URGENT

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

July 25, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-3403

TO: Legislative Liaison Officer -
TREASURY - Marina Weiss
LABOR - Robert A. Shapiro - (202)219-8201 - 330

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 Proposed Report RE: S 1757, Health Security Act

DEADLINE: 4:00 P.M. July 25, 1994

COMMENTS: KEN THORPE REQUESTED EXPEDIATED CLEARANCE -- The attached provides methods for congressional district analysis.

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
Jack Lew
Chris Jennings
Lynn Margherio
Judy Feder
Jerry Klepner/Andrea Levario
Greg Lawler
Len Nichols
Barry Clendenin (2)
Shannah Koss
Janet Forsgren

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 Proposed Report 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

Methods for Congressional District Analysis:

Uninsured Counts: Employed Uninsured and Uninsured Children
Data: Census; CPS
State percent of uninsured who are (1) employed, (2) unemployed, (3) armed forces, and (4) less than 16 years were applied to the Census' CD counts of the same populations adjusted to CPS 1992 totals. The CD totals were constrained to sum to the state CPS number of uninsured.

Uncompensated Care
Data: Census; CBO reported uncompensated care in the system ($25 billion)
The total amount of uncompensated care in the system was multiplied by the CD's share of the national number of uninsured persons (estimated as described above).

Number of People with Pre-Existing Condition Clauses in Employee Medical Plans
Data: Census; Employee Benefits Survey Brief, Bureau of Labor Statistics; November 1992
The 1989 Employee Benefits Survey of medium and large private establishments found that the percent of health care participants with a waiting period for pre-existing conditions was 40% for all plans, 47% for non-HMOs and 1% for HMOs. This 40% was applied to all employed, insured individuals in the CDs to estimate the number of employed, insured people with pre-existing condition clauses.

Number of People with Lifetime Limits on their Health Insurance Policy
Data: Census; Bureau of Labor Statistics
In 1992, 74% of full-time, insured employees in small private establishments had health plans with maximum limits in 1991; 76% of full-time, insured employees in medium and large private establishments had health plans with maximum limits; and 80% of state and local government employees. The national percentage of 76% was applied to the CD number of employed, insured individuals to estimate the number of insured people in the CD with lifetime limits on their health plan.

Number of Women Without the Recommended Breast Cancer Screening
Data: Census; Public Health Service
The proportion of women aged 50 years and over who had a clinical breast examination and a mammogram in the past two years totalled 51% in 1992, according to the Public Health Service's "Healthy People 2000 Review, 1993." In order to break this national figure down to the Congressional District level, we calculated 49% (100%-51%) of each District's 50 and over female population, which was obtained from the 1990 National Census.

Mammography remains the most effective method of detecting breast cancer in its early, most curable stage. Nearly one-third of the deaths from breast cancer can be prevented with such screening.

Number of Two-Year Olds Without the Recommended Immunizations
Data: Census; Centers for Disease Control and Prevention
Although state laws assure that over 96 percent of children are adequately vaccinated by kindergarten, about 15 to 35 percent of children under age two are inadequately protected against vaccine preventable childhood diseases such as measles. Between 11 to 15 vaccine doses are due by age two, requiring five visits to health care providers. This is about 80 percent of all vaccine doses recommended for children.

Vaccines are the most powerful and cost-effective ways to prevent nine infectious diseases in children. Cases of measles, polio and other diseases have decreased by over 90 percent since the introduction of vaccines. For every dollar spent on measles/mumps/rubella (MMR) vaccine it is estimated that over $21 dollars is saved. For diphtheria/tetanus/pertussis (DPT) vaccine the savings is over $30 for every dollar spent and over $6 saved for every dollar spent on polio vaccine. Despite ongoing and substantial efforts to improve the vaccine delivery system in the United States, vaccination levels for two year olds remain below 90 percent. The national goal is to adequately immunize at least 90 percent of the nation's two year olds by 1996. In addition, the Centers for Disease Control and Prevention (CDC) has reported that coverage varies by and are substantially lower in some population groups, especially those underserved by the health care system. Recently CDC found that children living below the federal poverty level were less well vaccinated than others.

National estimates of vaccination coverage were calculated annually from 1959-1985 but not for 1986-1990. The most recently available state level data has been done through retrospective school enterer surveys. This type of survey is a multi-stage sample of school health records of current kindergarten or first grade children. This method allows annual assessment of changes in coverage and of the effect of changes 3 to 4 years ago. The most complete state data available was collected in 1992-1993 for children who would have been two years old in 1989. Where data for 1989 was not available 1988 data was used. "Adequately immunized" is defined in these data sets as a two-year old having received four doses of DPT, three doses of polio, and one dose of MMR. South Carolina's data were missing from both surveys, so a different source was used. In June 1992 South Carolina conducted an immunization status assessment of its public health clinics and reported 46 percent of two year olds received 4 doses of DTP, 3 doses of polio, one dose of MMR, and one dose of Hib (Haemophilus influenza Type b). It is estimated that 70 percent of two year olds receive their immunizations in public health clinics in South Carolina. The state percentages of children who were adequately immunized were subtracted from 100% to get the states' percentages of children who were not adequately immunized. These state percentages were multiplied by the number two-year olds in the states' congressional districts. The number of two-year olds was derived from the 1990 Census' reported one- to two-year olds at the district level; it was assumed that half of the one- to two-year olds were two-year olds.

