and plans"

pg. 8
lines 9-12: re: "plan-level": are consumer surveys from plan data? What does this mean?

Section 5005 Evaluation and Reporting of Q. Performance

--This is unfunded.
--how do States get this information?
--what is the difference among the four reports?
a) health plan reports- state compiled, 50 separate reports, detailed and technical for analysis

--what is the difference among the four reports?

a) health plan reports- state compiled, 50 separate reports, detailed and technical for analysis

b) consumer report cards- above summarized like Consumer Reports
line 23: who summarizes?

c) quality reports- Council compiled, one detailed national report?

d) state reports- does this require the Council to assist States in compiling (a) or (b) or both?
– if (d) is an effort to provide for technical assistance for reports in (a), Council should provide oversight of TA program

line 22: what types of data are infered by (3)?

Section 5006 Practice Guidelines

Making the protocols available to the public may make it less bureaucratic. Suggest inserting a disclosure provision and deleting the requirement to develop standards.

May need to insert new sections:

(C) Nothing in these provisions shall preclude other agencies of the Public Health Service from carrying out their guideline activities established under the Public Service Act and the Food, Drug, and Cosmetic Act.

(D) In carrying out the provisions of this section, the Administrator will coordinate with other agencies, as appropriate, of the Public Health Service.

Section 5008 Quality Improvement Foundations

pg 13
line 9: delete "advisory"
line 16: confusing. (ii) somewhat akward grammatically

pg 14
line 25: (B) what do you mean by "and auditing samples of such data to assure its validity"? What does this entail?

pg 15
line 12: insert innovative staffing "patterns" of health professionals

pg 16
line 6: insert "are potentially subject to substantial harm"
delete: "are subject to potential harm"

Confidentiality issue: apply 1160 rules of Soc.Security Act rules to protecting QIO data

(non disclosure) but add language on page 9:

5008 (e):The restrictions on discosure of information applicable to peer review organizations under section 1160 of the Social Security Act shall also apply to the Quality Improvement Organizations except that:

1. QIOs shall make data available to qualified organizations and individuals for research for public benefit.

2. individuals and qualified organizations shall meet standards consistent with PHS statutes and policies regarding the conduct of scientific research including provisions related to confidentiality, privacy, peer review, protection of humans and shall pay reasonable

3. QIOs and PROs may exchange information with QIOs (Section 1160)

line 23: delete "health policy expertise" and insert "health advocacy expertise"

Section 5009 Consumer Information and Advocacy Centers

pg 17
(3) make it clear these are not State offices. Rename State-situated organizations as "Consumer Information and Advocacy Centers" (CIACs--pronounced Kayaks)

line 12: insert "and insurance agents"

pg 19
line 16: delete E

pg 20
(d) Concerned this may be too broad. Substitute "necessary"

Section 5010 Appropriations

--is there money for State ACE programs?

Section 5011: Role of Health Plans

pg 23
line 4: (B) insert "where practical"

pg 24
line 3: fix type-o. should read "provider"

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

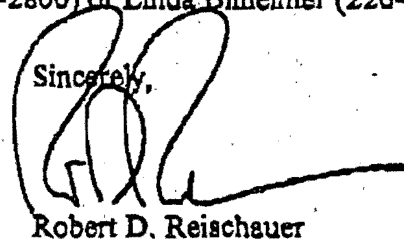
July 28, 1994

Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office and the Joint Committee on Taxation have prepared the enclosed preliminary analysis of the Health Security Act, as ordered reported by the Committee on Finance on July 2. If you have any questions about this analysis or would like further information, please call me, or have your staff contact Paul Van de Water (226-2800) or Linda Bilheimer (226-2673).

Sincerely,



Robert D. Reischauer

Enclosure

cc: Honorable Bob Packwood
Ranking Minority Member

A PRELIMINARY ANALYSIS OF THE HEALTH SECURITY ACT AS REPORTED BY THE SENATE COMMITTEE ON FINANCE

July 28, 1994

The Congress of the United States
Congressional Budget Office

INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared this preliminary analysis of the Health Security Act, as ordered reported by the Senate Committee on Finance on July 2, 1994. The analysis is based on the description of the Chairman's mark of June 28, the errata sheet of June 29, the amendments adopted during the Committee's markup, and information provided by the Committee's staff. Although CBO and JCT have worked closely with the staff of the Committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore be regarded as preliminary.

The first part of the analysis is a review of the financial impact of the proposal. The financial analysis includes estimates of the proposal's effects on the federal budget, the budgets of state and local governments, health insurance coverage, and national health expenditures. The analysis also includes a description of the major assumptions that CBO has made affecting the estimate.

The second part of the analysis comprises a brief assessment of considerations arising from the proposal's design that could affect its implementation. The issues examined in this discussion are similar to those considered in Chapters 4 and 5 of CBO's analyses of the Administration's health proposal and the Managed Competition Act.

FINANCIAL IMPACT OF THE PROPOSAL

The Health Security Act, as ordered reported by the Senate Committee on Finance, aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. In the Congressional Budget Office's estimation, the proposal would add about 20 million people to the insurance rolls, and the number of uninsured would drop to 8 percent of the population. Initially, the proposal would add to national health expenditures, but by 2004 national health expenditures would be slightly below the baseline. Over the period from 1995 to 2004, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce state and local government spending as well.

