Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Harold Ickes re: Equal Access - Ways and Means Issue (1 page)	6/3/94	P5

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

FOLDER TITLE:
Analysis [3]

gf62

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]

MEMO

DRAFT

TO: Pat

FR: Steve
Chris
Jack
Janet

DT: June 6, 1994
RE: Health Care Reform and Secondary Committees

It will be especially important over the next few weeks to stay in close touch with the relevant agencies regarding health care reform issues to be considered by the secondary committees in the House and Senate.

The health care interagency weekly meetings will take on the mission of focusing on key "hot button" issues expected to be addressed by the secondary committees in July. Representatives from the relevant agencies will be put on notice that their participation and input will be critical. They will be notified that if they are not present during these discussions they risk losing their opportunity to weigh in on these issues.

The key "hot button" issues to be discussed in the these meetings include:
*Antitrust reforms
*Tort/Medical Malpractice reforms
*Veterans health care reforms
*WIC/Appropriations funding reforms
*Federal workers and the FEHB program

Representatives from the agencies will be reminded that they should be in touch with relevant committees throughout this month assisting with any background information and data that commmittees may request. However, any requests for data or information must be discussed at the weekly interagency meeting before it is released.

The relevant agencies and departments involved in the health care interagency process include:
*Veterans Affairs
*Department of Defense
*Office of Personnel Management
*Health and Human Services
*Department of Justice
*Department of Labor
*Department of Interior

The relevant House and Senate secondary committees include:

*Veterans Committee
*Post Office and Civil Service Committee
*Armed Services Committee
*Interior/Natural Resources Committee
*Judiciary Committee
*Government Operations Committee
*Appropriations Committee
*Select Committee on Indian Affairs
*Small Business Committee
*Rules Committee

All estimates are preliminary and unofficial

The estimates attached are for the specific provisions we have reviewed. They should be interpreted as the rough ballparks that they are. Since we have not seen the full proposal nor complete language of the Chairman's mark, we cannot do fully interactive estimation.

The general outlines of the proposal as we understand it, and assumptions we have used, are:

- Benefit package priced, ceteris paribus, 10% lower than CBO's estimate of the HSA premium. This price reduction is to be achieved in unspecified ways. All other things are not equal to the HSA in this plan, of course.
- Firms with ≤ 20 employees are exempted from the employer mandate. Firms with ≤ 10 workers that do not offer health insurance pay 1% of payroll, and firm with 11-20 workers that do not offer pay 2%.
- Firm subsidies are based on the 2.8-12% individual wage cap schedule where the rate applicable to the workers of a given firm depends upon the firm's size and average wage.
- People in the community rating pool: households without connections to firms with more than 500 workers, i.e., nonworkers, self-employed, part-time workers, Medicaid non-cash, Medicaid cash, and workers in firms with ≤ 500 employees.
- Age rating of premiums, with a 2:1 limit.
- A Kennedy-esque FEHBP option for firms with 2-10 employees electing to provide coverage. This means the community rating of FEHBP and the regular community rating pool is done together, so that there is no premium difference between them.
- HSA premium growth rate limits.

with Rx drugs ok

1. **Basic premium subsidy costs** 95 - 99 2000 - 2004

1996-2000	1996-2004
345	905
350 billion	920 billion
366	946
396	1082

2010 - 5% — HSA

2. **Assessment revenue:**

1996-2000	1996-2004
55 billion	120 billion

About 20% of this is from firms with ≤ 20 workers that don't offer.

3. **Increase cigarette tax from $.75 to $1.00.**

1995-2000

83 billion

4. **Reduce Medicare program savings $35 billion over 5 years.**

Our estimate is that age rating will also reduce the Medicare worker savings in the HSA by $3 billion between 1996-2000 and $6 billion between 1996-2004.

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

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Trudy Vincent
224-8572

224-5232

- Competitive payment adjustment -

DRAFT

Remember to bring in Eric when talking re taxes.

RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

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

2. An assessment on high cost plans is used to protect the federal budget from the risk of higher premiums caused by windfall payments resulting from universal coverage or by a failure of competition to bring down premium increases over time.

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

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

   a. The assessment for a health plan is X% of the difference between the plan's premium and the "target premium" for the state (or substate area). Health plans with premiums below the target are not subject to an assessment.

      The target premium for a state (or substate area) is based initially on current health care costs, but with added funding for the uninsured and with the windfall backed out. The target premium grows from year to year at pre-established rates based on reasonable expectations for a more competitive health care marketplace.

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

   b. The percentage assessment (i.e. the value of "X") is set nationally each year, and is calculated to recoup excess federal subsidy costs. If the assessment raises too much or too little revenue to recapture excess federal costs, the percentage is adjusted accordingly in the following year.

   c. Initially, the assessment would be applied to high cost health plans in all areas. Over time, as better data is available to establish premium targets, competitive areas could be exempted from the assessment (i.e. those areas where health care premiums meet the targeted levels).

   d. The assessment is applied prospectively based on bids from health plans.

   e. The assessment could be administered as an offset to payments to health plans (assuming there is a premium clearinghouse, reinsurance pool, or some similar mechanism). Federal subsidy payments to an area would simply be reduced by the total amount of assessments.

4. The assessment would apply not only to community rated plans, but to experience rated and self-insured plans as well (with some modifications).

TO: Chris Jennings

FROM: David Nexon

DATE: 6/5/94

SUBJECT: Data items we need (all for Chairman's mark), per our earlier conversation

1) Estimates of overall impact of Chairman's mark on business by size of firm, divided between those currently providing and not providing coverage.

