CHRIS:

Lisa Nolan wanted the following info:

When the mandate comes in (here assuming 2000), how many would receive coverage due to the employer mandate provisions and how many would receive coverage under the individual mandate provisions?

Answer: About 80% of the under 65 population through the ER mandate (about 185 million) and the remained (about 52 million) would be covered through the individual mandate (nonworkers, remaining uninsured in firms under 25).

Len also has this info---may want to check to see if he agrees.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To CHRIS	From KEN
Dept./Agency	Phone #
Fax #	Fax #

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

Add to Presumptive Eligibility Section:

Under 1b.

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

OPTIONAL FORM 89 (7-90)

FAX TRANSMITTAL

# of pages ►

To CHRIS/LARRY

From KC

Dept./Agency

Phone #

Fax #

Fax #

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

Add to Presumptive Eligibility Section:

Under 1b.

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

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To: CHRIS/LARRY From: KEN

Dept./Agency Phone #

Fax # Fax #

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

Cost of Options, 2000-2004

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

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

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

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

TRIGGERED AFFORDABILITY TARGETS

AFFORDABILITY TARGET TRIGGER FOR COMMUNITY-RATED PLANS

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

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

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

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

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

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

AFFORDABILITY TARGETS FOR COMMUNITY-RATED PLANS

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

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

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

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

COST CONTAINMENT FOR EXPERIENCE-RATED PLANS

OPTION 1:

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

OPTION 2:

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

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

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

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

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

July 28, 1994
1:44 pm

$115,000 with a subsidy for the employer's share of the premium is about $2 billion (recall that this decomposition is for people with current retiree health insurance only; this is only 40 percent of the retired population). Finally, the family share of the premiums plus payments made by self-employed retirees is the remaining $3 billion.

Change in Payments for Early Retirees with Health Insurance if Program Were Fully In Place in 1994 (Dollars in Billions)

CURRENT PAYMENTS	**$16**
Employer	$13
• Private	$8
• Federal and State/Local	$5
Employee	$3
REFORM	
Reduction in Payments due to Community Rating, Move to Per Worker Premium, and Elimination of Uncompensated Care Cost-Shift	**$6**
Required Payments	**$10**
• Employer Payments*	$4
• Non-Worker Discounts	$1
• Additional Retiree Discounts	$2
• Remaining 20% Share, Plus Self-Employment Payments	$3
EMPLOYER SAVINGS **	**$7**
EMPLOYER RETIREE ASSESSMENT ***	**$4**

* Includes a small amount of subsidy payments to employers subject to the cap.

** Current employer payments, less reform employer payments, less 20% share paid by corporations.

*** In the 1998 to 2000 period.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To JACK LEW From THORPE

Dept./Agency Phone #

Fax # Fax #

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

IV. Won't This Induce More Retirement?

We expect there to be an increase in retirement as a result of the Health Security Act. Administration estimates are that there will be an increase in the number of retired people of about 350,000 to 600,000 (roughly 5 to 7.5 percent of the population aged 55 to 64). This will have some effect on subsidy payments, of about $1 to $2 billion annually (500,000 people x $2,000 each: $1 billion). To the extent that these people are replaced by younger people who would not otherwise be in the labor force, however, there will be employer payments for the newly hired to partially offset subsidies given to the early retirees (the young workers would otherwise have been non-workers and would presumably be covered by federal non-worker subsidies). The net effect on subsidies is likely to be small.

Much of the inducement to retire early comes from the provision of universal coverage itself. In today's market, it can be difficult if not impossible for an early retiree to obtain private (non-group) health insurance coverage. Under reform, this coverage will be available at an affordable level, even without the early retiree subsidy. The cost of health insurance for even a rich retiree would be one employer share (about $2,100 for a couple) plus the family's share of the premium (about $770 for a couple). For a retiree with income less than 250% of poverty (about $24,000 for a couple), the cost would be even smaller. Compared to the inducement to retire stemming from the community rating of premiums and other changes in the proposal, the additional subsidies to early retirees should not lead to much more early retirement.

V. What Effect Will This Have On Social Security and Medicare?

This increased retirement will cost the Social Security and Medicare trust funds some additional expenses. We estimate these costs to be $11 billion over the 1996 to 2000 period, and $3 to $4 billion per year after 2000.

There are a large number of provisions in the Health Security Act that will affect the trust funds, however. The reduction in employer health insurance spending would raise wages and lead to more revenue for the trust funds, for example. The full extent of the effects on the trust funds has not been estimated, however.

OPTIONAL FORM 89 (7-90)

FAX TRANSMITTAL # of pages ▶

To JACK LEW	From KEN THORPE
Dept./Agency	Phone #
Fax #	Fax #

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

The Health Secur

I. The Policy

Under the Health Security Act, employers are required to contribute (less any applicable discounts) 80 percent of the weighted average per worker adjusted premium for the appropriate family class of enrollment (i.e., single, couple, single-parent, two-parent family). The special retiree subsidy acts as a credit to a qualifying retiree for any portion of the employer's share of the weighted average premium that has not been paid by an employer or by a spouse's employer. This policy will be implemented on January 1, 1998.

A retiree qualifies for a credit of 80 percent of the weighted average premium if she/he is age 55-64, not working full-time or married to a full-time worker,[1] would be eligible for Medicare Part A benefits based on employment if they were 65 years of age, is not otherwise Medicare eligible, and has income[2] below the threshold amount ($90,000 per year for a single unit or $115,000 for non-single units). A person over these income limits who does not work at all, and who does not have a working spouse, is responsible for payment of the full "employer" share. Any employer contributions for months worked by an individual retiree or the spouse of a retiree offset the high income person's required payments for the "employer" share; any employer contributions would also offset the amount of subsidy received for individuals not exceeding the income threshold amounts.

Employers who contributed at least 20 percent of the cost of their early retirees' health insurance premium on October 1, 1993 will be required to pay 20 percent of the weighted average premium (the family share) towards their early retirees' insurance from 1998 until the retiree reaches age 65. All other retirees are responsible for the difference between the premium of the plan chosen and 80 percent of the weighted average premium in the alliance. However, if the family's income (footnote 2) is below 150 percent of poverty, that family would be eligible for a discount on the family obligation. The contribution is capped at 3.9 percent of income for those with income between 150 percent of poverty and $40,000 per year.