The estimated effects of the proposal are displayed in the four tables at the end of this document. Table 1 shows the effect on federal outlays, revenues, and the deficit. Table 2 shows the effects on the budgets of state and local governments. Tables 3 and 4 provide projections of health insurance coverage and national health expenditures, respectively.

Like the estimates of other proposals for comprehensive reform--such as the single-payer plan, the Administration's proposal, the Managed Competition Act, and the bill reported by the Committee on Ways and Means--CBO's estimates of

the effects of this proposal are unavoidably uncertain. Nonetheless, the estimates provide useful comparative information on the relative costs and savings of the different proposals. In estimating the Finance Committee's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

The Finance Committee's proposal would establish a standard package of health insurance benefits, whose actuarial value would be based on that of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit of privately insured people today and 8 percent less costly than the benefit package in the Administration's proposal.

The proposal adopts the four basic types of health insurance units included in the Administration's proposal--single adult, married couple, one-parent family, and two-parent family. In general, workers in firms with fewer than 100 employees (and their dependents) and people in families with no connection to the labor force would purchase health insurance in a community-rated market. Firms employing 100 or more workers would be experience-rated. The estimated average premiums in 1994 for the standard benefit package for the four types of policies are as follows:

	Community-Rated Pool	Experience-Rated Pool
Single Adult	$2,330	$2,065
Married Couple	$4,660	$4,130
One-Parent Family	$4,544	$4,027
Two-Parent Family	$6,175	$5,472

In addition, separate policies would be available for children eligible for subsidies, as explained below. Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

1. For descriptions of CBO's estimating methodology, see Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994), and *An Analysis of the Managed Competition Act* (April 1994).

Subsidies

The proposal would establish a system of premium subsidies for low-income people to encourage the purchase of health insurance. Families with income below 100 percent of the poverty level would be eligible for full subsidies, and those with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. The partial subsidies would be phased in between 1997 and 2000 by gradually increasing the income eligibility level. In addition, children and pregnant women with income up to 240 percent of the poverty level would be eligible for special subsidies.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty threshold for that family's size, except that the threshold would be the same for families with four or more members. The estimate assumes that this limitation would apply for computing both regular subsidies and the special subsidies for children and pregnant women.

The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for community-rated health plans in the area. The estimate assumes that a family's subsidy could not exceed the amount it paid for coverage in a qualified health plan. Therefore, if an employer paid a portion of the premium, the subsidy could at most equal the family's portion of the premium. The estimate also assumes that, except in 1997, the same formula would be used in each year to compute the amount of the subsidy, but that during the phase-in period no subsidies would be available to people above the applicable eligibility level.

Families would not be eligible, the estimate assumes, for both regular premium subsidies and special subsidies for children and pregnant women, but they could choose to receive the larger one. Families could use the special subsidies to help purchase coverage for the entire family, or they could purchase coverage only for the eligible children and pregnant women.

Families, children, and pregnant women with income below the poverty threshold would also be eligible for reduced cost sharing, as determined by the National Health Benefits Board. The estimate assumes that the board would require nominal cost-sharing payments. Health insurance plans would be required to absorb the cost of this reduced cost sharing. In addition, states would have the option of providing subsidies for cost sharing for people with income between 100 percent and 200 percent of the poverty level. The federal government would pay up to $2 billion a year to assist the states in providing these optional cost-sharing subsidies, and states would have to pay the rest of the cost.

The system of subsidies would be administered by the states. States would have the option of providing subsidies to eligible people beginning in 1996 and would be required to provide subsidies starting in 1997. Because of the difficulties involved in setting up the necessary administrative apparatus, the estimate assumes that states would not begin paying subsidies until 1997.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income would be integrated into the general program of health care reform and would be eligible for federal subsidies in the same way as other low-income people. Medicaid would continue to provide these beneficiaries with a wraparound benefit covering certain health care services not included in the standard benefit package. States would be relieved of their portion of Medicaid costs for these beneficiaries but would be required to make maintenance-of-effort payments to the federal government. The estimate assumes that these maintenance-of-effort payments would equal the appropriate portion of the states' Medicaid spending in 1994, increased in subsequent years by the rate of growth of national health expenditures plus an adjustment factor. The adjustment factor would equal 1 percentage point through 1997 and would be gradually reduced to zero by 2002.

The proposal would gradually phase out federal Medicaid payments to disproportionate share hospitals (DSHs). The estimate assumes that DSH payments would be limited to 10 percent of medical assistance payments in 1997, 8 percent in 1998, 6 percent in 1999, and 4 percent in 2000. In 2001, DSH payments would be repealed and would be replaced by a program to make payments to vulnerable hospitals. That program would have an annual appropriation of $2.5 billion.

Among the proposed changes in Medicare is a revision in the method of reimbursing Medicare risk contractors. The estimate assumes that this provision is intended to even out reimbursement rates without adding to total costs.

Revenues

The Committee's amendment that added the special subsidies for children and pregnant women also provided that the cost of these subsides would be covered by proportional increases in all of the revenue-raising measures in the proposal, as needed to keep the proposal from adding to the deficit. The estimate includes additional revenues of $13.6 billion over the 1996-2001 period as a result of this provision.