2) Estimates including 5,000 plus firms and payroll contribution for small exempt and large firms over 1,000 (earlier estimates did not include 5,000 plus firms and appeared to be for premiums only).

3) Five year and year 2000 figures for the components of Title IX: Employer premium payments, household premium payments, Federal subsidy payments (we have five year, but not year 2000); Federal payments for cash recipients; state payments, including moe and cash recipients. For employers, households, and states, we would like to be able to compare to baseline payments.

4) Is tobacco tax number ($32 billion) a 96-2000 figure or a 95-2000 figure. If the former, what is the 95-2000 figure?

5) Budget impact of various cost-containment scenarios provided to Ken.

6) Difference between average premiums of 1,000 plus firms and all people in community-rated pool. How does what the 1000 plus firms would pay if they were paying community-rated premiums relate to the one per cent assessment?

TO: CHRIS JENNINGS

FROM: ANTHONY TASSI

DATE: 06/06/94

SUBJ: Additional Data Items Needed for Chairman's Mark

After talking it over with David, it turns out we need a couple of additional items:

1) The breakout of the revenue from the 2% assessment and 1% assessment

2) The number of firms and workers for each subsidy payroll cap (ie, how many workers are in firms paying 5.5% and how many firms are there)

3) For the Bingaman Option, the number of firms, workers in the exemption -- and revenue broken down for the 1% and 2% assessment of the exempt firms.

Much thanks -- you can fax the info to me (224-3533) or telephone if you prefer (224-6366; -6064; - 5406 david's line)

Post-It™ brand fax transmittal memo 7671	# of pages ▸ 1
To CHRIS J.	From ANTHONY/DAVID DIXON
Co.	Co. SEN KENNEDY
Dept.	Phone #
Fax # 456-7431	Fax #

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PHONE: (202) 690-5824
FAX: (202) 690-8344

TO: A. Epstein

FROM: B. Biles

FAX NUMBER _____

DATE 6.6.94

TOTAL NO. OF PAGES (INCLUDING COVER) 5

Pls. distribute to:

A. Epstein
L. Margherio
C. Jennings
J. Lew

n:\wp\clear.21

JUN 6 1994

NOTE TO JUDY FEDER

House Education & Labor Committee staff have requested a table showing the impact of three options for geographic adjusters for DME payments. The three options would be the Medicare hospital wage index, the RBRVS total index and the professional component of the RBRVS index.

Attached is a draft table comparing DME all payer cost based payments to national average per resident payments adjusted by these three indexes. The figures in this table have all been included in previously cleared tables with the exception of those in the fourth column -- the RBRVS professional component.

If there are any questions regarding this material, please call Kate Rickard at 690-5824.

Brian Biles

cc: Bob Pellicci

DME Comparison of All Payor Cost Based Payments and HSA Per Resident Payments In Thousands of Dollars

	N	All Payor Cost Based Payment	HSA/ Not Adjusted	Percent Change	Medicare Hosp. Wage Index	Percent Change	RBRVS Professional Component	Percent Change	RBRVS Total	Percent Change
All Hospitals	976	$5,800,000	$5,800,000	0.0	$5,800,000	0.0	$5,800,000	0.0	$5,800,000	0.0
All Teaching Hospitals										
AMC	78	$1,738,451	$1,912,010	10.0	$1,884,810	8.4	$1,889,168	8.7	$1,861,811	7.1
Non AMC COTH	150	$1,645,050	$1,459,517	−11.3	$1,510,270	−8.2	$1,488,548	−9.5	$1,526,773	−7.2
Non COTH	748	$2,416,500	$2,428,473	0.5	$2,404,920	−0.5	$2,422,264	0.2	$2,411,416	−0.2
Interns and Residents/Bed										
Low	501	$615,180	$627,152	1.9	$583,449	−5.2	$591,908	−3.8	$583,301	−5.2
Medium	291	$1,761,269	$1,715,136	−2.6	$1,696,026	−3.7	$1,719,887	−2.3	$1,719,346	−2.4
High	74	$896,124	$831,771	−7.2	$854,605	−4.6	$854,730	−4.6	$863,490	−3.6
Highest	110	$2,527,428	$2,625,941	3.9	$2,665,920	5.5	$2,633,476	4.2	$2,633,862	4.2
Size										
Urban 0−99 beds	55	$32,936	$42,263	28.3	$42,447	28.9	$41,476	25.9	$42,720	29.7
Urban 100−199 beds	206	$340,319	$339,019	−0.4	$335,591	−1.4	$330,479	−2.9	$334,406	−1.7
Urban 200−299 beds	221	$718,137	$753,503	4.9	$754,968	5.1	$737,955	2.8	$733,570	2.1
Urban 300−399 beds	192	$1,016,495	$1,082,708	6.5	$1,055,207	3.8	$1,060,305	4.3	$1,054,520	3.7
Urban 400−499 beds	112	$1,004,167	$1,027,855	2.4	$1,012,011	0.8	$1,018,912	1.5	$1,029,070	2.5
Urban 500+ beds	145	$2,612,823	$2,463,056	−5.7	$2,527,828	−3.3	$2,535,414	−3.0	$2,529,515	−3.2
Rural 0−49 beds	4	$404	$968	139.9	$758	87.7	$750	85.8	$811	100.8
Rural 50−99 beds	7	$1,845	$2,439	32.2	$1,943	5.3	$2,192	18.8	$2,188	18.6
Rural 100−149 beds	6	$3,204	$5,215	62.8	$3,667	14.4	$4,198	31.0	$4,754	48.4
Rural 150−199 beds	10	$12,498	$14,227	13.8	$10,573	−15.4	$10,272	−17.8	$11,384	−8.9
Rural 200+ beds	18	$57,171	$68,746	20.2	$55,008	−3.8	$58,047	1.5	$57,063	−0.2