II. The Cost of the Retiree Provisions

We estimate the five year cost of the special retiree provision to be approximately $13 billion. This is the subsidy cost over and above any subsidies that would be paid out to the early retirees as a result of the basic non-worker subsidy policy (regular non-worker subsidy payments to early retirees are estimated to be $29 billion over the 1996 to 2000 period).

[1]In addition, a married couple with 12 months of full-time work between the two spouses (e.g., each works half-time all year, or each works full-time for 6 months) is a couple with a full-time equivalent worker, and thus does not qualify for the special retiree subsidy because their employer share would be paid in full.

[2]Income for these purposes is defined as adjusted gross income plus non-taxable interest income.

Subsidies to Persons Aged 55 - 64 Years (Dollars in Billions)[3]

Subsidy	1996	1997	1998	1999	2000	Total
Non-Worker Subsidies to Early Retirees	$1.1	$3.0	$7.9	$8.2	$8.5	$28.8
Additional Retiree Subsidy	$0.0	$0.0	$3.5	$4.8	$5.1	$13.4
TOTAL						$42.2

On the revenue side of the retiree policy, for the years 1998 to 2000, companies and state and local governments are required to pay 50 percent of the greater of (1) the estimated decrease in early retiree costs due to the Health Security Act, and (2) the annual average of the actual amount paid for early retirees in 1991, 1992, and 1993. These figures will be adjusted to 1998 to 2000 based on the medical component of the Consumer Price Index.

Some savings result as federal obligations for retired federal employees and military health beneficiaries are decreased due to the retiree provisions in the Act. Over the 1996 to 2000 time period, these savings amount to $5.6 billion.

In addition, the costs presented in the previous table are offset slightly in the years 1999 and 2000 as a result of the "recapture" of subsidies paid out to the high income retirees.

Revenues from Retiree Issues (Dollars in Billions)[3]

Item	1996	1997	1998	1999	2000	Total
Assessment	$0.0	$0.0	$2.4	$4.4	$4.7	$11.4
Payments from High Income Retirees	$0.0	$0.0	$0.0	$0.1	$0.1	$0.2
Savings from Federal Health Programs	$0.0	$0.0	$1.3	$2.0	$2.2	$5.6
TOTAL						$17.2

[3]All numbers are consistent with the Administration estimates made in November, 1993, for the Health Security Act.

III. How Much Do Corporations Benefit?

Corporations benefit by the difference between what they currently pay for retiree health insurance and the amount they will have to pay under reform. It is estimated that total annual health insurance payments for early retirees with employer sponsored health insurance will be about $16 billion in 1994; this will increase to $25 billion in 2000, if there is no reform. Under reform, payments by corporations for the 20 percent share of the former employee's premiums will be about $2 billion per year in 1994 dollars, and the three-year assessment will cost them about $4 billion per year in the years it is paid. Hence there are substantial savings to firms from the retiree provisions. There are two important points about the savings to corporations:

- The benefits are greater than the assessment, because the assessment is on only one-half of the gains, and the assessment applies for only three years;

- The benefits are greater than the $11 billion government cost of the retiree subsidy, because the subsidy is the cost of community-rated, adjusted per worker premiums, and under current law, the corporations are currently paying experience-rated costs for each individual. In addition, due to universal coverage under the Health Security Act, uncompensated care costs would no longer be added to private insurance payments.

The following is a summary of changes in payments for currently retired workers with employer sponsored health insurance:

- Of the $16 billion that employers and employees are paying under the current system, $6 billion is eliminated because of community rating, the change to adjusted per worker premiums, and savings to employers resulting from the elimination of uncompensated care cost-shifting. That is, when the early retirees are pooled with the rest of the population, the cost of providing them insurance decreases. In addition, under the Health Security Act, employers do not pay 80 percent of the actuarial premium, but instead pay 80 percent of a premium that has been adjusted down to take into account the presence of two worker families.[4] Of course, these costs are shared by all Americans as part of the community rating and universal coverage.

- Of the remaining $10 billion, $4 billion is received in payments from employers. This money is collected because many people aged 55 to 64 work part-time or have spouses who work. Contributions from employers of part-time workers offset the retiree and non-worker subsidies. There is $1 billion of the subsidies paid as part of the regular non-worker discount system. The additional cost of providing everyone below $90,000 or

---

[4]For example, the estimated weighted average premium for a couple without children is $3,865. There are 17,531,000 couple units in the country. Since there are 7,969,000 couple units with two adult workers, however, there are 25.5 million (17,531,000 + 7,969,000) payers contributing to the system on behalf of the couples. This is a ratio of 1.455 payers to each couple unit. Consequently, instead of $3,092 ($3,865 x 0.80), each employer need only pay $2,215 ($3,092/1.4555) for each worker who is part of a couple unit.

$115,000 with a subsidy for the employer's share of the premium is about $2 billion (recall that this decomposition is for people with current retiree health insurance only; this is only 40 percent of the retired population). Finally, the family share of the premiums plus payments made by self-employed retirees is the remaining $3 billion.

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If House goes w/ Ways + Means, how much would it cost to add retiree benefit.

~~Same~~

A from NSA - • AVO per worker
• different for non workers
subsidies

COSTS FOR CURRENT RETIREES

Look @ Ways + Means for "applicable plan."

Could do ~~as~~ base on NSA

= • # of families + average income.

(CALCULATE SUBSIDIES W/O REGARD SPECIAL SUBSIDIES.
• REMAINDER = SUBSIDY (COULD COPY).

UNDER W & M, consider not including costs.

URGENT

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

July 29, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-3479

TO: Legislative Liaison Officer -

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

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

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

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

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

COMMENTS: SENATOR MITCHELL REQUEST FOR NUMBERS TO SHOW THE DIFFERENCE BETWEEN THE ORIGINAL PHYSICIAN UPDATE PROVISIONS IN THE hsa AND THE NEW PROVISION TO CORRECT THE MVPS UPWARD BIAS.