Fail-Safe Mechanism

In the present estimates, the fail-safe mechanism would not be called into play. If necessary, however, the proposal would scale back eligibility for premium and cost-sharing assistance, reduce the new tax deductions, and increase the out-of-pocket limits in the standard benefit package to prevent the proposal from adding to the deficit over a period of years. The deficit would be allowed to increase in any one year, however, but by no more than the amount of any cumulative savings from previous years.

Unforeseen circumstances--such as a major recession, an acceleration in the growth of health care costs, or a more rapid increase in the number of Medicare or Medicaid beneficiaries--could create a shortfall in funding and trigger the fail-safe mechanism. Although the proposal would give the Administration some flexibility in offsetting any unfinanced health spending, the bulk of any savings would have to come from limiting eligibility for subsidies. As a result, application of the fail-safe mechanism could make previously eligible people ineligible for subsidies and would reduce the extent of health insurance coverage.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, the plan reported by the Senate Committee on Finance would require many changes in the current system of health insurance. For the proposed system to function effectively, new data would have to be collected, new procedures and adjustment mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done but also that they could be accomplished in the time frame laid out in the proposal.

In CBO's judgment, however, there exists a significant chance that the substantial changes required by this proposal--and by other systemic reform proposals--could not be achieved as assumed. The following discussion summarizes the major areas of possible difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

The proposal, like most others, assumes that an effective system could be designed and implemented to adjust health plans' premiums for the actuarial risk of their enrollees. In fact, the feasibility of developing and successfully implementing such a mechanism in the foreseeable future is highly uncertain. Inadequate risk-

adjustment techniques would have adverse consequences for both the community-rated and the experience-rated health insurance markets.

The primary purpose of the risk-adjustment system in the community-rated market would be to redistribute premium payments among health plans, compensating them for differences in risk. Without effective risk adjustment, the profitability of health plans in those markets would be partly determined by the plans' skill in attracting relatively healthy people. Since high-cost plans would be subject to a premium tax under this proposal, an effective risk adjustment would also be important to ensure that health plans were not taxed because their enrollees presented a higher risk.

While there would be no risk-adjustment payments in the experience-rated market, each plan that was not self-insured would have to have a risk-adjustment factor in order to determine whether it was liable for the tax on high-cost plans. Developing such factors would be extraordinarily difficult because the agency responsible for doing that would have to collect and analyze significant amounts of information from the many health plans, some of which would be very small, that made up the experience-rated market.

States' Responsibilities

Virtually all proposals to restructure the health care system incorporate major additional administrative, monitoring, and oversight functions that some new or existing agencies or organizations would have to undertake. A key question with any proposal is whether the designated organizations would have the appropriate capabilities and resources to perform their roles. In the Senate Finance Committee's proposal, states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether--and, if so, how soon--some states would be ready to assume them.

The states' primary responsibilities under the proposal would fall into four broad areas:

- determining eligibility for the new subsidies and the continuing Medicaid program;
- administering the subsidy and Medicaid programs;
- establishing the infrastructure for the effective functioning of health care markets; and
- regulating and monitoring the health insurance industry.

Determining Eligibility for Subsidies and Medicaid. The task of establishing and monitoring eligibility for subsidies would be an enormous one for states, even without the complications resulting from the dual structure that would subsidize premiums using two sets of rules (discussed in more detail below). According to CBO's estimates, in the year 2000, about 30 million families and single individuals would be receiving subsidies for health insurance premiums at any time. The actual number of applications would be much greater than that because of changes in employment, family status, or geographic location during the year. In addition, because Medicaid would be required to provide wraparound benefits, states would have to continue to operate their Medicaid eligibility systems using income criteria for families with more than four members that were different from the criteria used by the premium subsidy program.

States would also bear the responsibility for the required end-of-year reconciliation process in which the income of a subsidized family was checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a major undertaking since, although federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Moreover, the process would require extensive interstate cooperation in order to track people who moved from one state to another during the year.

Administering the Subsidy and Medicaid Programs. The states would have other major administrative responsibilities for the subsidy and Medicaid programs. In particular, they would make subsidy payments to health plans and engage in outreach efforts to encourage enrollment of the low-income population. Health plans would be required to have an open-enrollment period of 90 days during the first year and only 30 days in all subsequent years. Establishing effective outreach programs would therefore be essential to ensure that low-income people enrolled in health plans during the open-enrollment window.

The optional programs in which states could participate would also have major administrative components. States electing to subsidize cost sharing for people with income between 100 percent and 200 percent of the poverty level would be responsible for administering those subsidies. Similarly, states would have to administer the complex system of subsidies incorporated in the proposal if they chose to expand home- and community-based services for the disabled. States could also choose to enroll beneficiaries of the Supplemental Security Income program in health plans, in which case they would have to negotiate separate premiums.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would be required to designate the geographic boundaries for the community-rating areas as well as the service areas for implementing the provisions regarding essential community providers. The liability for the tax on

high-cost community-rated and experience-rated plans would be calculated separately for each community-rating area. In addition, states would have to sponsor or establish purchasing cooperatives to serve those community-rating areas in which none were established voluntarily.

States would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include establishing the system for adjusting premiums for risk, operating reinsurance pools until the risk-adjustment system was operating effectively, and redistributing losses resulting from the requirement that plans absorb the cost-sharing expenses for people with income below the poverty threshold.