DME Comparison of All Payor Cost Based Payments and HSA Per Resident Payments In Thousands of Dollars

	N	All Payor Cost Based Payment	HSA/ Not Adjusted	Percent Change	Medicare Hosp. Wage Index	Percent Change	RBRVS Professional Component	Percent Change	RBRVS Total	Percent Change
Region										
New England	80	$510,212	$506,640	−0.7	$531,336	4.1	$472,136	−7.5	$461,665	−9.5
Mid Atlantic	236	$2,171,980	$1,667,095	−23.2	$1,792,541	−17.5	$1,782,321	−17.9	$1,877,066	−13.6
South Atlantic	111	$653,771	$754,021	15.3	$677,538	3.6	$716,994	9.7	$667,859	2.2
East North Central	231	$1,145,182	$1,284,904	12.2	$1,223,881	6.9	$1,313,533	14.7	$1,315,736	14.9
East South Central	49	$205,081	$274,205	33.7	$223,778	9.1	$230,904	12.6	$208,776	1.8
West North Central	52	$87,474	$104,406	19.4	$89,727	2.6	$85,941	−1.8	$93,384	6.8
West South Central	67	$255,257	$344,732	35.1	$293,820	15.1	$295,930	15.9	$272,324	6.7
Mountain	34	$138,173	$166,667	20.6	$158,794	14.9	$154,357	11.7	$150,753	9.1
Pacific	116	$632,871	$697,331	10.2	$808,584	27.8	$747,883	18.2	$752,436	18.9
Owner										
Voluntary	811	$4,526,693	$4,324,670	−4.5	$4,391,336	−3.0	$4,398,456	−2.8	$4,441,590	−1.9
Proprietary	44	$58,034	$75,116	29.4	$67,349	16.1	$69,067	19.0	$71,661	23.5
Govt−Urban	114	$1,211,616	$1,396,406	15.3	$1,338,641	10.5	$1,329,426	9.7	$1,283,572	5.9
Govt−Rural	7	$3,656	$3,807	4.1	$2,674	−26.9	$3,050	−16.6	$3,177	−13.1

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DME Comparison of All Payor Cost Based Payments and HSA Per Resident Payments
In Thousands of Dollars

	N	All Payor Cost Based Payment	HSA/ Not Adjusted	Percent Change	Medicare Hosp. Wage Index	Percent Change	RBRVS Professional Component	Percent Change	RBRVS Total	Percent Change
ALABAMA	14	$52,166	$70,867	35.8	$56,646	8.6	$60,436	15.9	$59,273	13.6
ARIZONA	11	$64,202	$71,087	10.7	$66,493	3.6	$66,048	2.9	$71,476	11.3
ARKANSAS	7	$14,675	$25,444	73.4	$19,756	34.6	$20,136	37.2	$16,638	13.4
CALIFORNIA	89	$546,269	$607,391	11.2	$716,338	31.1	$660,068	20.8	$666,557	22.0
COLORADO	14	$52,841	$64,279	21.6	$63,678	20.5	$59,074	11.8	$52,502	−0.6
CONNECTICUT	23	$138,297	$145,626	5.3	$161,217	16.6	$140,038	1.3	$139,784	1.1
DELAWARE	3	$18,267	$18,550	1.5	$18,685	2.3	$19,294	5.6	$15,509	−15.1
DIST OF COLUMBIA	10	$111,023	$100,437	−9.5	$101,844	−8.3	$116,957	5.3	$98,424	−11.3
FLORIDA	32	$114,070	$154,377	35.3	$135,648	18.9	$143,819	26.1	$156,146	36.9
GEORGIA	15	$95,564	$111,821	17.0	$95,778	0.2	$90,768	−5.0	$91,938	−3.8
HAWAII	6	$12,292	$16,075	30.8	$17,225	40.1	$15,327	24.7	$15,495	26.1
IDAHO	2	$782	$1,045	33.6	$932	19.2	$854	9.2	$900	15.1
ILLINOIS	64	$320,405	$322,606	0.7	$307,448	−4.0	$352,088	9.9	$383,597	19.7
INDIANA	19	$66,650	$90,342	35.5	$79,606	19.4	$84,030	26.1	$69,759	4.7
IOWA	16	$22,927	$19,378	−15.5	$15,936	−30.5	$17,238	−24.8	$15,533	−32.3
KANSAS	14	$42,743	$53,226	24.5	$46,923	9.8	$43,294	1.3	$49,743	16.4
KENTUCKY	13	$40,235	$62,291	54.8	$50,899	26.5	$54,813	36.2	$49,356	22.7
LOUISIANA	15	$55,152	$71,559	29.7	$58,850	6.7	$58,154	5.4	$64,906	17.7
MAINE	8	$17,975	$19,331	7.5	$15,996	−11.0	$14,765	−17.9	$15,686	−12.7
MARYLAND	21	$111,026	$154,036	38.7	$145,498	31.0	$161,677	45.6	$142,795	28.6
MASSACHUSETTS	40	$297,799	$272,459	−8.5	$289,629	−2.7	$256,550	−13.9	$250,034	−16.0
MICHIGAN	61	$329,644	$351,791	6.7	$354,283	7.5	$395,189	19.9	$404,972	22.9
MINNESOTA	2	$1,852	$2,038	10.0	$2,000	8.0	$1,014	−45.3	$1,328	−28.3
MISSISSIPPI	2	$4,472	$22,215	396.8	$15,920	256.0	$17,581	293.1	$16,791	275.5
MISSOURI	10	$13,943	$20,795	49.1	$17,282	24.0	$17,319	24.2	$19,782	41.9