Bruce + Fredda
1507 Noyes Dr.
Silver Spring, MD
20910

07/06/94 13:25 ☎002

TRANSITION EMPLOYER SUBSIDIES FOR NON-INSURED WORKERS: TOTAL EMPLOYER PREMIUM PAYMENTS AS A PERCENT OF EMPLOYEE WAGE

Worker Wage:	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
$12,000 & Under......	1/	1/	0%	2%	4%	6%	6%	6%	6%	6%
$12,001-$13,000......	1/	1/	0%	2%	4%	6%	7%	7%	7%	7%
$13,001-$14,000......	1/	1/	0%	2%	4%	6%	8%	8%	8%	8%
$14,001-$15,000......	1/	1/	0%	2%	4%	6%	8%	9%	9%	9%
$15,001-$16,000......	1/	1/	0%	2%	4%	6%	8%	10%	10%	10%
$16,001-$17,000......	1/	1/	0%	2%	4%	6%	8%	10%	11%	11%
$17,001-$18,000......	1/	1/	0%	2%	4%	6%	8%	10%	12%	12%

1/ No subsidies available in 1995 and 1996.
NOTE: Employer subsidies phase out for workers with wages between $18,000-$28,000.

07/06/94 13:26 003

TABLE 2: PHASE IN OF EMPLOYER SUBSIDIES FOR CURRENTLY INSURED WORKERS

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Percent of Maintenance Subsidy Available to	0%	0%	20%	30%	40%	50%	60%	70%	100%	100%

HEALTH CARE REFORM: POSSIBLE COMPROMISE

- <u>No Mandates</u>. Under this option, there would be no mandate on either employers or individuals to purchase health insurance.

- <u>Subsidies Encourage Participation</u>. Generous subsidies would be available to encourage both employers and employees to purchase insurance voluntarily. The subsidy system would not go into effect until 1997, allowing offsetting Medicare cuts and tobacco taxes to accrue in a trust fund.

- <u>Employer Subsidies</u>. All firms would ultimately be eligible for the same subsidies. But to encourage firms to provide coverage to non-insured workers, firms would initially be eligible for more generous subsidies for uninsured workers (earning up to $18,000) than would be available to firms for already insured workers. Offering such generous subsidies upfront will ease the transition for firms which provide coverage to uninsured low and moderate wage employees. Specifically:

    - For currently uninsured workers earning up to $18,000, firms would initially have their share of insurance costs ***wholly offset*** if they chose to pick up their employees' health costs.

    - These transitional subsidies would eventually be phased down to a permanent maintenance level: In the second year, the employer's total payment would be capped at 2 percent of the worker's wage; growing each year thereafter by 2 percentage point increments up to the permanent subsidy level for that worker. (See attached Table 1.) NOTE: We would like CBO's advice on how to modify the phase down structure so that it would maximize the amount that employers can reasonably pass back to their employees annually.

    - The permanent subsidies would cap employer premium payments between 12 percent and 6 percent of each worker's individual wage, based on the employee's wage, for employees earning up to $18,000. The subsidy would be phased out for workers earning between $18,000 and $28,000.

    - During the transition, employer subsidies for currently insured workers would be somewhat below the maintenance level. In the first year, currently insuring firms would calculate the federal subsidy to which they would be entitled under the permanent subsidy regime, and they would receive 20 percent of that total. That percent would grow to 30 percent in the second year, 40 percent in the third year, 50 percent in the fourth year, 60 percent in the fifth year, 70 percent in the sixth year, and 100 percent in the eighth year. (See attached Table 2.)

    - The caps on employer premium payments would apply regardless of what portion of the premium the employer chose to pay.

    - Assume provisions to minimize gaming by both employers and employees.

- <u>Anti-Discrimination Clause</u>. A firm's coverage policy must be consistent across its entire workforce. That is, a firm that contributes to the insurance costs of any of its full-time workers must offer the same contribution to all of its full time workers. Similarly, a firm offering insurance to any of its part-time workers must offer it to all part-time workers. (Senate Finance Committee Chairman's mark.)

- **Individual Subsidies.** For those individuals receiving coverage through an employer, their individual share would be capped at 3.9 percent of income, based on a sliding scale up to 150 percent of poverty. The 3.9 percent cap would apply to any shared employee/employer contribution scheme, regardless of what portion of the premium the individual had to pay. Individuals without employer coverage who pay the full premium themselves would pay both the employer and individual share, subject to the same caps. For example, an individual whose wage would have capped his employer's payment at 10 percent of the worker's wage would pay up to 13.9 percent of his income on his own insurance (10 percent + 3.9 percent).

- **Curbing Cost Increases.** Plans are free to set per capita premiums at any level they want, but to protect the federal government from higher costs and encourage cost constraints, high cost plans would pay a 35 percent assessment on the amount by which their premiums exceed target growth rates. (Allowable growth rates for self-insuring firms would include a factor for age changes in their workforce.) The assessment would be set at a level designed to protect the federal government against higher subsidy costs. The targets would be as follows:

1996:	CPI + 3.0%
1997:	CPI + 2.5%
1998 & beyond:	CPI + 2.0%

- **Minimizing Federal Risk.** After the transition period, subsidies would be based on target growth rates, not actual growth. This would ensure that premium cost increases above the target rate would be borne by individuals and businesses, not by the federal government.

- **PAYGO Offsets.** This proposal includes the HSA cigarette tax and the approximately $70 billion in five year Medicare cuts included in the Senate Mainstream proposal.