Providing consumers with the necessary information to make informed choices among health plans would be another function of the states. States would be required to produce annual, standardized information comparing the performance of health plans in each community-rating area; they would also distribute that information, educate and provide outreach to consumers, and respond to complaints from consumers. To do all that effectively would require that states establish extensive systems for reporting and analyzing data and qualitative information. They would also be responsible for ensuring that health plans met federal standards for data reporting.

Regulating and Monitoring the Health Insurance Industry. The responsibilities for certifying insured health plans, self-insured plans that operated in one state only, and insurance plans for long-term care would all fall on the states. So too would the task of enforcing the new health insurance standards. Consequently, the duties of state insurance departments would grow considerably. Not only would they be responsible for many more health plans than they oversee today, but the activities they would have to monitor would be much more extensive. States would be encouraged to use private accreditation organizations to assist them with these tasks.

States would, moreover, be required to act in the event that health plans did not meet federal standards. For example, they might have to operate failed or noncompliant health plans for a transitional period to ensure continued access for the plans' enrollees, develop corrective programs, or design other options.

States would have to develop and implement programs to recover payment from automobile insurers for medical services resulting from automobile accidents. These programs would be required to have electronic data bases and include mechanisms for resolving liability issues or disputes rapidly.

At present, state insurance departments vary widely in their capabilities. It seems doubtful, therefore, that all of them would be ready for such an expanded role by 1997.

The Dual System of Subsidies

The proposal includes two subsidy schedules--one for low-income families and the other for low-income children and pregnant women. The two subsidy schemes would have to be integrated because children and pregnant women are a part of families; but integrating them in a sensible and administrable fashion would be extremely difficult. As now structured, the dual system of subsidies would create a confusing array of options from which low-income families would have to choose, would greatly complicate state administration of the already burdensome processes for determining eligibility and reconciling subsidies at year-end, and could result in real or perceived inequities in the treatment of low-income families.

In making its estimates, CBO assumed that no family could participate in both subsidy schemes at the same time but that families could choose whichever scheme gave them the larger subsidy. Permitting families to participate in both programs concurrently--for example, by obtaining special subsidies for the children individually as well as regular subsidies for single or dual policies for the parents --could cause the estimated cost of the subsidies to be somewhat higher than that shown in Table 1.

Insurance Costs for Moderate-Sized Firms

As is the case under other proposals that limit participation in the community-rated market to small firms and nonworkers, some moderate-sized firms--those with 100 to 300 or 400 employees--might face relatively high costs for coverage under the Senate Finance Committee's proposal. Just as they do under the current system, such firms would have to either self-insure or offer coverage through the experience-rated market. Moreover, they would be required to provide their employees with a choice of three plans, including a fee-for-service plan. Thus, the enrollment in some of those plans could be extremely small, especially since some employees in families with two workers could obtain their coverage elsewhere.

Small enrollments would, in turn, result in high administrative costs. Furthermore, because the firm's premiums would be experience-rated, a single employee with a costly medical problem could raise the firm's premiums significantly. Some plans could end up with ever-increasing premiums and

shrinking enrollment as people who could obtain cheaper coverage through their spouse's employer left the plan, raising its premiums further. At a minimum, employees would no longer have a realistic choice of three plans, and in extreme cases, all three plans might be quite expensive. In principle, individuals with income below the poverty level enrolled in such plans would be fully subsidized, but in fact they might have to contribute to the costs of their coverage if the premiums for all three plans were above the average for the community-rated market, which determines the maximum possible subsidy.

Tax on High-Cost Health Plans

The proposed tax on high-cost health plans would be difficult to implement. It would, moreover, result in different effective tax rates on excess premiums of the health plans offered by different insurers or sponsors. These differences might be viewed as arbitrary because they would vary significantly within and among community-rating areas.

The tax would be imposed at a 25 percent rate on the amount by which high-cost premiums exceeded a target premium set for each community-rating area. Various adjustments would be made to premiums to determine which plans would be classified as having high costs. Those adjustments would be difficult to make. Moreover, some of the necessary adjustments--such as those for differences in risk and the cost of living among geographic areas--would require data and methodologies that do not now exist.

The effective tax rate on excess premiums would generally be much higher than the statutory rate of 25 percent for two reasons. First, unlike most other excise taxes, this one would not be a deductible expense for health plans and self-insured employers; in effect, the tax would be paid from after-tax, rather than before-tax, profits. Second, if insurers that expected to be subject to the tax increased their premiums to reflect the additional tax liability, both their excise tax and income tax liabilities would also rise. As a result, the effective tax rate on excess health insurance premiums would not be 25 percent but 62.5 percent for most plans offered by taxable insurers and 33 percent for nontaxable (nonprofit) insurers. Self-insured employers who reduced other compensation to offset their higher expenses for health benefits would face an effective tax rate of 38.5 percent if they were taxable corporations and 25 percent if they were nontaxable sponsors of a health plan.