Option 1

- Reduce benefits package 5% (Alternatively 8%)
- No premium caps
- Age-adjusted community rate. Use Chafee age-adjusted rating specifications.
- Phase-in employer subsidies (Mitchell model) over 5 years. Mandate does not go into effect until subsidies fully phased-in.
  - Phase-in should be based on individual wages and not on firm size.
- Impose a windfall profits tax (or some other mechanism).
- Impose a 1% (alternatively 2%, 3%) health plan premium tax on all plans. Use a premium equivalent for self-insured plans.

Option 2

- Reduce benefits package 5% (Alternatively 8%)
- No premium caps
- Age-adjusted community rate. Use Chafee age-adjusted rating specifications.
- Phase-in Chafee individual mandate over 5 years to 240% of poverty. (Alternatively, phase to 200% of poverty).
- Impose a windfall profits tax (or some other mechanism).
- Impose a 1% (alternatively 2%, 3%) health plan premium tax on all plans. Use a premium equivalent for self-insured plans.

Adjustments

- For each of the above options, what happens if a premium cap is imposed in year 3 (alternatively year 4, year 5). Set the cap at the previous year's weighted average premium increased by growth in per capita GDP.
- For each of the above options set the age-adjusted rate at 3-1 in the first year and phase it down to 2-1 over five years.
- For each of the above options, impose the premium tax only on those plans who grow faster than the average in the area.

- .5% pt for ea 1% over Avg grow

- In Calc WAP - exclude any growth in plan over the avg growth in area.

FUNDING SOURCE	1995	1996	1995-1996	1997
Tobacco	1.8	2.4	4.2	3.5
Medicare revenue provisions	0	1.9	1.9	3.1
Medicare savings	1.4-1.7	6.6-7.1	8 - 8.8	9.6-10.1
Medicaid savings	0	0	0	
TOTAL	3.2-3.5	10.9 - 11.4	14.1 - 14.9	

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + 5 DATE: 7/25/94

TO:
Chris Jennings
Fax: _____
Phone: _____

FROM:
Debbie Chang
Fax: (202) 690 - 8168
Phone: _____

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

CHRIS FYI PJ

TALKING POINTS: MITCHELL/GEPHARDT vs SENATE FINANCE AND vs DOLE

PURPOSE There is great need for talking points for our allied groups and for the Hill on a variety of issues related to comparisons of the Mitchell vs Dole and vs Senate Finance and on Gephardt. The audience is Hill staffers and policy people for constituency groups, so these talking points should be at a fairly specific level of detail.

THEMES

1. How is Mitchell an improvement over Senate Finance?

2. In what areas is Mitchell better than Dole?

3. What are the good things about Gephardt?

SPECIFIC CATEGORIES THAT SHOULD BE INCLUDED

Why is Mitchell 100 not 95?

Impact on middle class: affordability, choice, etc.

Government role: ex: percentage of people in "gov't plans" (ex: Medicare C in Gephardt)

Alliances/purchasing cooperatives

Mandate

Benefits in Mitchell: taxation, definition and power of Board

Cost containment

Subsidy structure

Issues that affect unions (Meredith Miller DOL 219-8233)

Incentives for employers who currently provide to continue covering under Mitchell?

Impact on State budgets (esp Medicaid on Dole)

Seniors

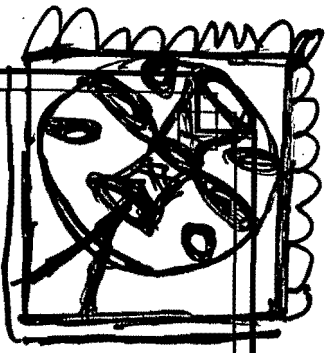
Impact on Big and Small Businesses

Others? Where else do Mitchell/Gephardt look good in comparison?

TURNAROUND

Bring on disk (Wordperfect 5.2/5.1) to Paul Jamieson in 207 (p 65547, F 67431) by COB today if possible.

Statutory language on Mitchell now available in 213.5 with Stacey Rubin.



MAINSTREAM GROUP
OBJECTIVES FOR HEALTH REFORM

ACHIEVE UNIVERSAL COVERAGE
NOT INCREASE THE DEFICIT
LOWER HEALTH CARE COSTS
MAINTAIN QUALITY
EXPAND CHOICE FOR ALL AMERICANS
THE MAINSTREAM AMENDMENT WILL:

Achieve universal coverage through:

- effective insurance reforms -- portability, renewability, eliminate preexisting condition limitations, adjusted community rating in small group market;
- expanded tax deductions; and
- subsidies for low-income families that make health care affordable for ALL Americans.

Limit government intrusion/bureaucracy/regulation:

- NO market-distorting price controls
- NO prescriptive regulations that stifle innovation
- NO new big mandated state or federal bureaucracies.

Protect against deficit growth through:

- full financing of new health spending; and
- effective "fail-safe" mechanism that prohibits deficit financing of health spending.

Lower health care costs by making health plans compete on quality and price through:

- standard benefits packages;
- better consumer information and health plan accountability
- voluntary purchasing cooperatives
- administrative simplification
- measures to eliminate fraud and abuse
- aggressive malpractice reform.