- **Insurance Market Reforms.** Insurance market reforms must be modified to avoid adverse selection. Modifications include allowing both age adjustments for community rating (2 to 1 age band) and 6 month pre-existing condition exclusions for the currently uninsured.

- **Community Rating Threshold/Assessment.** Firm size threshold for community rating would be reduced from 5,000 to 500. Firms with more than 500 employees would be assessed 1 percent of payroll. All firms, regardless of size, would be eligible for employer subsidies.

- **Benefits Package.** Actuarial equivalent of the Blue Cross/Blue Shield standard option. Assume no outyear expansion.

- **Medicaid Population.** Integrate Medicaid population into the health system in a manner similar to HSA. Assume a reimbursement growth rate consistent with the premium targets outlined above.

- **Other Provisions.** For non-delineated provisions, assume Labor Committee approach.

HEALTH CARE COMPROMISE -- ISSUES

- *Offering generous transitional subsidies to currently non-insuring firms would encourage greater participation. However, such a strategy would increase short-term costs dramatically. What is the general cost containment strategy in this proposal? How would the additional costs of the transitional subsidies be offset?*

  -- Several different mechanisms could be employed to contain and/or offset costs:

    - Implement tobacco tax increase immediately, but delay availability of subsidies for two years. This would create an upfront trust fund to help defray the costs of the transitional subsidies.

    - During the transition period, higher subsidies to currently non-insuring firms could be partially financed by setting subsidies to currently insuring employers below the maintenance level. As subsidies to currently non-insuring firms are gradually phased down to the maintenance level, subsidies to currently insuring firms would be ***phased up*** to the maintenance level.

    - Target premium growth rates would be established from the outset. Once subsidies become available, plans which rise faster than the target would pay an assessment on their cost increases above the target.

    - After the transition period, subsidies would be based on target growth rates, not actual growth. This would ensure that premium cost increases above the target rate would be borne by individuals and businesses, not by the federal government.

    - Firms with more than 500 employees would pay a 1 percent assessment.

- *Providing more generous transitional subsidies to non-insuring firms might encourage currently insuring firms to drop coverage so that they can take advantage of the more generous transitional subsidies.*

  - To avoid this kind of gaming, the more generous transitional subsidies would only be available for workers who are uninsured as of August 1, 1994.

- *What type of subsidies are available to new firms which are formed after the transition period?*

  - Transitional subsidies would not be available to new firms after the transition period. Generous transitional subsidies are designed to give non-insuring firms a longer and more realistic time period over which they can pass back the cost of health insurance to their workers in the form of lower wages. After the transition period, wages throughout the job market will have adjusted downward to reflect the passback of health care costs onto workers. In this new market, firms starting up can provide insurance, pay the prevailing wage rate, and not suffer any competitive disadvantage.

- *How are "non-insuring firms" defined? (1) Many firms insure some, but not all of their workers. Are such firms considered insuring or non-insuring? (2a) What about firms which currently pay less than 80 percent of their employees's insurance costs? Are they considered to be not insuring their employees? (2b) What if a firm currently providing no insurance starts picking up less than 80 percent of insurance costs? For what subsidies are they eligible?*

  - (1) To most effectively target the transitional employer subsidies, employers will only get them for currently uninsured workers, including part-time and temporary workers. Hence, a firm with 20 insured employees and 200 uninsured employees would only get the supplemental transitional subsidies for the 200 uninsured employees. The ongoing costs of the 20 insured employees would also be subsidized, but at a lower level during the transition period.

    - A potential problem with this approach is that any worker that joins a firms during the transition could be considered currently uninsured and eligible for the more generous transitional subsidies. This problem could be alleviated by prohibiting subsidies to (1) new workers at firms which currently insure all their workers, and (2) new workers whose wage or job description is similar to that of other co-workers who were covered before the transition.

  - (2a) Firms paying less than 80 percent coverage could be treated any number of ways: We could, for example, offer extra subsidies to encourage them to increase their contribution up to 80 percent, but it is not clear how much additional coverage would be bought with these federal dollars -- just those workers who would be willing to purchase already available insurance if their employer would increase their contribution. Nor -- if you believe in passback -- would supplemental subsidies to these employers ultimately reduce the burden on employees.

  - (2a) A second alternative would be to give firms paying less than 80 percent of their employees' insurance costs the same subsidies we give to other insuring firms. Alternatively, we could pro-rate their subsidies based on the portion of the premium they cover.

  - (2b) The same issues -- and possible responses -- exist for currently non-insuring firms which start providing insurance, but at less than the 80 percent rate.

- *How fast – and in what manner – should the transitional subsidies be phased down to the long term maintenance level?*

  - The phase down of transitional subsidies should reflect the speed with which employers can pass back the cost of insurance onto their employees in the form of lower wages. But an employer's ability to pass back such costs may vary depending on the size of the firm and the wage of the employee. For example,

    - Among higher wage workers, health care insurance represents a much smaller percentage of income than it does for a worker making the minimum wage. Insurance costs can be passed back to these higher wage workers much more quickly than they could to lower wage workers.

    - Firm size can also play a role. A small firm with limited capital and a small payroll may have to pass back costs more slowly than a large firm.

  - Given the role wage and firm size can play in determining the pace of a firm's passback, these factors should be incorporated into the phase down mechanism. Employer subsidies to high wage workers in large firms should be phased down more rapidly than subsidies to low wage workers in smaller firms.