Although the tax would provide incentives for insurers to offer lower-cost plans, how insurers would actually respond is unclear. Because the calculation of the tax would be based on the combined cost of standard and supplemental policies, insurers might, for example, try to discourage enrollees from purchasing

supplements by raising those premiums considerably. Alternatively, they might not offer supplemental policies at all. A more fundamental problem for insurers is that they would not know the target premium--and, hence, their potential tax liability--at the time they established their premiums because those targets would be announced 90 days after the end of each open-enrollment period. That uncertainty would tend to increase the margins between insurance premiums and expected payouts as insurers attempted to protect themselves from the possibility that their plan would be considered a high-cost plan and thus subject to the tax.

The tax might be considered inequitable for a variety of reasons. In some community-rating areas, a small number of health plans--perhaps two or three--might dominate the market. Using the criterion that high-cost plans covered 40 percent of the primary insured population in an area could necessitate highly arbitrary decisions in the face of such indivisibilities. (For example, the highest-priced plan might cover 20 percent of the primary insured population while the top two plans covered 60 percent.) In the experience-rated market--if accurate risk-adjustment factors cannot be developed--small plans with little ability to control their premiums might well be the ones subject to the tax. Finally, plans in some areas of the country with low payments to providers and parsimonious practice patterns might be subject to the tax even though they were far less costly (even after the required adjustments) than nontaxed plans in other areas. This result could occur in spite of the fact that plans with adjusted premiums in the lowest quartile nationwide would not be subject to the tax.

Reallocation of Workers Among Firms

The proposal would encourage a reallocation of workers among firms and, in doing so, would increase its budgetary cost. This sorting would occur because the subsidies could be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that paid for health insurance would receive a smaller subsidy than a worker at a firm that did not pay. Some low-income workers could gain thousands of dollars in higher wages by moving to firms that did not contribute to employee health insurance, and a significant number of them would probably do so. That process would occur gradually as employment expanded in some firms and contracted in others. In the CBO estimate, this reallocation of low-wage workers among firms accounts for $12.6 billion of the cost of the subsidies in 2004.

In addition, some companies might stop paying for insurance, but the effect of that action on the government's costs would probably not be large, for several reasons. For one thing, the number of firms that would be likely to stop paying is limited because, if firms did so, high-wage workers in those firms would lose the tax benefits of excluding health insurance from the payroll tax. Moreover, the

net additional subsidy cost to the government from low-income workers in firms that dropped coverage would be largely offset by higher tax revenues from the workers because, without employer-paid coverage, wages would be higher.

Last, reducing subsidies by up to the amount that employers pay for insurance would mean that people with similar incomes and family circumstances would not be treated alike. In particular, workers at firms that paid for insurance would face larger costs for their insurance than similarly placed counterparts at firms that did not pay.

Work Disincentives

Like other reform plans with substantial subsidies, the Senate Finance Committee's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all, because subsidies would be phased out as family income increased. For example, the subsidies for low-income families would be phased out as family income rose between 100 percent and 200 percent of the poverty threshold, and those for low-income children and pregnant women would be phased out between 185 percent and 240 percent of poverty. In both cases, many workers who earned more money within the phaseout range would have to pay more for their own or their children's health insurance, thereby cutting into the increase in their take-home wage. In essence, phasing out the subsidies would implicitly tax their income from work.

Estimating the precise magnitude of the implicit tax rates requires information that is not readily available, but rough calculations suggest that the rates could be substantial. In 2000, for example, the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies and 20 to 40 percentage points for workers in families choosing the subsidies for pregnant women and low-income children. Moreover, those levies would be piled on top of the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, the phaseout of the earned income tax credit, and the loss of eligibility for food stamps. In the end, some low-wage workers would keep as little as 10 cents of every additional dollar they earned.

If the employer did not pay for insurance, the implicit marginal rates from the phaseout of low-income subsidies would apply to workers whose income was within the broad range of 100 percent to 200 percent of the poverty level. But if the employer paid some of the costs for insurance, these marginal levies would apply to workers in a much smaller income range. Although this treatment of employer payments would reduce the size of the working population affected by higher marginal levies, it would create the previously described incentive for workers to move to firms that did not pay for insurance.

R=90%

TABLE 1. - PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	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	-16.8	-24.0	-26.2	-28.4	-30.8	-33.4	-36.2	-39.2
3 Disproportionate Share Hospital Payments	0	0	-4.1	-7.0	-9.5	-11.6	-18.8	-20.7	-22.9	-25.2
4 Long Term Care Program/Change Fed Match	2.5	2.8	3.1	3.5	3.9	4.4	4.9	5.5	6.1	6.9
5 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	2.5	2.8	-42.7	-64.7	-73.3	-82.0	-96.6	-106.3	-116.9	-128.1
Medicare										
6 Part A Reductions										
PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reduction	0	-0.7	-0.8	-0.8	-0.9	-1.0	-1.2	-1.3	-1.4	-1.6
Disproportionate Share Hospital Reductions	0	0	0	-0.9	-1.2	-1.3	-1.4	-1.5	-1.7	-1.9
PPS-Excluded Payment Changes	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0.0	0.0	0.0	0.0
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
7 Essential Access Community Hospitals										
MAF 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
8 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
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.6	-0.9	-1.0	-1.0
Elim Formula Driven Overpayments	-0.5	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-6.5	-7.1	-9.1
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
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
Nurse Pract/Phys Assistant Direct Payment	0	0	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.6
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.8	-0.6	-2.8	-5.2	-8.2	-10.6
9 Parts A and B Reductions										
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Expend Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Risk Contracts	a	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total - Medicare	-1.3	-2.9	-4.5	-8.6	-14.5	-21.0	-26.3	-32.8	-40.0	-47.4