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

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

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew 2/2P
Lynn Margherio
Judy Feder
Greg Lawler
Barry Clendenin (2)
Len Nichols
Janet Forsgren

LRM #I-3479

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

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

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

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

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

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

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

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

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

July 29, 1994

NOTE TO: Chris Jennings
Bob Pellicci

FROM: Bridgett Taylor

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

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

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

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

Thanks.

cc: Jerry Klepner
Karen Pollitz

attachments

Physician Updates

Table 1 shows actuarial projected physician fee schedule updates for 1994 through 2000, using President's budget baseline, for the following three scenarios:

(A) Current law,
(B) Current law with real GDP/capita proposal, and
(C) Current law with both the real GDP/capita proposal and and the cumulative MVPS proposal.

(Note that the current law option includes the 5 percent limit on downward MVPS adjustments. However, any option with real GDP proposal eliminates 5 percent limit since the elimination is contained in the language for that provision).

Table 2 shows actuarial projected physician fee schedule updates for 1994 through 2000, using President's budget baseline, for the following three scenarios:

(A) Current law with correcting MVPS upward bias proposal (retaining the 5 percent limit on downward adjustments to update),
(A') Current law with correcting MVPS upward bias proposal (eliminating the 5 percent limit on downward adjustments to update), and
(B) Current law with both correcting MVPS upward bias proposal and real GDP/capita proposal.

(Note that option B eliminates the 5 percent limit since the elimination is contained in the language for the real GDP proposal).

Table 1

A) Current Law	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-5.0%	-5.0%	-5.0%	-3.1%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-1.2%	-1.5%	-1.6%	0.1%

B) With GDP Only	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-8.3%	-8.0%	-4.9%	-4.0%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-4.5%	-4.8%	-1.5%	-0.8%

C) With GDP, Cum	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-8.3%	-17.9%	-15.8%	-0.6%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-4.5%	-14.4%	-12.4%	2.6%

Table 2

Projected Default Updates (CY)

A Current Law with Correct MVPS Bias	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-5.0%	-5.0%	-5.0%	-5.0%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-1.2%	-1.5%	-1.6%	-1.8%

Projected Default Updates (CY)

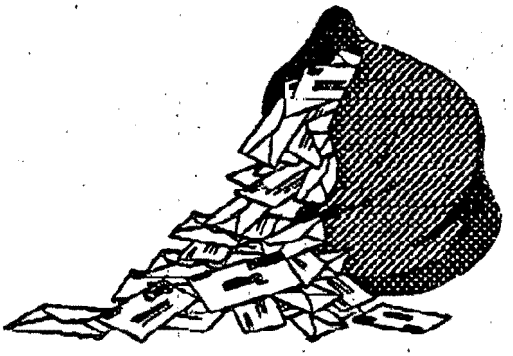
A' Current Law with Correct MVPS Bias (no 5% limit)	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-7.3%	-9.7%	-8.9%	-8.3%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-3.5%	-6.2%	-5.3%	-5.1%

B Current Law with Correct MVPS Bias and Real GDP	1994	1995	1996	1997	1998	1999	2000
MEI	2.3%	2.3%	3.4%	3.8%	3.5%	3.4%	3.2%
Perf Adj	7.1%	4.0%	-4.3%	-8.5%	-10.2%	-8.9%	-9.3%
OBRA-93 Adj	-2.3%	-2.2%					
Total	7.1%	4.1%	-0.9%	-4.7%	-6.7%	-5.5%	-6.1%

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet



URGENT

FROM: Bob Pellicci -- 395-4871

DATE: 7/29 **TIME:** 4:55 p.m

Pages sent (including transmittal sheet): 4

COMMENTS:

DO NOT SEND. document is being re-done by HHS (Gary Claxton)

TO:

STACY / CHRIS

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

FLOW OF MONEY ISSUES

1. **Payments to health plans.**

   a. Employers that offer coverage to their employees make payments directly to health plans (or, if the employer elects to provide coverage through a cooperative, or the employee elects through the cooperative). For employees that choose to take their premium contribution to FEHBP (assuming that employer did not choose FEHBP), the employer makes the payment to FEHBP.

   Employers withhold the employee's contribution and pay it to the plan along with their payments.

   b. Families without employer-provided coverage make payments directly to community-rated health plans. Families that purchase coverage through a cooperative make payments through the cooperative.

   c. Option for AFDC recipients: Permit AFDC recipients to enroll in a health plan through the State office where they qualify for AFDC. All health plans would accept applications through the State office. The State would pay premiums for such recipients directly to the plans.

   d. After the Mandate: Payments are essentially the same, except:

      i. [Changes to reflect Per Worker Premium]. Each State would contract with one HIPC in each HCCA ("designated HIPC") (or with such other entity as the State determines appropriate) to collect payments made by employers of for non-enrolling employees.

         (1) Community-rated employers would make payments for non-enrolling employees to the designated HIPC in the area where such employee resides.

         (2) Experience-rated employers could choose to make payments to one designated HIPC for all its non enrolling nationally. In such cases, the employer would be required to identify the appropriate amount to be transferred by the designated HIPC to the designated HIPCs in each HCCA where the non-enrolling employees of the employer reside.

      ii. [Change to assure universal coverage].

         -- Eliminate ability of health plans to cancel coverage for non-payment.

-- Add bad debt provisions from Senate Labor.

2. **HIPCs.**

HIPCs would be required to comply with standards established by the National Board relating to fiduciary responsibility, cash-management, and the accounting and reporting of financial matters.

. . . et .

3. **Subsidy Administration; Reconciliation.**

a. In general, States administer the household subsidies. The application and reconciliation provisions from Senate Labor appear to make sense.

b. In general, States administer the employer subsidies for community-rated employers and the Secretary of ? administers the subsidies for experience-rated employers.

Pre-Mandate. Employers seeking subsidies would make an initial application for subsidies. The application would require employers to explain how they were expanding coverage and such other information as the Secretary requires in regulation. Community-rated employers would apply to the State(s) in which their employees reside. Experience-rated employers would apply to the Secretary.

After an employer's application is approved, the employer would cap their premium payments for newly covered workers in the same manner as the described below (for post-mandate).

. . . et .