- *What's to stop firms from staying out of the system, and continuing to shift their employers' health care costs onto their spouses' employers?*

  - In a world in which employers are not required to purchase health care coverage, and there is no standard premium payment, many employers will end up providing coverage to some of their employees' spouses (and possibly not covering other employees who are picked up by their spouses' plans). This is no different than the current system, and will not necessarily affect the extent of coverage.

- The number of firms which insure only a portion of their workforce could be minimized through an anti-discrimination provision which required firms to have a consistent coverage policy across its entire workforce. That is, a firm that offers insurance to any of its full-time workers would have to offer it to all of its full time workers. Similarly, a firm offering insurance to any of its part-time workers would have to offer it to all part-time workers.

Chris — from Nancy-Ann

DRAFT PANETTA OP-ED ON HEALTH CARE COST CONTAINMENT (DRAFT 10 - 6/16 8:30 p.m.)

IF IT DOESN'T CONTROL COSTS, IT'S NOT REFORM

There is a clear consensus that the nation cannot sustain the inadequacies, the bureaucracy, and the waste of the present health care system.

Yet one of the controversies in the present debate is over the establishment of effective curbs on health care costs, a key goal of the President's plan. If we are going to protect families, businesses, and government budgets from skyrocketing costs, real cost constraints are essential.

The Stakes

Some argue that we should rely on those in the health care system to hold down costs. But as one observer has written, the health care system has become overbuilt, overused, and overpriced. How can we reform the system and not deal directly with costs? The answer is, we cannot. By the end of the decade, we will be spending 18 percent of our economic resources on health care, yet more than 40 million Americans will have no health coverage.

The stakes in constraining national health spending are huge -- for families, for businesses, and for government.

For government, we reversed the trend of rising Federal budget deficits last year with the President's economic plan, but deficits will rise again in the latter part of this decade. Why? Health costs, which contribute far more than any other area to future spending increases -- almost $476 billion over the next five years.

Businesses face the same problem. For example, health costs for the Big Three automobile manufacturers average well over $1,000 per car. And small businesses are charged

an average of 35 percent more than large businesses for the same insurance. All businesses need predictable, affordable health costs.

For families, particularly middle-class families, rising costs place them one serious illness or job change away from losing their health insurance. Protecting families is at the core of health care reform.

If someone had sought to design a high-cost system, they could not have done better than what we have now. Today, forces conspire to drive up demand for care: the consumer bears only a fraction of costs; providers have enormous influence over consumer decisions; and most consumers will pay whatever providers charge. In such a market, real competitive pressures must be created *and then guaranteed with cost constraints*.

The Solution

Managed competition, upon which the President's and other plans rely, will slow down costs by creating greater choices as well as responsibilities for consumers, who will be well-informed about their options. However, it would be irresponsible not to provide the protection of health *and* cost security.

In addition to forcing real competition, the President's plan uses three mechanisms to control costs:

First year. Today, millions of uninsured individuals cannot pay when they use the health care system. Doctors and hospitals set their fees -- and insurers set their premiums -- about 25% higher to cover these "uncompensated" costs.

With universal coverage, all Americans would be insured, so there would be virtually no uncompensated costs. But if we do not set an appropriate premium ceiling in the first year of health reform, the health industry will reap a huge windfall because they will continue the old

rate structure. This windfall, worth hundreds of billions of dollars to insurance companies over the next several years, would come straight out of our pockets.

Future premiums. To provide the long-term protection that American businesses and families demand, the President's plan ties the future growth in health insurance premiums to a reasonable scale of increases. This will allow providers and insurers to negotiate among themselves within broad ceilings.

This protection makes sense. Premium caps are preferable to direct Federal micro-management of health care costs -- for example, through a system of Federal price controls for specific procedures. The Federal government should not set prices for all of the tens of thousands of private health transactions that take place every day. The President rejected that approach in favor of broad limits on the rate at which insurance companies may raise premiums. The President's plan leaves it to those who know the system best -- health plans, doctors, and nurses -- to eliminate waste while improving the quality of care.

Some argue that these limits are too stringent to maintain the high quality of care that Americans receive today. This is simply untrue. First, the ceilings allow for regional variations and demographic shifts. But more fundamentally, in 2004, even with these limits, the U.S. health industry would have an income of $2.1 ***trillion***. The average annual growth in national health spending between 1996 and 2004 would be reduced to 7.3% per year from the 8.4% projected under current law -- an important achievement but one that would more than allow the health sector to continue the quality care and medical advances which are the hallmark of our system.

Subsidy caps. Finally, the President's plan assists small businesses and low-income families and individuals in paying their share of the cost of insurance. However, the President

rejected the notion of creating another runaway entitlement program. Therefore, the plan sets a cap on total discounts. If costs rise beyond that level, Congress and the Administration must revisit the program and fix the problem.

Regardless of the means, we need to put an end to the fantasy that we can reform the nation's health system and provide coverage to every American without containing health costs. We cannot hope to have the economic growth, prosperity, and security that the American people deserve, and we cannot hope to keep Federal budget deficits heading downward if we do not constrain health costs.

And this should be noted: Universal coverage, the President's bottom-line goal for health reform, is also essential to cost containment. Senator John Chafee was right when he said, "If there's no mandate that people have to belong, then...costs are going to be carried by those who are sick." And without an approach requiring universal coverage, as the Congressional Budget Office points out, it is the middle class -- not the poor -- who largely end up uninsured.