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Health Programs										
10 Vulnerable Hospital Payments	0	0	0	0	0	0	2.5	2.5	2.5	2.5
11 Home and Community Based Care Program	0	0	0.3	0.7	1.0	1.4	1.6	1.7	1.9	2.0
12 Academic Health Centers Trust Fund	0	4.7	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
13 Grad Medical & Nursing Education Trust Fund	0	2.7	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
14 Medicare Transfer - Graduate Medical Education	0	-1.6	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
15 Medicare Transfer - Indirect Medical Education	0	-4.2	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
Total - Other Health Programs	0	1.6	4.6	7.2	9.1	10.8	14.3	15.2	16.3	17.2
Designated Urban/ Rural Health Care Access										
16 Investment in Infrastructure Development (Loans	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Total - Urban/Rural Access	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Subsidies										
Premium Subsidies:										
17 Persons between 0-200% of Poverty	0	0	52.4	86.2	97.6	109.3	121.0	133.6	147.3	161.2
18 Pregnant Women and Kids 0-240% of Poverty				---------- Included in Line 17 ----------						
Cost-Sharing Subsidies:										
19 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	53.7	88.2	99.6	111.3	123.0	135.6	149.3	163.2
Administrative Expenses										
20 Mandatory Administrative Expenses c/	0	0	2.4	4.0	4.3	4.7	4.8	4.9	4.9	5.0
MANDATORY OUTLAY CHANGES	**1.4**	**1.8**	**13.9**	**26.5**	**25.5**	**24.2**	**19.6**	**17.2**	**14.0**	**10.4**
DISCRETIONARY OUTLAYS										
Administrative Expenses										
21 Administrative and Start-Up Costs	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
Studies, Research, & Demonstrations										
22 Network and Plan Development Grant Program	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.3
23 Operating Asst - Telemedicine Demonstrations	0.1	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
24 Capital Investment - Grants	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
25 Biomedical & Behavioral Research Trust Fund	0	0.7	1.2	1.4	1.5	1.6	1.7	1.9	2.1	2.2
26 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	0.4	1.6	2.3	2.5	2.5	2.6	2.7	3.0	3.2	3.4
DISCRETIONARY OUTLAY CHANGES	0.9	2.6	3.3	3.5	3.5	3.6	3.7	4.0	4.2	4.5
TOTAL OUTLAY CHANGES	2.3	4.4	17.1	30.0	29.0	27.7	23.3	21.2	18.2	14.8
RECEIPTS										
27 Increase in Tax on Tobacco Products	13.9	16.3	15.4	15.0	14.3	13.9	13.5	11.3	11.1	10.9
28 1.75% Excise Tax on Pvt Health Ins Premiums	0	3.5	6.2	7.2	7.8	8.5	9.2	10.0	10.9	11.8
29 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
30 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
31 Include Certain Svc-Rel Income in SECA and Excl Certain Invn-Rel 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
32 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
33 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rule	0	a	a	a	a	a	a	a	a	a
34 Repeal Flexible Spending Arrangements	0	0.3	0.5	0.7	1.1	1.3	1.4	1.4	1.4	1.5
35 Extend 25% Ded for Health Ins Costs of Self-Employed Individuals	-0.5	-0.3	0	0	0	0	0	0	0	0
36 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
37 Deduct for Individuals Purchasing Own Health In	0	-1.4	-5.5	-8.1	-8.4	-8.7	-9.1	-9.8	-10.4	-11.0
38 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Sv	---------- Negligible Revenue Effect ----------									
39 Trmt of Certain Ins Co with Regard to Sect 833	---------- Negligible Revenue Effect ----------									
40 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
41 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
42 Clarify Tax Trmt of Long Term care Ins & Svcs	0	a	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4
43 Tax Trmt 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
44 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
45 Post-Retirement Med & Life Ins Reserves	----------Negligible Revenue Effect----------									
46 Modify COBRA Continuation Care Rules	----------Negligible Revenue Effect----------									
47 Tax Credit for Practitioners In Underserved Area	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
48 Increase Expensing Limit for Certain Med Equip	a	a	a	a	b	a	a	a	a	a
49 Tax Credit for Cost of Personal Asst Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
50 Disclosure of Return Info to State Agencies	----------No Revenue Effect----------									
51 Exempt Doctors from Section 457 Limits	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
52 Impose Prem Tax with Respect to Certain High Cost Plans	0	a	0.9	1.4	1.6	1.7	1.9	1.8	1.9	2.0
53 Indirect Tax Effects of Changes in Tax Trmt of Employer & Household Health Ins Spending	0	a	1.2	1.4	1.4	1.4	1.4	1.6	1.6	1.5
TOTAL RECEIPT CHANGES	13.3	19.8	21.3	19.8	20.3	21.1	21.8	20.3	21.3	22.6
DEFICIT										
MANDATORY CHANGES	-11.9	-18.0	-7.4	6.7	5.2	3.1	-2.2	-3.1	-7.3	-12.2
TOTAL CHANGES	-11.0	-15.4	-4.2	10.2	8.7	6.6	1.5	0.9	-3.1	-7.7
CUMULATIVE DEFICIT EFFECT	-11.0	-26.4	-30.6	-20.3	-11.6	-5.0	-3.4	-2.6	-5.6	-13.3

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.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

c. States would have substantial administrative responsibilities under this plan.