Post-mandate. Senate labor provisions appear to work. Essentially, employers cap their payments at applicable percentage of each employee's wage; there is an end of the year reconciliation that employer's make with State/Secretary. See Sections 6123, 6131 and 6207.

Add to Senate Labor provisions the following:

i. Employers that claim a subsidy for a month (by capping their payment) must file information with the health plan (or HIPC or designated HIPC, as appropriate) and with the applicable authority (State or Secretary) specifying the difference between the premium owed and the amount of subsidy claimed.

ii. Pursuant to regulations, the Secretary could require the filing of such information at such times (with the Secretary or the State, as appropriate) as is necessary to verify eligibility

. . . et .

for subsidies. The Secretary (and, in the case of community-rated employers, States) would have the authority to audit employers claiming subsidies.

iii. (Note: This really belongs in Title IX). The State, in the case of subsidies for community-rated employers, and the Secretary, in the case of subsidies for experience-rated employers, would make payments to health plans, HIPCs and designated HIPCs for the amounts of subsidies provided to such employers.

4. Filing of Premiums.

a. i. Community-rated health plans file premiums each year for each health care coverage area. The premiums for the appropriate areas are filed in each State where the health plan operates. Plans file one premium for each health care coverage area, with any marketing fees that are charged for distribution shown separately. HIPC fees are also filed separately.

ii. Each year, community-rated health plans file an actuarial certification (with such information as required by the State, consistent with rules of the Board), demonstrating that its premiums for the previous year in a community-rating area were determined on the basis of community-rating.

b. Experience-rated insured health plans negotiate premiums with eligible sponsors. Self-funded health plans calculate an estimated premium equivalent prior to each year (consistent with regulations of the Secretary of ?). Subsidies are calculated based on the premium equivalent.

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division
Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

URGENT

FROM: Bob Pellicci -- 395-4871

DATE: 7/29 **TIME:** 1:15 p.m.

Pages sent (including transmittal sheet): 3

COMMENTS:

Cleared -- note comment on 2nd page regarding CBO's scoring of proposal.

TO: STACY / CHRIS

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

SENT BY:Xerox Telecopier 7021 ; 7-28-94 ;11:30AM ; → 202 395 6140;# 3

Finance Committee Mark-up Proposal

4. Changes in Payment Methodology for PPS-Excluded Hospitals

Present Law

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis subject to a rate of increase limit on operating costs per discharge. The per discharge limit, or target amount, is updated annually.

Description of Proposal

Rehabilitation hospitals and distinct part units would be assigned their 1990 and 1991 Medicare cost reporting periods as a new base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost averaged over the two year period. The rebasing would:

(a) Hold harmless those hospitals and units under their limits by paying them their costs plus incentive payments;

(b) Provide a floor of 70 percent of the national average for each type of facility for those facilities with very low limits; and

(c) Provide a ceiling of 110 percent of the national average for each type of facility for new facilities.

The Secretary would be required to complete development of a prospective payment system for rehabilitation hospitals and distinct part units, including a patient classification system, and present recommendations to Congress by October 1, 1996.

Conditions for exclusion of rehabilitation hospitals and distinct part units from the PPS would be expanded to account for the impact of new technologies and survival rates and the changes in the practice of rehabilitation medicine over the past decade.

Any long term hospital meeting a two year financial loss test and a low-income patient load test, would be assigned an average of their 1990 and 1991 Medicare cost reporting periods as a new base year. In any subsequent two year period in which both tests were met, the Secretary would be required to assign the hospital a new base year averaging the costs of the two years. A hospital meets the financial loss test if it has had two consecutive years of losses where its costs exceed its limit. A hospital satisfies the low-income patient load test if it has a Medicare disproportionate share patient percentage of greater than 25 percent.

Effective Date

October 1, 1994.

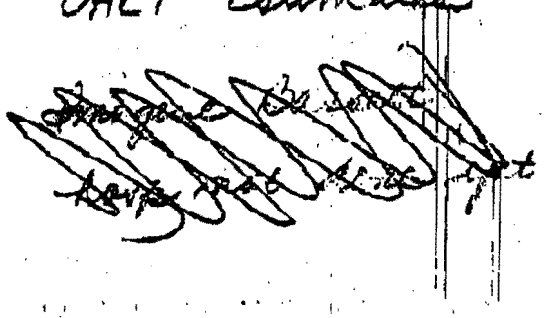
NARF REBASING PROPOSAL 7/28/94
COST/(SAVINGS)
(millions)

YEAR	REBAR
1995	$110
1996	115
1997	120
1998	125
1999	130
2000	135
2001	140
2002	145
2003	150
2004	155
TOTAL	$1,325

REBASING PROPOSAL FOR LONG-TERM CARE HOSPITALS
COST/(SAVINGS)
(millions)

YEAR	
1995	$10
1996	15
1997	15
1998	15
1999	20
2000	20
2001	20
2002	20
2003	20
2004	25
TOTAL	$185

OACT Estimates Total $1,510



NOTE: CBO Estimate total is $2.1 billion

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

FROM: Bob Pellicci -- 395-4871

DATE: 7/29 **TIME:** 5:05 P.M

Pages sent (including transmittal sheet): 2

COMMENTS:

Cleared, no changes.

TO:

STACY / CHRIS

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

I-3465

Add to Presumptive Eligibility Section:

Under 1b.

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

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

# of pages ▶

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Fax #

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

FAX

DATE: _____ **TIME:** _____

TO:

RECIPIENT: Chris Jennings

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: John Hilley

ORGANIZATION: _____

NUMBER OF PAGES: 4
(including this one)

COMMENTS: Draft letter we're working on.

National Health Care Commission

A National Health Care Commission would be established to monitor and make recommendations with respect to trends in health insurance coverage and costs. The Commission would consist of seven members to be appointed by the President based on their expertise and national recognition in the fields of health economics, including insurance practices, benefit design, provider organization and reimbursement, and labor markets.

The Commission would be appointed by the President within nine months of enactment and confirmed by the Senate. The President would designate one individual to serve as Chairperson of the Commission. The terms of members of the Commission shall be for six years, starting on January 1, 1996, except that of the members first appointed three shall be for a term of four years and three for a term of five years, other than the Chairperson.