WHY MITCHELL HEALTH CARE LEGISLATION FALL SHORT OF MAINSTREAM OBJECTIVES

IMPOSES MARKET DISTORTING PRICE CONTROLS

- Premium Assessment relies on Government imposed price caps
- New National Health Care Cost and Coverage Commission has power to recommend government price controls under an expedited procedure

IMPOSES NEW MANDATES

95% - Comprehensive

- Triggered Employer/Individual mandate
- All employers with less than below 500 employees must join "Voluntary" purchasing cooperatives

EXPENSIVE NEW SPENDING

- New non-means tested entitlement for prescription drugs
- New non-means tested entitlement program for long term care
- New employer subsidies to encourage expanded coverage
- New subsidies to fund health benefits for families up to 300% of poverty
- New subsidy for the temporary unemployed
- New subsidies for cost sharing for low income participants
- New authorizations for existing Public Health Programs
- Six new trust funds for medical workforce (a superfund for medical education) and new trust fund for research funded by a 1.75% tax on premiums
- Expanded private remedies for benefit delay and denial destroys ability of health plans to control costs
- Deep cuts in Medicare exacerbates cost shift onto private sector
- Fail safe not established until massive new entitlements have been incorporated into baseline
- Fail safe subject to manipulation by the Executive Branch by changing baseline and setting inflation factors

SUBSTITUTES GOVERNMENT REGULATION FOR PRIVATE MARKET FORCES

- 500 Employee threshold herds majority of employees and employers into large collectives and destroys employers' ability to control costs
- Gives National Health Board excessive power to practice medicine
- Pure community rating beginning in 2002 penalizes the young and dooms the voluntary system

- The new employer subsidy decreases incentive to control costs once payment limit is reached
- Premium assessment is not used to provide consumer incentive to save costs and undermines competition be setting a Government imposed target
- Opening of FEHBP creates Federal Government run purchasing cooperatives that could become a back door single payer system
- Creates Federal Government central planning of health work force
- Creates an unlevel playing field in the marketplace by mandating all employers and HIPCs offer a Fee -For -Service plan
- Requires employers to offer only standard benefit package-- only individuals can use "alternative standard plan"
- Triggered mandate creates counterproductive business and hiring incentives by exempting employers with less than 25 employees
- Creates a government run long term care health insurance system
- Undermines competition in the prescription drug industry with a mandatory rebate agreements
- Provides no incentive for Medicare seniors or providers to choose cost effective private systems
- Destroys ability to manage health costs by requiring health plans to contract with a wide range of "essential" community providers
- Uncertain scope of "State Option" may severely hamper multi-state employers and providers
- Institutes bureaucratic Federal and State inspection and reporting systems for providers and health plans
- Weak malpractice reforms ensure continued defensive medicine

HIDDEN COST SHIFTS

- Federal Government shifts costs of insuring Medicaid population onto private health plans and States
- Underfunded mandate to States to administer subsidies
- Institutionalizes cost-shifting by requiring self-insured employers to risk adjust and subsidize the community rated system

FEDERAL BUDGET EFFECTS OF MITCHELL PROPOSAL

	10-Year Estimate ($ billions)	
Outlay increases:		
Low-income subsidies (Finance)	$ 924	*
Prescription drugs for Medicare Beneficiaries (Mitchell)	$ 99	
Home and Community Based Care Program (Mitchell)	$ 48	
GME/AHC initiatives	$ 75	
Total outlay increases	$1,146	
Funding Sources:		
Eliminate Medicaid acute care (Mitchell)	$ 516	
State maintenance of effort payments (Mitchell)	$ 232	
Medicare cuts (Mitchell)	$ 278	
Means test Medicare Part B premiums (Finance)	$ 22	
Tobacco tax (rough estimate)	$ 50	
High Cost Plan Assessment	$ 40	
Eliminate Section 125/Flexible Spending Arrangements (Finance)	$ 35	
1.75% premium assessment	$ 75	
Other revenue changes (net)	$ 0	
Total funding sources	$1,248	

* The bill approved by the Finance Committee did not include the subsidies to employers or the subsidies for short-term unemployment.

Bradley / Hardeman

Kreb > 240%

- 1997 vs. 2004 premiums
- comparison of premiums & bodily to nibbles
- 500 & below cost of gas & 100 & risk adjusting ? Nordon / Klein
- Feinstein - why cant self-insure
  Krebs — why there will be regulatory policies
- Example with employees with firms of different sizes
- Risk adjustment - Larry
- MSA - why bad - Gary - Get Burned - finance
- Market oriented - Larry

Who Would Incremental Reform Really Hurt? Middle Class Families

Some propose an incremental approach to health reforms aimed not at guaranteed coverage for everyone, but at trying to increase the number of people with insurance by enacting some insurance reforms with subsidies for the poor. Employers could continue to drop coverage, and millions of families would continue to go without insurance.

It's hard-working Americans -- the middle class -- who would be hurt by such an approach. It's middle class families who will continue to lose their coverage when they change a job; to take out a second mortgage to pay the bills from a child's illness, to forego career advancement for fear of losing the coverage they have with their current job.

Besides, all the evidence suggests an incremental approach won't work; in fact, health reform that falls short of universal coverage could actually make things worse. Millions would remain uncovered, including some previously insured through their company. Costs would not be controlled, leading to higher prices for working familes and a ballooning federal deficit.