TABLE 2. PRELIMINARY ESTIMATES OF THE STATE AND LOCAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-18.4	-27.5	-30.7	-34.3	-38.4	-42.7	-47.3	-52.3
2 State Maintenance-of-Effort Payments	0	0	16.8	24.0	26.2	28.4	30.8	33.4	36.2	39.2
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	0.5	0.9	1.2	1.4	-0.2	0.0	0.3	0.6
4 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	0	0	-1.3	-3.0	-3.7	-5.0	-8.3	-9.9	-11.4	-13.2
Cost-Sharing Subsidies:										
5 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Administrative Expenses										
6 Expenses Associated with Subsidies	0	0	0.8	1.2	1.3	1.5	1.5	1.5	1.5	1.6
7 General Admin and Start Up Costs	0	1.4	2.2	2.4	2.4	2.5	2.7	2.8	3.0	3.2
8 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	1.7	3.0	3.7	3.9	4.1	4.3	4.5	4.7	4.9
Total State and Local Budgetary Impact	**0**	**1.7**	**3.0**	**2.7**	**2.1**	**1.1**	**-2.0**	**-3.4**	**-4.7**	**-6.2**

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

Table 3. Health Insurance Coverage
(By calendar year, in millions of people)

	1997	1998	1999	2000	2001	2002	2003	2004
			Baseline					
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	16	16	16
	Health Security Act as Reported by the Committee on Finance							
Insured	241	244	246	249	251	253	255	257
Uninsured	23	22	22	21	21	21	21	21
Total	264	266	268	270	272	274	276	278
Increase in Insured	16	18	19	20	20	21	22	23
Uninsured as Percentage of Total	9	8	8	8	8	8	8	8

SOURCE: Congressional Budget Office.

Table 4. Projections of National Health Expenditures
(By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Health Security Act as Reported by the Committee on Finance	1,297	1,403	1,515	1,635	1,761	1,903	2,056	2,218
Change from Baseline	34	32	27	21	13	9	3	−2

SOURCE: Congressional Budget Office.

- Low Income 100% phases out to 200%
- uninsured kids @ 185% phasing out 240.
- welfare to work.
- unemployed / uninsured -
- employer subsidies at mandate - work +

Questions

- How many people?
- How much costs?
- Employer [illegible]
- Premiums [illegible] [illegible] [illegible] costs [illegible] + [illegible]

Risks premiums going up.

-
-
-
- What do I get
-
-

Unemployed
&
children

INSURANCE REFORM IN THE MITCHELL BILL

Community-rated vs Experience-rated pools

- Individuals in firms with 500 or fewer workers much purchase at community rate, which will be adjusted for age and geography only.
- Individuals in large (500 or more) firms purchase policies at experience rate.
- If they offer any policies, employers must offer at least three plans and can contribute toward employees' policies at any rate.
- 4 different types of family classifications.

Benefit Packages

- Standard benefit package with approximately 16 levels of services
- High Deductible package with Medical Savings Accounts
- Individuals can purchase supplemental insurance

Annual open enrollment period designated by States

Guaranteed Issue with 6 month pre-existing condition exclusion

Portability regulations similar to those in HSA (?)

Self Employed (?)

FEHBP

- In addition to buying policies through their employer, every individual will be able to purchase a policy through the Federal plan.
- Individual brings in employer contributions, if any.
- Regional adjustments of rates as in the pools purchased through employer.
- Federal employees will continue to get policies as they do today.

Alliances/HPCC's

- States must establish voluntary alliances (purpose? do they have negotiating power?)

Risk Adjustment

- Individuals in both community-rated and experience rated pools contribute for poorer, sicker populations through an assessment. (?)

FAX

Health Division

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

TO: NANCY-ANN / JUDY F. / KEN T / PAM SHORT / CHRIS J.

FROM: LEN

Fax Destination
Organization:
Phone Number:

Number of Attached Pages: 1

Notes: FED #
NEWLY INSURED PERSONS

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

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

PRELIMINARY

7/29

4:55 p.m.

ID:

IMPLICATIONS FOR MIDDLE CLASS WORKING FAMILIES

Insurance reforms provide protections:

- **If a family member gets sick:** Premiums will not rise, coverage cannot be cancelled, and annual or lifetime limits cannot be imposed. Those whose premiums are high today because of a health condition will see their premiums fall.

- **If a co-worker gets sick:** Premiums will not rise and coverage cannot be cancelled.

- **If a family member wants to change jobs or start a business:** There can be no pre-existing exclusions or denial of coverage.

- **If a family member becomes unemployed:** An unemployed person can obtain coverage with no exclusions or limits at the same premium paid by employers with as many as 500 employees.

- **If your health plan becomes insolvent:** The family is not liable for unpaid claims to providers, and can obtain new coverage with no exclusions or waiting periods.

Some will see premiums rise as a result:

- In general, families who are now healthy and work for an employer with a healthy work force will see their premiums rise somewhat.