Likewise, without cost containment, it is middle class families who will bear the largest burden of skyrocketing costs.

For 16 years, I served as a member of Congress, and efforts were made to deal with the health care problem as it became a health care crisis. Those efforts failed.

If we enact health care reform that does not provide for universal coverage and control costs -- whether through the mechanisms proposed by the Administration or by some other means -- this effort, too, will have failed.

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EXECUTIVE OFFICE OF THE PRESIDENT

Washington, D. C.

FAX TRANSMITTAL COVER SHEET

DATE: 24-May-94

TO: JENNINGS

SUBJECT:

SCHEDULE FOR RICCHETTI - 5

FROM:

GORDON LI (202) 456-6493

OFFICE OF LEGISLATIVE AFFAIRS

If there are any problems receiving this transmission,
please call the sender, or (202) 395-7370.

SCHEDULE FOR STEVE RICCHETTI
Wednesday, May 25, 1994

Updated: Tuesday, May 24, 1994 7:31 pm

TIME: 8:00-9:00
EVENT: Meeting with Health Care Groups
LOCATION: Old Ebbitt Grill
NOTES:

TIME: 11:30-12:15
EVENT: Meeting with Senator Feinstein
LOCATION: 331 Hart
NOTES:

TIME: 12:30-2:00
EVENT: DPC Health Lunch
LOCATION: Capitol
NOTES:

TIME: 3:00-3:45
EVENT: Meeting with Senator Danforth
LOCATION: 249 Russell
NOTES: With Pat

TIME: 4:00-4:45
EVENT: Senate Message Meeting
LOCATION: Capitol
NOTES:

TIME: 5:00-6:00
EVENT: Health Care Leadership Meeting
LOCATION: Capitol EF-100
NOTES: With POTUS

TIME: 6:00-6:30
EVENT: Democratic Caucus Meeting
LOCATION: 1100 Longworth
NOTES: With POTUS

TIME: 7:00-
EVENT: Dinner with Harold Ickes
LOCATION: TBA
NOTES:

DRAFT

RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

SUMMARY OF THE PROPOSAL

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

- If competition fails to moderate premium increases -- leading to higher subsidies and lower federal tax revenues -- an assessment on high cost health plans is used to make up the difference and protect the federal budget.

  - High cost health are those plans with a premium above the "target premium" for a 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 no windfall for the health industry. The target premium grows from year to year based on reasonable expectations for a more competitive health care marketplace.

WHAT THE PROPOSAL ACCOMPLISHES

- The proposal limits the federal budgetary risk from health care reform, without the use of premium caps.

- Because the proposal targets assessments on high cost plans, it encourages plans to lower costs and encourages employers and individuals to choose more efficient health plans.

- The high cost plan assessment proposal accomplishes some of the goals of a tax cap, but without most of the drawbacks of tax cap approaches.

  - This proposal does not in any way alter the tax treatment of employer-sponsored health benefits. Benefits would continue to be fully deductible by employers and excluded from taxable income for employees.

  - A tax cap would apply regardless of whether or not competition is effective. However, a high cost plan assessment would be triggered only if competition fails to moderate premium increases.

  ?

  Large employer self-insured or experience rated plans would be subject to the assessment, but again, only to the extent that costs grow faster than targeted growth rates. In effect, the base for the assessment would be the current spending level in a self-insured or experience rated plan, rather than some arbitrary amount as under a tax cap.

  - A primary problem with a tax cap is that it specifically targets employees with

generous employer-sponsored health benefits. In contrast, the high cost plan assessment proposal targets all high cost health plans, not just generous employer-sponsored health benefits.

- Tax caps impose higher taxes on employers or employees. A high cost health plan assessment charges *insurers* -- not employers and employees -- who have excessive premium levels. While insurers might pass some of the assessment onto employers or employees, a considerable portion would likely be absorbed by insurers and providers.

Chafee:

- Perfectionists [illegible] with [illegible] 2
- Mathews, Boren, Baucus, Breaux, Bradley
- Get off employer mandate [illegible] do [illegible] & Com [illegible]
- Trigger – how [illegible], particularly hard triggers
- Incremental reform will [illegible] stability – That will help [illegible] decline of coverage
- CBO's estimate of Chafee [illegible] – fail safe mechanism will [illegible] variations
- 92-95% in the [illegible]
- FEHB option
- modified plan for individual market, with FEHB [illegible]
- plug it into Federal system

CJ. The death of health care for all!

I am dying & I am in shock Disaster

[illegible] – I am scared [illegible] to [illegible] → Kennedy mentions [illegible]

Give encouragement to
Moynihan
Bradley
Breaux
Boren

Individual market – I see no other negotiation. (BC)

To Chris

Date 6/10 Time 11:25

WHILE YOU WERE OUT

M Roger Altman

of [illegible]

Phone 622-1070

Area Code | Number | Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message

W/C

Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

INCREASING COVERAGE IN A VOLUNTARY INSURANCE SYSTEM

- Most of the uninsured do not have insurance coverage because they work for a firm that does not offer it and because they cannot afford to buy it in the individual insurance market.

    - State demonstration projects have shown that providing subsidies does not significantly increase the number of businesses or families purchasing insurance unless the subsidies are very large.

    - The Lewin analysis of the Cooper/Breaux bills indicates that it might be possible to increase the percentage of the population insured to around 91%. However, CBO has estimated that the Cooper bill would cost about $300 billion over ten years.

- Reducing benefits below the level of coverage most people currently have would reduce federal costs, but is unlikely to significantly decrease the number of uninsured people.