The Commission may be advised by expert private as well as public entities which focus on the economic, demographic, and insurance market factors that affect the cost and availability of insurance. The Commission would conduct analyses of health care costs and health care coverage.

Beginning in 1998, the Commission would issue annual reports detailing trends in health care coverage and costs. The reports will include measurements of structure and performance of both costs and coverage broken down nationally, by state, and to the extent practical by health care coverage area.

Among other things, the Commission would report generally on:

Demographics and employment status of the uninsured and reasons why they are uninsured;

Structure of health delivery systems;

Status of insurance market reforms;

Development and operations of health insurance purchasing cooperatives;

Success of market mechanisms in expanding coverage and controlling costs among employers and among households;

Success of high cost health insurance premium tax in controlling costs;

Adequacy of subsidies for low-income individuals and employers;

Success of subsidy program in expanding coverage through employers and among households;

The Commission would also issue detailed findings on the per capita cost of

health care, including the rate of growth by type of provider, by type of payor, within States and within health care coverage areas. Such findings would also include the expected rate of growth in per capita health care costs, the causes of health care cost growth, and strategies for controlling such costs.

On January 15, 1999, the Commission would determine whether the voluntary system has achieved 95 percent coverage of all Americans. If the Commission determines ..(combine paper on mandate trigger)

On January 15, 1999, the Commission would determine whether the market reforms and assessments in this legislation have succeeded in controlling health care costs relative to the target rates of growth. Such determinations would be made on a national and State basis.

If the target rate of growth for national per capita premium growth have not been met, the Commission will consider and recommend to Congress a means of controlling health care costs to the target set in this legislation or to an alternative target if the Commission determines that would be more appropriate. Congress shall consider such Commission recommendation under the same procedures, and at the same time, as it considers the Commission recommendation for achieving universal coverage.

If Congress fails to pass such legislation, stand-by premium caps will go into effect requiring health plans to limit future per capita premium increases to the target level.

Alternative A: If at any point in the future, the Commission determines that health care costs in a State have failed to meet the per capita premium targets, standby premium caps will go into effect in that State.

Alternative B: If at any point in the future, the Commission determines that one half the insured population in the nation is enrolled in health plans subject to the high cost premium assessment, the following year standby premium caps will go into effect absent Congressional action.

Alternative C: If at any point in the future, the Commission determines that more than half of the insured population in a State is enrolled in health plans subject to the high cost plan assessment, the following year standby premium caps will go into effect in that State.

QUESTION: HOW DO YOU BREAK THIS DOWN BY STATE; TO INDIVIDUALS RESIDING IN THE STATE? TO HEALTH PLANS IN A STATE? TO PROVIDERS IN A STATE?

Alternative D: The Commission will make a determination whether the subsidy caps in the legislation are undermining the affordability of health insurance premiums to subsidized households and businesses. If the Commission determines that such subsidies are being seriously eroded, it will recommend to Congress a means of making insurance more affordable including through higher subsidies or health care cost controls, which

Congress will consider under special fast track procedures.

A. PRE-MANDATE EMPLOYER SUBSIDIES

1. In general, employers would be eligible for subsidies under this _____ if they expand their health benefits plan to employees (or classes of employees) that were not previously covered.

2. To be eligible for such subsidies, the employers would have to:

   a. Meet the general requirements for employers offering coverage to employees (e.g., offer choice of three plans and a HIPC, payroll deduction, etc.).

   b. Contribute at least 50% of the cost of coverage for each class of family enrollment (e.g., the employer must offer to contribute the minimum percentage toward the appropriate class of family enrollment for each employee).

   c. Expand coverage to all employees of the same type (e.g., full-time or part-time workers).

   d. Self-employed people generally would not be eligible for the subsidy. A sole proprietorship with at least 3 full-time employees (including the sole proprietor) that reports a minimum amount of wages (as defined in regulation by the Secretary of [?] would eligible for the subsidy.

3. Employers requesting subsidies under this ____ would be required to certify that they had not offered health benefits to the employees for whom they were requesting the subsidy.

   a. An employer would be considered to not have offered health benefits to an employee if the amount of the contribution to the worker was less than $500 (annualized).

   b. The Secretary of [?] would establish regulations to define the types of situations for which an employee would be determined to previously have been offered or covered by an employer's health plan. For example, a new employee in a position that was previously covered would not be eligible for subsidies.

4. The subsidies would be available to an employer for only five years.

   a. An employer would be eligible for the subsidy only once. In general, a sole proprietor or partner that requests a subsidy would be required to certify that they had not owned a business or enterprise that had previously received a subsidy under this _____. The Secretary of [?] would establish regulations relating to the eligibility enterprises that are related to or successors of enterprises that previously received the subsidies under this _____.

b. The subsidies would phase-out for an employer as described below.

5. The subsidy for an employer under this _____ for a previously uninsured worker would be calculated as follows:

a. Subsidy = 50% of the lower of (a) the reference premium or (b) the weighted average premium of the HIPC chosen by the employer, minus 8% of the individual's wages, but in no case less than zero.

The reference premium and the weighted average HIPC premiums would be based in the applicable class of family enrollment for the employee.

b. In the fourth and fifth year that an employer receives subsidies under this _____, the subsidy is reduced. In the fourth year, the subsidy is based on 75% of the 50% contribution level (or 37.5% of the reference or average HIPC premium). In the fifth year, the subsidy is based on 50% of the 50% contribution level (or 25% of the reference or average HIPC premium).

c. Employer contributions that exceed 50% of the weighted average premium of the HIPC chosen by the employer are not subsidized.

A. SPECIAL SUBSIDIES FOR TEMPORARILY UNEMPLOYED

1. **Eligibility.** In general, workers that lose their jobs would be eligible for enhanced income protection under the Low-Income Voucher Program.

   a. Workers that have been employed on a full-time basis (or a substantially full-time basis, as defined in regulations by the Secretary of [?]) and that lose employment would be eligible for the enhanced income protection under the Low-Income Voucher Program.

   b. The enhance protection would apply only for uninsured members of the family (e.g., members of the family covered by other insurance at the time a worker loses his or her job would not be eligible for the enhanced income protection).

   c. A family that is otherwise eligible for a subsidy under this program is required to take advantage of any employer contribution (for which the family is otherwise eligible) towards the standard benefits (and, if multiple employer contributions are available, to take advantage of the contribution that results in the lowest possible contribution by the family).