- According to the Lewin/VHI study for the Catholic Health Association, incremental insurance reform will increase average premiums by about $4 per month per person. Most of this increase is paid by employers, and some is paid directly by families.

- purchasing coop
- choice
- market

IMPLICATIONS FOR MIDDLE CLASS WORKING FAMILIES

Subsidies make insurance more affordable for the middle class as well as the poor:

- **People who lose their jobs:** A family that becomes unemployed is eligible for subsidies, with income disregards that recognize the drop in means. For example, for an unemployed family of four, about $900 per month in wages is disregarded in determining eligibility for subsidies for a family of four.

- **Pregnant women and children:** Insurance is provided at no cost to pregnant women and children with income under 185% of poverty (about $27,000 a year for a family of four). Partial subsidies are provided up to 240% of poverty (about $35,000 a year for a family of four).

- **Employers who expand coverage:** Subsidies are available to employers who expand coverage to the working uninsured, many of whom are middle class.

Sources of funds used to pay for subsidies will cost many middle class families more:

- **Cafeteria plans:** Families will no longer be able to pay health care expenses with before tax dollars through cafeteria plans.

- **High cost plan assessment:** Health plans that are unable to control premium increases will be assessed, and plans may pass a portion of the assessment on to businesses and families by increasing premiums.

- **Medicaid savings and increased coverage:** Community rating the Medicaid population generates federal and state savings, but increases private premiums by a about one percent (after savings from reducing cost shifting are taken into account). Insuring non–workers in community–rated health plans increases private premiums by about x%.

TABLE 1. PRELIMINARY 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)

	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	-22.6	-25.2
4 Offset to Medicare Prescription Drug Program	0	0	0	-0.7	-1.6	-1.8	-2.0	-2.2	-2.5	-2.6
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	-71.5	-76.9	-87.5	-102.8	-113.2	-124	-137.1
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.0	-1.9	-3.0	-3.5	-3.8	-4.2	-4.6
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
Graduate Medical Education (Cash Lag)	0	-0.1	-0.1	-0.2	-0.3	-0.3	-0.4	-0.5	-0.6	-0.7
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	-0.6	-1.0	-1.3	-1.6	-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	0.0	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	0.2	0.3	0.3	0.4	0.5	0.6
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	0.4	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

07/28/94 21:03 SENT BY:Xerox Telecopier 7021 ; 7-28-94 ; 8:49PM ;

TABLE 1. PRELIMINARY 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)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Public Health Initiative										
29 Biomedical and Behavioral Research Trust Fund										
30 Health Services Research	a	0.2	0.3	0.5	0.6	0.6	0.4	0.2	0.1	0
31 PHS Core Functions	0.1	0.2	0.3	0.4	0.5	0.6	0.3	0.7	0	0
32 Health Promotion/Disease Prevention	0	0.1	0.1	0.1	0.1	0.1	0.6	0.2	0	0
33 Development of Community Health Groups	0.1	0.2	0.4	0.5	0.4	0.3	0.1	0.0	0	0
34 Investment in Infrastructure Development (Loans)	0.1	0.1	0.1	0.1	0.1	0.1	0	0	0	0
35 Supplemental Services Grants	a	0.1	0.2	0.2	0.3	0.3	0.1	0.3	0	0
36 Enabling Grants	0	a	0.2	0.4	0.4	0.4	0.2	0.1	0	0
37 National Health Service Corps	0	0.1	0.1	0.2	0.2	0.3	0.1	a	0	0
38 Mental Health/Substance Abuse Grants	a	0.1	0.1	0.1	0.1	0.1	0.1	a	0	0
39 School Health Grants	a	0.1	0.2	0.4	0.5	0.6	0.4	0.1	0	0
40 Occupational Safety/Health Grants	0.1	0.2	0.2	0.2	0.2	0.2	a	0	0	0
41 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	4.4	3.6	2.3	2.4
MANDATORY OUTLAY CHANGES	-2.1	0.3	21.5	39.4	47.3	48.7	42.5	41.5	39.2	38.7
DISCRETIONARY OUTLAYS										
Administrative Expenses										
41 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
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	1.0	1.1	1.1	1.1	1.2
Studies, Research, & Demonstrations										
42 Department of Labor Programs	a	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
43 EACH/MAF/Rural Transition Demonstrations	a	0.0	0.0	0.0	a	a	a	a	a	a
Total Studies, Research & Demonstrations	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
DISCRETIONARY OUTLAY CHANGES	0.5	1.1	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.4
TOTAL OUTLAY CHANGES	-1.6	1.4	22.7	40.6	48.5	49.9	43.8	42.8	40.5	40.1

002/004

07/28/94 21:03 SENT BY:Xerox Telecopier 7021 ; 003/004

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION I
(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

	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 Add'l 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	1.8	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. PRELIMINARY 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)

	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	-3.9	14.2	30.9	37.0	38.0	31.7	30.3	27.3	25.7
TOTAL CHANGES	-2.1	-2.8	15.4	32.1	38.2	39.2	33.0	31.6	28.6	27.1

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.

Group meeting

- Drugs – [illegible] – [illegible] pricing
- NGA – Ray [illegible]

624-5320 – Mitchell

- Bradley – [illegible]

* Call Carol Moseley-Braun re: prescription drugs. HRC promised you'd call her.