Millions of families remain at risk

- Incremental reform bills will not cover everyone -- not even close. An estimated 24 - 40 million people would remain uninsured without universal coverage.

- One in six Americans will still lose their health insurance at some point during the year.

Middle class will take the hardest hit

- Since the poor and non-working would get free coverage, and since wealthy Americans could afford coverage on their own even if costs continue to rise, those hardest hit by incremental reform would be middle-class working families.

- Under a non-universal, managed competition-style reform plan , an estimated 24-40 million people, *more than two thirds of them in middle-class, working families,* would remain uninsured. The main reason these families wouldn't be covered is the cost of insurance.

- What's worse, many people who now have insurance protection today would find themselves without coverage under an incremental reform plan. An estimated one in ten workers with employer-sponsored insurance would be dropped by their employer.

To: C.J. 8:50 AM
Fr: C.H. 6/21/94

The cost shift will continue

- Under the Band-Aid approach, those who take responsibility for insurance coverage will continue to pay for those who do not. Senator Chafee, a Republican from Rhode Island, puts it this way: "If there's no mandate that people have to belong, then young healthy males who don't ride motorcycles aren't going to join and so the costs are going to be carried by those who are sick." Alain Enthoven, the so-called "father" of managed competition, adds that "such a system would be destroyed by free-riders".

The deficit will increase

- Without any change to the existing system, two-thirds of the growth in federal spending between 1993 and 1996 will be accounted for by health care spending.

- Incremental reform plans aim to extend coverage to low-income families and the unemployed by providing government subsidies to those Americans. Under a plan with subsidies for the poor but no universal coverage, CBO says there would be over $300 billion added to the deficit in financing the subsidies for low income Americans. By contrast, the President's plan is expected to curb expenditures by $30 billion by the year 2000, and by $150 billion by 2004.

Universal coverage is the only way to guarantee controllable costs, and fair, equitable financing of health care.

Imagine a diner where everyone in a community goes for lunch. Most people have lunch, pay, and leave, but every eighth person who walks into the diner sits down, orders (usually the most expensive thing off the menu because they're famished), and gets up and walks out without paying. The cost of that patron is spread over the other seven who did pay. It only makes sense that when that eighth person pays for their lunch like everybody else, and orders like everybody else, the cost to the other seven paying diners will go down.

We don't think the solution is to charge working families through the nose for lunch, and let the poor eat for free by taxing everyone who orders a steak. We think the free lunch should end.

All Americans deserve the security of high quality health care coverage they can't lose, even if they move or take a better job. The American health care system will be stronger, better, and less costly if Congress finishes the job they've started and guarantees private health insurance to all Americans this year.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR GREG LAWLER
STEVE RICCHETTI
JACK LEW
CHRIS JENNINGS
IRA MAGAZINER
MIKE LUX

FROM: CAREN WILCOX

SUBJECT: POSITIONING OF RETAILERS

DATE: JUNE 17, 1994

I attach a copy of the position of the National Retail Federation indicating that they intend to "continue to deliver a strong no-mandate, no-trigger message in our communications to members of the House and Senate."

Clearly the authors of triggers have not gained favor with their retail constituency by doing so.

The retailer litany of talking points include:

* triggers would distort the market, businesses would delay capital investment and expansion, reduce employment to fit the triggers;

* a trigger will kill jobs and stifle wage growth in the retail industry;

* a trigger in the future would be just as bad as a mandate today;

* they want big firms which don't offer benefits to get the same benefits as small firms which don't offer them.

It would appear to me from this document that the retailers would certainly not "voluntarily" change their benefits programs if there were a soft or hard trigger, but would undoubtedly try to keep defeating it.

cc: Alexis Herman
Steve Hilton

NATIONAL RETAIL FEDERATION

MEMORANDUM

TO: Government and Legal Affairs Committee
Task Force on Health Care Reform

FROM: Steve Pfister, Vice President, Director of Political Affairs

RE: EMPLOYER MANDATE "TRIGGER"

DATE: June 16, 1994

As you are aware, many key Members of Congress have recently offered their tentative support for a health care reform compromise which would implement or "trigger" an employer mandate at a future date in time if certain coverage thresholds were not achieved through market reform and other measures. NRF is strongly opposed to any mandate "trigger" and believes that members are using this tactic as political cover so they may "have it both ways" on the volatile issue of employer mandates.

The attached paper "The Truth About Triggers" will provide background information and talking points on this critical development. Clearly, we must continue to deliver a strong no-mandate, no-trigger message in our communications with Members of the House and Senate.

As always, if you have any questions or comments, please do not hesitate to contact me at 202/783-7971.

Attachment

The World's Largest Retail Trade Association

Liberty Place, 325 7th Street, NW, Suite 1000
Washington, DC 20004
202.783.7971 Fax 202.737.2849

National Retail Federation
June 15, 1994

THE TRUTH ABOUT TRIGGERS

As Congressional support for the employer mandate wanes, several members of the House and Senate have settled upon the notion of using a so-called "hard trigger" mechanism to ensure that universal health coverage is achieved by a specified date. Each of the various "hard trigger" proposals which have been circulated (the most prominent of which has been offered by Senators Bradley and Packwood) would provide for automatic implementation of an employer mandate if market-based reforms do not achieve specified coverage levels within a certain time frame. The "hard trigger" concept has been touted as a bridge to compromise between members who support voluntary, market-based reforms and those who favor a mandatory, top-down restructuring of our nation's health care delivery system.