2. **Amount of Enhanced Income Protection.**

   a. For families eligible for enhanced income protection under this program, the family's income for the purposes of calculating eligibility for subsidies under the Low-Income Voucher Program would be adjusted as follows:

      (1) Unemployment compensation (UI) would not be counted in determining family income under the Low-Income Voucher Program, and

      (2) In determining family income for the year, the family would be permitted to reduce the amount of any wages earned in a month by 75% of the monthly poverty level (applicable to the family's size). For wages earned prior to the period of unemployment, the reduction would be applied in determining the amount of subsidy the family would receive during the period of unemployment (but not more than six months). For wages earned after the period of unemployment (but during the period of determining family income), the reduction would be applied through any reconciliation process related to the subsidies received by the family for the year.

   b. A family is eligible for enhanced income protection under this _____ for the lesser of the period of unemployment or six months.

E. OUTREACH TO MAXIMIZE PARTICIPATION

1. **Presumptive eligibility at point of service.** To maximize participation, each participating State would be required to have a system of presumptive eligibility for subsidies, as approved by and subject to rules of the _____.

   a. A participating State would be required to develop and make available to providers of health care a simple application for presumptive eligibility for full premium subsidies (e.g., for people at or below 75% of poverty, pregnant women and kids below 185% of poverty, etc.). The application must provide for a simple declaration of eligibility for a full subsidy, as well as the opportunity to enroll in a community-rated health plan.

   b. A provider -- as a condition of accepting payment in a year from any certified health plan -- would be required to provide to any uninsured patient the application for presumptive eligibility. The provider would be required to accept from a patient a completed application, and to forward the application to the appropriate administrative entity (as designated by the State).

   c. An individual who enrolls in a plan through the presumptive eligibility process would be considered to have been enrolled in a plan as of the date of submission of their application (including submission to a provider).

   d. Presumptive eligibility would apply for a period of two months. States would be exempt from responsibility for administrative errors (for inaccurate subsidy determinations) with respect to presumptive eligibility.

   e. During the two months of presumptive eligibility, a State would be required to provide a subsidy recipient with the opportunity to apply for more permanent eligibility.

   f. If an individual is found not to be eligible for a full premium subsidy (either at the time of application for more permanent eligibility or through a year-end reconciliation), the individual shall still be considered to have been eligible during the two months of presumptive eligibility.

2. **Other outreach efforts.** Participating States must make additional efforts, consistent with rules developed by _____, to provide maximum reasonable opportunities for individuals to apply for and receive subsidies. These

efforts must include, at a minimum, making subsidy applications accessible at locations where eligible individuals are likely to obtain them (e.g., schools).

TRIGGERED AFFORDABILITY TARGETS

AFFORDABILITY TARGET TRIGGER FOR COMMUNITY-RATED PLANS

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

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

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

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

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

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

AFFORDABILITY TARGETS FOR COMMUNITY-RATED PLANS

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

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

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

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

COST CONTAINMENT FOR EXPERIENCE-RATED PLANS

OPTION 1:

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

OPTION 2:

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

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

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

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

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

July 28, 1994
1:44 pm

DRAFT

B. ADDITIONAL SUBSIDIES FOR UNINSURED KIDS

1996

1. **Eligibility:** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Infants who are currently covered to 133 percent of poverty, with an option to 185 percent of poverty, would be covered up 185 percent of poverty.

   b. Children up to age 6 who are currently covered up to 133 percent of poverty would be covered up to 185 percent of poverty.

   c. Children between ages 6 and 19 who are currently covered up 100 to percent of poverty on a phased-in basis would be covered up to 185 percent of poverty.

   d. States that currently use 1902(r)(2) to cover children at higher income levels could continue to cover these persons, or be treated as other states with 100% Federal financing only for those with income up to 185 percent of poverty.

2. **Coverage through Private Plans:** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, State options include:

   a. Family option of employer plan: A state may elect to enroll children in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll the children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll the children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d. A state may elect to enroll children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for the services covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans for those who are in the states' Medicaid eligible groups prior to the 1996 expansion.

3. **Financing:** The Federal government would provide the following Federal matching through Medicaid.

a. All current eligibility categories would continue to matched at the state's regular Medicaid matching rate (FMAP), except as noted below.

1. Coverage for infants with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

2. Coverage for children up to age 6 with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

3. As of 1/1/96, coverage for children born before 10/1/83 up to age 19 (children ages 14 through 18) with family incomes above AFDC but below 100 percent of poverty would be 100 percent Federally financed.

4. Coverage for children age 7 up to age 19 with family incomes between 100 percent and 185 percent of poverty would be 100 percent Federally financed.

5. Coverage for children in 1115 waiver states who are currently covered at various levels of income would be 100 percent Federally financed up to 185 percent of poverty. Individuals covered through the 1115 waiver above the 185 percent threshold would no longer be eligible for Federal financing; i.e., all Statewide waivers would be terminated.

6. Children in states that use more liberal eligibility rules under 1902(r)(2) in families with incomes up to 185 percent of poverty would be covered at the levels indicated above. Children covered

with family income above the 185 percent threshold would no longer be covered; i.e., all 1902(r) changes would be terminated.

1997 And Subsequent Years

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

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

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

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

2. **Amount of Subsidy:**

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

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

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

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

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

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

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

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

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

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

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

6. **Wrap-around Benefits:** Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services) for those who are in the states' Medicaid eligible groups prior to the 1996 expansion.

C. ADDITIONAL SUBSIDIES FOR PREGNANT WOMEN

1996

1. **Eligibility:** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Pregnant women who are currently covered to 133 percent of poverty, with an option to 185 percent, would be covered up 185 percent of poverty.

   b. States that currently use 1902(r)(2) to cover pregnant women at higher income levels could continue to cover these persons, or be treated as other states with 100 percent Federal financing only for those with income up to 185 percent of poverty.

   c. As under current Medicaid law, pregnant women who would otherwise lose Medicaid eligibility due to a change in income remain Medicaid-eligible throughout their pregnancy and three-month post-partum period.