    - State demonstrations have also shown that businesses and families are unlikely to purchase catastrophic insurance packages, even if they are offered at very low rates.

    - Many of the uninsured are poor. They cannot afford the higher deductibles and cost-sharing that are necessary to significantly reduce the benefit package.

- Subsidy costs could be reduced below what CBO estimates the Cooper bill would cost by making subsidies for the poor less generous or by capping their rate of increase. But doing so would decrease the incentives to purchase coverage, and therefore not achieve even 91% coverage.

- FEHBP could be used in a voluntary or universal insurance market to provide affordable coverage to employers and families. This could work as follows:

    - As they do today, FEHBP would select a broad range of health plans for federal employees throughout the country.

    - Employers below a certain size and families without employer coverage could choose the same plans offered by FEHBP to federal employees.

    - FEHBP would negotiate with plans and use financial incentives to ensure that there are a sufficient number of health plans at an affordable premium level.

    - If there are no health plans in an area offering coverage at an affordable premium level, a fee for service plan using Medicare-type provider payment rates would be made available to employers and families in the area through FEHBP.

could do it; trade-offs ...

Can you get to given course

cost: CBO $3 ...

if no tax cap

- slash benefits package low bene
  no drugs, mental ...

pro: eliminate $300 B

don't have 97% anymore

still have significant cost shifting

spending a lot on subsidies for package people
don't work; only reason people buy
it is because subsidy available to

Still have tax cap hole
could do more Medicare cuts; but
could not get there
unless made offsets

cold do Bowen tax;
politically ready to can't get over

benefits and tax don't help

individual mandate on revenue cost will make silly more

After all this, problem of catastrophic benefits and individual mandate.

politically difficult

No support from left

If don't reduce benefits much, have to look at other revenues

no political support from left

for catastrophic already

sells better under predicted

91% coverage could be achieved through a voluntary approach like the Cooper plan, but the following trade-offs would be required:

THE COST OF THE PLAN AS WRITTEN IS PROHIBITIVE

- CBO says the Cooper plan would add $300 billion to the deficit over ten years.
- This $300 billion figure assumes tens of billions from a tax cap pegged at the lowest cost plan. Without the tax cap, the deficit problem would grow.

CUTTING BENEFITS TO REDUCE COST

- CBO says the Cooper plan could be made approximately deficit neutral by dramatically reducing the benefits package (e.g. eliminating coverage for mental health, prescription drugs, preventive care, and dental, and limiting hospital coverage).
- However, providing a bare bones benefits package presents significant trade-offs:
    - Significant cost shifting remains. 97% of health care costs would no longer be covered under the plan.
    - State demonstrations show that few businesses and families would voluntarily purchase bare bones insurance, even if it is offered at very low rates. The only way to increase coverage with a bare bones package is to pay all or nearly all of the premium for the poor.
    - We would be spending a great deal of money for a benefits package that few people really want.

REMAINING COST PROBLEM

- Even with a dramatic reduction in the benefits package, the plan would still increase the deficit without a tax cap.
- Options to fill this gap include:
    - More Medicare cuts, which would be difficult to do without providing additional benefits for the elderly.
    - A tobacco tax, which may be difficult to achieve without universal coverage.

	Corp	Sm Sale		
	350	150	220	200
cap	-50	-150	80	100
	300	0	300	

progr w/o tax cap 350 130

tax cap

<u>Roger</u>:

the attack and the ensuing war in some symbolic way. But the current government in Tokyo, having limped into power after a succession of financial scandals, apparently believed that it could be harmed domestically by what might be seen by Japanese audiences as an abject act.

ANALYSIS: Clinton Welfare Bill Modest Compared to Past Plans (Washn) By Ronald Brownstein= (c) 1994, Los Angeles Times=

WASHINGTON Richard Nixon promised ``total welfare reform the transformation of a system frozen in failure." Jimmy Carter asked Congress ``to abolish our existing welfare system." Ronald Reagan called for ``real and lasting emancipation" from welfare.

Now comes Bill Clinton, who will release a reform plan in Kansas City Tuesday that is intended to redeem his celebrated promise ``to end welfare as we know it."

Like his predecessors', Clinton's plan begins with the assumption that the welfare system has failed both the taxpaying public and those it is intended to help. But, in both its ambitions and its modesty, Clinton's plan has been shaped by the frustrations these earlier reform efforts have left behind.

The most ambitious aspects of Clinton's plan attempt to distill into social policy a widening public consensus around both the importance of work, and the urgency of reversing the growing trend toward out-of-wedlock birth and single-parent families. In the plan, Clinton will require even the mothers of very young children to accept work after two years on the rolls; and he launches several controversial initiatives to discourage illegitimacy ideas almost entirely absent in the earlier reform efforts.

``The times have changed and today's debate reflects the changed times," says Richard P. Nathan, who directed Nixon's welfare reform effort. ``The centrist Democrats today are further to the right than Nixon and the child care and job training for welfare recipients, and then requiring more of them to work. Clinton's plan shares that approach, but differs in ways that illuminates changing attitudes toward the family and government alike.

Under Nixon's plan, mothers with children age 6 and younger were exempt from work requirements; Carter's plan exempted women with children up to age 7. Even the Family Support Act in 1988 exempted women with children under 3. Clinton's plan will exempt from work only women with children 1 year or younger and provide subsequent exemptions of only 12 weeks for children conceived while on welfare, officials say.