But a mandate is still a mandate, regardless of when it is implemented. These "trigger" proposals are nothing but a placebo for members trying to straddle the ideological boundary between the market-based and regulatory approaches to health care reform. A vote for a "hard trigger" is a vote for an employer mandate -- it's that simple.

Implementation of an employer mandate via a "hard trigger" mechanism would have catastrophic consequences for the retail industry and our nation's overall economy, for the following reasons:

- Imposing a mandate "trigger" would be like holding a gun to the head of every business owner in America. As soon as a trigger is enacted, the market will become distorted as business owners start to plan for its potential implementation. Faced with such uncertainty, they will, at a minimum, delay capital investment and expansion. In addition, many firms would be motivated to actually reduce employment where the "trigger" is aimed according to firm size. For example, where a "trigger" would be pulled in year 4 for firms with 25 to 99 employees and in year 5 for firms with fewer than 25 employees, a company with 30 employees would have a huge incentive to lay off six workers in year three to postpone the pull of the "trigger" for two additional years. The threat of tomorrow's mandate will clearly shape today's economic reality.

  Market forces, which might otherwise succeed in correcting much of the uninsured problem, will never be given an opportunity to work as firms operate in the shadow of the impending mandate. Recent studies conducted by Lewin-VHI and CBO both concluded that a voluntary, market-based approach with appropriate subsidies and insurance reforms would provide coverage for 91 percent of Americans.[1] Lewin-VHI also found that approximately 97 percent of all health spending would be covered by insurance because the majority of those who would remain uninsured would be younger, healthier individuals who are low users of care.[2]

National Retail Federation
June 15, 1994

Congress should give the newly reformed market a chance to succeed before imposing unduly burdensome requirements on employers.

- A bad idea isn't like a fine wine -- it doesn't improve with age. Tomorrow's employer mandate will be just as destructive to jobs and the economy as today's. A mandate -- whenever implemented -- will kill jobs and stifle wage growth in the retail industry. Unlike higher-wage industries which can shift forms of compensation to defray greater health care costs, the retail industry cannot shift the increased labor costs imposed by a mandate back onto wages. Nor can retailers pass these cost increases onto customers through price increases. Most retail employers would have no choice but to cut jobs or reduce work hours in order to meet the staggering health insurance bills they would face under an employer mandate -- delayed or otherwise.

  A study conducted by Nathan Associates, Inc. for the National Retail Federation conservatively estimated that at least 500,000 retail jobs would be eliminated under an employer mandate.[3] The Employment Policies Institute estimates that retail job losses could total 726,000 under an employer mandate.[4]

  Opponents of employer mandates must not succumb to "feel good" measures which are aimed more at providing cover for members than coverage for Americans. A vote for a "hard trigger" is a vote for an employer mandate, plain and simple.

- Congress shouldn't just close its eyes and shoot. Congress does not -- and cannot -- know now what the future holds for our nation's economy. It is therefore sheer folly for members to presume that they can know now what the best way to achieve universal coverage will be in three, five, or seven years. In the face of double digit unemployment, would implementation of a mandate be the wisest course? Surely not. But under the "hard trigger," today's decision irrevocably seals tomorrow's fate.

  In addition, the "triggering" of an employer mandate will have serious fiscal consequences for the Federal government. Potential subsidy obligations will place a huge question mark in the Federal budget -- but the "trigger" will fire at date certain, regardless of its impact on the deficit.

  After implementing market-based reforms, Congress should adopt a wait and see approach before setting in motion an irreversible force that could destroy the economy.

- No state has successfully fired a trigger yet. In 1988, Massachusetts enacted a delayed employer mandate. The state's economy steadily declined thereafter and implementation of the mandate has been postponed again and again due to fear to further decline. In Oregon, the only other state to enact a "trigger" proposal, the "hard trigger" has been

delayed twice, moving implementation from 1994 to 1998 -- nine years from the date of enactment.

Congress should not hang the success of its health care reform efforts on a concept with such a poor track record.

➢ Some proposed "triggers" are based on an unrealistic definition of "universal coverage." Even in Hawaii, which has an employer mandate, only 93 percent of the population has health insurance. Trigger proposals (such as that floated by Senate Finance Committee Chairman Moynihan) which threaten to drop the mandate hammer unless 95 to 99 percent of employees have health insurance by a specified date ignore the very real possibility that universal compliance could be unachievable for reasons beyond an employer's willingness or unwillingness to provide health insurance coverage for its workers. For example, employees (especially young and/or part-time workers earning low wages) might be unwilling to bear even 20 percent of the cost of health insurance. Should an employer fire a worker who refuses to pay his/her insurance premiums in order to avoid pulling the mandate trigger?

The various "hard trigger" proposals erroneously assume that a failure to achieve "universal coverage" (however defined) is necessarily the fault of the business community.

➢ Most proposed triggers are wrongly aimed at businesses according to size, rather than coverage ratios. The same principles which support the extension of special treatment (via subsidies or delayed implementation dates) to small, low-wage employers apply with equal force to all low-wage employers. A physician group with five employees and an average annual wage of $50,000 is arguably better able to afford to purchase health insurance for its employees than a 100-employee retail business with an average annual wage of $10,000. As is apparent from this example, it is not so much the size of a business, but rather its compensation structure which dictates the impact an employer mandate would have on it.

In addition, by tying the "hard trigger" to firm size, most proposals exert significant downward pressure on job growth in small businesses. A small employer will hesitate seriously before hiring employee number 25 or 100 when doing so will cause the "trigger" to fire years earlier.

Penalizing employers and employees based on firm size alone lacks a compelling rationale and is an inefficient and off-point attempt to appear sympathetic to small business concerns.