2. **Coverage through Private Plans:** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a. Family option of employer plan: A state may elect to enroll pregnant women in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll pregnant women in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll pregnant women in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

   d. A state may elect to enroll pregnant women in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid in that state.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services) for those who are in the states' Medicaid eligible groups prior to the 1996 expansion.

3. **Financing:** The Federal government would provide the following Federal matching through Medicaid.

   a. All current eligibility categories would continue to matched at the State's regular Medicaid matching rate (FMAP), except as noted below.

      1. Coverage for pregnant women with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

      2. Coverage for pregnant women in 1115 waiver states who are currently covered at various levels of income would be 100 percent Federally financed up to 185 percent of poverty. Individuals covered through the 1115 waiver above the 185 percent threshold would no longer be eligible for Federal financing; i.e., all Statewide waivers would be terminated.

      3. Pregnant women in states that use more liberal eligibility rules under 1902(r)(2) in families with incomes up to 185 percent of poverty would be covered at the levels indicated above. Individuals covered with family income above the 185 percent threshold would no longer be covered; i.e., all 1902(r) changes would be terminated.

1997 And Subsequent Years

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

   a. Pregnant women would not be eligible for this subsidy if they have available an employer's plan where the employer offers to contribute at least 80 percent (could make it a lower level if there would be an

assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a policy covering the women.

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

c. Eligibility would continue for three months after delivery.

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

e. As under current Medicaid law, pregnant women who would otherwise lose Medicaid eligibility due to a change in income remain Medicaid-eligible throughout their pregnancy and three-month post-partum period.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid in that state.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services) for those who are in the states' Medicaid eligible groups prior to the 1996 expansion.

2. **Amount of Subsidy:**

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

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

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

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

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

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

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

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

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

D. SUBSIDIES FOR PEOPLE LEAVING WELFARE FOR WORK

1996

1. **Policy:** To provide subsidies for people leaving welfare for work, the existing Medicaid transition benefit would be extended to cover eligible individuals for 24 months.

2. **Duration of Coverage:** Current law allows for a simple 6-month extension, and then a more complex second 6-month extension. We recommend eliminating the second extension and lengthening the first by 18 months to create a single 24-month transition benefit.

3. **Eligibility:** Currently, the two-phased extension terminates if the family no longer has a dependent child. In the health reform context, family policies are provided to various family configurations, not just to couples with dependent children. For this reason, as well as to provide additional work incentives, we recommend striking the "termination for no dependent child" provision.

   In addition to those who have been off of welfare for work for one year, those who are in their second year off of welfare for work and who are currently uninsured would be eligible for this program.

4. **Coverage through Private Plans:** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a. Family option of employer plan: A state may elect to enroll a caretaker relative and dependent children in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll the caretaker relative and dependent children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d. A state may elect to enroll the caretaker relative and dependent children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services).

5. **Financing:** The Federal government would cover 100 percent of the expense related to this expansion.

1997 And Subsequent Years

1. **Eligibility:** Welfare recipients who return to work would receive subsidized coverage for two years.

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

3. **Wrap-around Benefits:** Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans.

Revenue Estimate of High Cost Plan Assessment

Assumes Mandate in 2000 (No Premium Caps)

(Fiscal Years; $ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995–1999	1995–2004
35 Percent High Cost Plan Assessment	0	0	0.6	1.2	2.1	7.5	12.2	16.1	21.9	28.7	3.9	90.3
25 Percent High Cost Plan Assessment	0	0	0.4	0.8	1.4	5.1	8.2	10.8	14.7	19.2	2.6	60.6

Department of the Treasury
Office of Tax Analysis

July 23, 1994

NOTE: Based on initial specifications which assumed that any plan would be subject to the assessment if the premium exceeded target. Does not take i contained in July 21 specification, in which a plan would only be subject to the assessment if, in addition, the weighted average premium for plar exceeded the reference premium for the area.

Insurance Assessments in July 22 Option

Assessments as Percent of Cost of Average Plan

	2000		2004	
	Community Rated Plans	Experienced Rated Plans	Community Rated Plans	Experienced Rated Plans
Mandate in 2000				
Academic Health Centers	1.75%	1.75%	1.75%	1.75%
Risk Assessment 1/		1.5%		1.5%
25% High Cost Plan Assessment 2/	1.4%	2.0%	3.2%	3.5%
Total	3.2%	5.2%	4.9%	6.7%
% of Plans Subject to High Cost Assessment	99%	71%	100%	100%

1/ Community-rated plans would receive an offsetting payment, equal in the aggregate to the revenues collected by the risk assessment.

2/ Based on initial specifications which assumed that any plan would be subject to the assessment if premium exceeded target. Does not take into account modification contained in July 21 specification, in which a plan would only be subject to the assessment if, in addition, the weighted average premium for plans in a region exceed the reference premium for the area. Ratio is the gross revenue as percent of premiums for taxed plans.