Clinton's plan also reflects the eroding confidence in government's capacity to design and administer massive new programs as well as the increasing strain on its purse. The Carter plan would have created as many as 1.4 million public sector jobs. Clinton's plan calls for government to fund only about 400,000 jobs for welfare recipients five years after implementation and even many of those would be subsidized private-sector work, rather than public employment.

The increased emphasis on values particularly deterring out-of-wedlock births constitutes an even sharper break between Clinton's effort, and its recent predecessors.

With the public, there is now ``a consensus that you ought to discourage out of wedlock births," says political pollster Geoff Garin, who has extensively examined public attitudes toward welfare.

That consensus rests on a different foundation than the fears of ``immorality" that dominated welfare policy in the first half of this century. Today, for both the public and policymakers, what's primarily driving the anxiety over births outside marriage are the practical fears that family disintegration is contributing to crime, urban disorder, and a cycle of dependency.

In his plan, Clinton will propose a nationwide campaign to discourage teen pregnancy, including efforts to encourage abstinence; requirements that teen-agers

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- Options to fill this gap include:
  - More Medicare cuts. But aging groups would oppose additional cuts unless they were offset by benefit expansions (which would eliminate any savings).
  - A tobacco tax, which may be difficult to achieve without universal coverage.

ADDITIONAL POLICY/COST TO ACHIEVE UNIVERSAL COVERAGE

- Achieving universal coverage would require at least an individual mandate.
- With an individual mandate, providing subsidies for the remaining uninsured would require substantial additional spending.
- The risk of relying solely on an individual mandate is that loss of your left base will not be offset by gains from the right.

BREAUX-COOPER COST/TAX CAP TABLE

	Comprehensive Benefits	Basic Benefits
Program Cost Without Tax Cap	350	150
Tax Cap	-50	-150
Total	300	0

W/ Breaux-Cooper Table

PROBLEMS WITH THE 91% APPROACH

- **LEAVES MILLIONS OF AMERICANS UNINSURED.** 25 MILLION AMERICANS WOULD BE UNINSURED. AS MANY AS 40 MILLION AMERICANS WOULD BE WITHOUT HEALTH INSURANCE FOR SOME PERIOD OF TIME EACH YEAR. ALMOST ALL OF THE NEWLY INSURED WOULD BE UNDER THE POVERTY LEVEL.

- **INCREASES THE DEFICIT** FROM 1996-2004. THE FEDERAL DEFICIT INCREASES BY OVER $300 BILLION TO FUND SUBSIDIES AND TAX INCENTIVES. WITHOUT A TAX CAP, THE DEFICIT INCREASE IS $350 BILLION.

- **PLACES HEAVY BURDEN ON MIDDLE INCOME INDIVIDUALS.** MANY PEOPLE WILL PAY OVER 10% OF THEIR GROSS INCOME FOR HEALTH INSURANCE. A WORKER EARNING $30,400 COULD HAVE TO SPEND OVER $6,000 TO BUY A FAMILY POLICY AND WOULD NOT BE ELIGIBLE FOR GOVERNMENT SUBSIDIES.

- **MAY ENCOURAGE EMPLOYERS TO DROP COVERAGE.** THE EXISTENCE OF LOW-INCOME SUBSIDIES MAY ENCOURAGE FIRMS THAT CURRENTLY PROVIDE HEALTH INSURANCE TO DROP COVERAGE FOR LOW-WAGE WORKERS. THE LEWIN ANALYSIS ASSUMES THAT FIRMS CURRENTLY PROVIDING HEALTH INSURANCE WILL CONTINUE TO DO BUT FROM 1989 TO 1992, THE NUMBER OF AMERICANS WITH EMPLOYER COVERAGE DROPPED BY 3 MILLION.

- **TOTAL COVERED DOLLARS GOES FROM 94.1% TODAY TO 96.8%.** THIS IS AN INCREASE OF $37 BILLION FOR WHICH THE FEDERAL GOVERNMENT IS SPENDING $42 BILLION OF NEW MONEY IN 1998.

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THE LEWIN ANALYSIS OF COOPER/BREAUX

THE MIDDLE CLASS LOSES

MILLIONS OF PEOPLE

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
PEOPLE BELOW POVERTY	9.3	7.9	1.4
100-150% OF POVERTY	6.0	3.7	2.3
ABOVE 150% OF POVERTY	21.9	3.2	18.7
TOTAL	37.2	14.8	22.4*

	NUMBER CURRENTLY UNINSURED	NUMBER WHO RECEIVE INSURANCE	NUMBER WHO REMAIN UNINSURED
UNDER AGE 18	9.7	4.3	5.4
18 - 34	14.4	4.9	9.5
OVER 34	13.1	5.6	7.5
TOTAL	37.2	14.8	22.4*

*CBO ESTIMATES 25 MILLION REMAIN UNINSURED

THE LEWIN ANALYSIS OF COOPER/BREAUX

FEDERAL SUBSIDIES INCREASE COVERAGE NOT THE MARKET

	NEWLY INSURED	
	NUMBER PEOPLE\MILLIONS	PERCENT
INSURANCE MARKET REFORMS	1.1	7
INCREASE TAX DEDUCTIBILITY	1.1	7
GOVERNMENT PAYS 100% OF THE PREMIUM	7.9	53
GOVERNMENT PAYS A SIGNIFICANT PORTION OF PREMIUM	4.7	33
TOTAL	14.8	100%