[1] Congressional Budget Office, An Analysis of the Managed Competition Act 20 (April 1994); Lewin-VHI, Inc., Expanding Insurance Coverage Without a Mandate 1 (May 18, 1994).

[2] Lewin-VHI at 1.

[3] Nadlin Associates, Inc., Retail Trade Industry Cost of Managed Competition with an Employer Mandate (March 1993).

[4] Employment Policies Institute, The Impact of a Health Insurance Mandate on Labor Costs and Employment (Sept. 1993).

DRAFT (7/26/94 #1)
BREAUX-LIEBERMAN PROPOSAL

PURPOSE: Attached is a proposal to ensure that the goal of universal coverage is met in the event that Congress fails to act on Commission recommendations under the process set forth in the Senate Finance Committee bill. The proposal would require the states to achieve universal coverage and would give them flexibility and resources to do so.

CONTEXT: The Finance Committee bill sets up a national commission that would report to Congress every two years on the status of the uninsured and suggest ways to expand coverage.

If less than 95% of the U.S. population is insured in 2002, the Commission would send recommendations to Congress on how those parts of the country that have not achieved 95% coverage could do so. These recommendations would be considered by Congress under fast-track procedures that would allow for relevant amendments but which would ultimately require that Congress take a vote. The following proposal would apply only if, at the end of fast-track procedures, Congress failed to pass legislation to reach universal coverage.

SUMMARY OF PROPOSAL: This proposal would set up a default process in the event that Congress fails to approve legislation (based on Commission recommendations) in the year 2002. States with less than 95% coverage would be required to submit a plan to the Department of Health and Human Services that would bring them to universal coverage.

The proposal was written with the following guiding principles in mind: (1) states should be given a reasonable amount of flexibility and resources so that they can act to expand coverage within their borders, (2) states should not be presented with an unfunded federal mandate, (3) the federal government should not promise the states more resources than can realistically be provided, and (4) any new commitment of federal resources must be fully financed.

The proposal would establish:

- **1995 TO 2002:** incentives and flexibility for states to encourage and enable states to act aggressively to reach 95% coverage;
- **BEGINNING IN 2002:** additional authorities that states can use to reach 95% coverage (should Congress fail to enact legislation based on Commission recommendations); and
- **CONSEQUENCES OF STATE INACTION AFTER 2002:** limited federal interventions in states that fail to make substantial progress within a reasonable period of time after the year 2002 (if Congress has failed to act).

DRAFT

Add new section II (E) to Senate Finance Committee mark:

E. DEFAULT STRATEGY FOR ASSURING UNIVERSAL COVERAGE

In the event that Congress fails to act on the recommendations of the Commission as described in section II (D), any state in which fewer than 95% of residents are insured must submit a plan of action to the Secretary of Health and Human Services for achieving 95% coverage. Flexibility will be permitted for states that have extremely high rates of uninsured.

Such plans shall address all relevant parties, including State and local governments, employers, employees, unemployed and low income individuals, beneficiaries of public programs, etc.

1995 TO 2002: The following provisions are designed to give states the resources and flexibility they need in order to reach the goal of universal coverage before the year 2002:

- Allow limited flexibility under ERISA: under a waiver process, states will be given limited authority to impose requirements on ERISA plans if they can demonstrate that these requirements would significantly increase coverage.

- Provide funding for state outreach efforts to low-income and other populations at risk of remaining uninsured. (Funds are intended for administrative and technical support.)

- Allow states to impose additional "risk adjustments" among health plans based on factors other than health status (such as geography) that are designed to encourage health plans to cover populations that are at risk of remaining uninsured.

- Provide funding and additional flexibility to states to encourage the development of provider networks in rural and urban underserved areas. (Funds are intended for administrative and technical support.)

- Provide funding for state planning and reporting requirements.

DRAFT

BEGINNING IN 2002: Those states that are required to submit action plans to the Secretary of Health and Human Services for approval may include application for the following additional authorities:

- Adjustments to low-income subsidy structure. This could be done: (1) in a revenue neutral way that allows states to create different eligibility rules for low-income subsidies, or (2) in a manner that allows states to receive as a block grant additional, untapped subsidies for eligible state residents who remain uninsured. (It may be necessary to cast option #2 as a capped amount for the states to address concerns about potential costs. A rough estimate of the cost of allowing states to tap every potential dollar of subsidies would probably be in the range of $100-$200 billion in additional costs over five years.)

- Additional flexibility regarding state regulation of ERISA plans under an HHS/DOL waiver process.

- Adjust threshold for self-insuring and participation in community-rated pools.

- Structure of purchasing cooperatives: states would be given flexibility to restructure purchasing cooperatives (for example, establish coops as state-based and/or mandatory entities) and limit or increase the number of coops in an area.

CONSEQUENCES OF STATE INACTION AFTER 2002: The commission would continue to report biennially on the status of health insurance coverage. Failure of states to reach 95% coverage (or to maintain that level of coverage) would result in one or more of the following limited sanctions, under rules established by HHS:

- Loss of federal payments for costs of outreach programs to populations at risk of remaining uninsured. Outreach functions would then be assumed by HHS.

- Loss of state flexibility to establish special risk adjustments among health plans designed to encourage coverage of populations that remain uninsured. This function would then be assumed by HHS.

- Loss of funds and state flexibility to establish special provisions for the development of provider networks in rural and urban underserved areas. This function would then be assumed by HHS.

- Possible assumption of additional authorities by HHS.