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OPTION C - HCFA Revised

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

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PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
PART A - Savings/Receipts													
Hospital Update at MB-0.5 (1997-2000)	0	0	0	-587	-1,050	-1,600	-1,776	-2,035	-2,228	-2,440	-1,637	-3,237	-11,716
Reduce Indirect Med. Ed. Payments (5.2%)	0	-964	-1,319	-1,535	-1,741	-1,964	-2,210	-2,480	-2,778	-3,104	-5,559	-7,523	-18,095
Reduce Payments for Hospital Capital	0	-808	-977	-1,216	-1,598	-2,097	-2,163	-2,449	-2,651	-2,872	-4,599	-6,696	-16,831
Phase Down DSH (20% reduction)	0	-112	-370	-1,006	-1,097	-1,196	-1,304	-1,422	-1,551	-1,692	-2,585	-3,781	-9,750
Cash Lag During GME Funds Transfer	0	-61	-92	-191	-264	-336	-414	-499	-591	-691	-608	-944	-3,139
Extend OBRA93 SNF Update Freeze	0	-63	-150	-188	-204	-218	-233	-249	-266	-284	-605	-823	-1,855
Prohibit PPS Exemptions for New LTC Hosp	-20	-40	-70	-100	-130	-170	-220	-270	-320	-370	-360	-530	-1,710
Part A Interactions	0	0	26	109	203	311	358	399	445	498	338	647	2,349
Extend HI Tax to All State/Local Employees	0	-1,595	-1,590	-1,485	-1,470	-1,360	-1,340	-1,205	-1,055	-900	-6,140	-7,500	-12,000
PART A - Costs													
Medicare Dependent Hospitals (ends FY99)	40	50	50	50	10	0	0	0	0	0	200	200	200
Rural Transition Grants (authorization; non-add)	30	30	30	30	30	0	0	0	0	0	150	150	150
Part A Sub-total	20	-3,593	-4,492	-6,149	-7,341	-8,630	-9,302	-10,210	-10,995	-11,855	-21,555	-30,187	-72,547
PART B - Savings/Receipts													
Use Real GDP in MVPS for Physician Services	0	0	-258	-803	-1,606	-2,477	-3,305	-4,206	-5,301	-6,589	-2,667	-5,144	-24,545
Eliminate Formula Driven Overpayment	-765	-1,012	-1,333	-1,760	-2,346	-3,181	-4,224	-5,480	-7,057	-9,086	-7,216	-10,397	-36,244
Competitive Bidding for Lab Services	-47	-236	-266	-298	-333	-373	-419	-471	-531	-599	-1,180	-1,553	-3,573
Competitive Bidding for Oxygen/MRI/CT	-31	-155	-172	-189	-206	-224	-244	-267	-292	-319	-753	-977	-2,099
Extend Part B Premium at 25% of Costs (net)	0	542	1,432	2,116	1,504	154	-1,368	-3,267	-5,589	-7,230	5,594	5,748	-11,706
Income-Related Part B Premium	0	-10	-1,730	-1,230	-1,660	-2,010	-2,470	-3,030	-3,700	-4,520	-4,630	-6,640	-20,360
PART B - Costs													
Incentives for Physicians for Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0
Prohibition on Balance Billing	0	118	195	213	230	248	268	289	312	337	756	1,004	2,210
Payments to Eye/Ear Specialty Hospitals	2	3	3	0	0	0	0	0	0	0	8	8	8
Payments for MD Assistants/Nurse Practitioners	0	0	100	170	210	250	310	380	470	580	480	730	2,470
Part B Sub-total	-841	-750	-2,029	-1,781	-4,207	-7,613	-11,452	-16,052	-21,688	-27,426	-9,608	-17,221	-93,839
PARTS A and B - Savings													
20% Copayment for Home Health Services	-201	-2,237	-2,661	-3,000	-3,240	-3,513	-3,820	-4,144	-4,495	-4,875	-11,339	-14,852	-32,186
Extend OBRA93 Medicare Secondary Payer	0	0	0	0	-1,219	-1,788	-1,906	-2,131	-2,163	-2,303	-1,219	-3,007	-11,510
HMO Payment Improvements	-30	-90	-165	-250	-350	-400	-440	-490	-540	-595	-885	-1,285	-3,350
Reduce Routine Cost Limits for HHAs	0	0	-292	-551	-669	-732	-800	-876	-956	-1,049	-1,512	-2,244	-5,925
Expand Centers of Excellence	0	-100	-110	-90	-80	-60	-30	-10	0	0	-380	-440	-480
PARTS A and B - Costs													
Repeal Medicare/Medicaid Data Bank	57	154	347	388	---	---	---	---	---	---	946	946	946
Parts A and B Sub-total	-174	-2,273	-2,881	-3,503	-5,558	-6,493	-6,996	-7,651	-8,154	-8,822	-14,389	-20,882	-52,505
HCFA Proposed Additions (7/21/94):													
Lower MSP Threshold from 100 to 20 employees	0	0	0	-176	-236	-303	-342	-266	-392	-420	-412	-715	-2,135
Extend ESRD Secondary Payer to 24 months	0	-84	-119	-127	-140	-154	-169	-186	-205	-225	-470	-624	-1,409
Reduce 1995 Phys Fee Update (-3%; exempt PC)	-252	-416	-458	-499	-540	-583	-629	-680	-735	-794	-2,165	-2,748	-5,586
Correct MVPS Upward Bias (eff. FY95 MVPS)	0	0	-20	-210	-910	-1,880	-2,770	-3,600	-4,490	-5,480	-1,140	-3,020	-19,360
MEDICARE TOTAL, including HCFA Additions	**-1,247**	**-7,116**	**-9,999**	**-12,445**	**-18,932**	**-25,656**	**-31,660**	**-38,645**	**-46,659**	**-55,022**	**-49,739**	**-75,397**	**-247,381**
Possible Addition to Reach Savings Targets													
Reduce Payments to High-Cost Medical Staffs	0	0	0	-524	-804	-763	-820	-937	-971	-952	-1,328	-2,091	-5,771
MEDICARE TOTAL, including all Additions	**-1,247**	**-7,116**	**-9,999**	**-12,969**	**-19,736**	**-26,419**	**-32,480**	**-39,582**	**-47,630**	**-55,974**	**-51,067**	**-77,488**	**-253,152**

OPTION C - HCFA Revised

MEDICARE OPTION - SAVINGS AND COSTS

Estimated CBO scoring
All estimates are preliminary and unofficial
($ millions, by FY)

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PROVISION	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	5-yr Total 1995-1999	6-yr Total 1995-2000	10-yr Total 1995-2004
HCFA Proposed $25 billion Add'l Package													
Hospital Update at MB-2 (FY2001-2004)	0	0	0	0	0	0	-1,896	-4,340	-7,128	-10,408	0	0	-23,772
Reduce DSH Additional 5% (total = 25%)	0	-28	-93	-252	-274	-299	-326	-356	-388	-423	-647	-946	-2,439
Part A Interactions	0	0	0	0	0	0	200	200	200	200	0	0	800
Additional Package Sub-total	0	-28	-93	-252	-274	-299	-2,022	-4,496	-7,316	-10,631	-647	-946	-25,411
TOTAL, with HCFA $25 billion additions	-1,247	-7,144	-10,092	-13,221	-20,010	-26,718	-34,502	-44,078	-54,946	-66,605	-51,714	-78,434	-278,563