THE LEWIN ANALYSIS OF COOPER/BREAUX

PERCENT OF POPULATION REMAINING UNINSURED

	TODAY %	AFTER REFORM %
UNDER 18	13.9	7.7
18 - 24	29.4	20.2
25 - 34	19.5	12.5
34 - 65	13.0	7.7
TOTAL UNDER AGE 65	16.0	9.6

ADDITION TO DEFICIT UNDER COOPER/BREAUX

TO ACHIEVE 91% COVERAGE

BILLION $

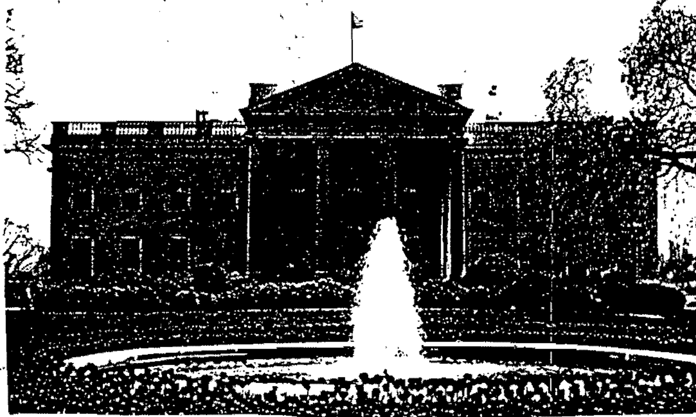
	1996	1997	1998	1999	2000	2001	2002	2003	2004	TOTAL
WITH TAX CAP	35	46	42	36	30	32	31	27	22	301
WITH-OUT TAX CAP	41	61	58	53	48	52	54	51	47	465

SOURCE: CBO

	NEW GOVERNMENT COST 1998	NEWLY INSURED PEOPLE	FEDERAL COST PER PERSON
1998 FEDERAL COST FOR EACH NEWLY INSURED PERSON	$42 BILLION	14.8 MILLION	$2,838 PER PERSON

THE WHITE HOUSE

WASHINGTON



Fax Cover Sheet

DATE: ____________ **TIME:** ____________

TO: Jane Horvath

PHONE: ____________ **FAX:** 228-5568

FROM: Chris J

PHONE: 202-456-________ **PAGES AFTER COVER:** ________

COMMENTS: Here you go. I think this responds to your request. Pl. call [illegible] re your Medicaid request.

[signature]

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL # of pages ▸
To Jennings From Thorpe
Dept./Agency Phone #
Fax # For Jane Horvath Fax #
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

ANALYSIS OF REG
CONSTRAINED
Split Families Follo

SINGLE

Alliance Firmsize	AFDC & SSI Per Capita	% Change	Total Premiums	AFDC & Non-Cash Per Capita	% Change	Total Premiums	All Per Capita	% Change	Total Premiums
	$2,200			$2,200			$2,200		
All	$2,288	104.0%	$108,087	$2,237	101.7%	$106,654	$2,321	105.5%	$113,163
5000	$2,392	108.7%	$95,253	$2,331	105.9%	$93,820	$2,427	104.6%	$100,329
1000	$2,470	112.3%	$87,799	$2,401	109.1%	$86,366	$2,507	108.0%	$92,875
500	$2,507	114.0%	$84,588	$2,434	110.6%	$83,155	$2,544	109.6%	$89,665
100	$2,638	119.9%	$75,862	$2,550	115.9%	$74,429	$2,673	115.2%	$80,938

COUPLE

Alliance Firmsize	AFDC & SSI Per Capita	% Change	Total Premiums	AFDC & Non-Cash Per Capita	% Change	Total Premiums	All Per Capita	% Change	Total Premiums
	$2,200			$2,200			$2,200		
All	$2,223	101.1%	$87,630	$2,213	100.6%	$87,660	$2,235	101.6%	$89,096
5000	$2,277	103.5%	$68,372	$2,263	102.9%	$68,402	$2,292	104.2%	$69,837
1000	$2,302	104.7%	$57,828	$2,286	103.9%	$57,858	$2,320	105.5%	$59,294
500	$2,287	104.0%	$52,679	$2,269	103.1%	$52,709	$2,307	104.9%	$54,144
100	$2,360	107.3%	$41,783	$2,336	106.2%	$41,813	$2,384	108.4%	$43,248

228-5568

Community rate for
individual and
self & wife

2 - 100
2 - 500
2 - 1000

06/06/94 20:47 ☎202 401 7321 HHS ASPE/HP ⊠003/003
JUN-06-1994 14:38 FROM HCFA ORCT TO KEN THORPE P.03

ANALYSIS OF RE
CONSTRAINED
Split Families Foll

1 ADULT & KIDS

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	AFDC & Non-Cash Per Capita	AFDC & Non-Cash % Change	AFDC & Non-Cash Total Premiums	All Per Capita	All % Change	All Total Premiums
	$1,412			$1,412			$1,412		
All	$1,497	106.0%	$44,879	$1,481	104.9%	$48,682	$1,536	108.8%	$51,114
5000	$1,550	109.8%	$39,998	$1,526	108.1%	$43,803	$1,589	112.5%	$46,235
1000	$1,588	112.4%	$37,223	$1,558	110.3%	$41,027	$1,625	115.1%	$43,459
500	$1,605	113.7%	$36,117	$1,572	111.4%	$39,921	$1,642	116.3%	$42,353
100	$1,658	117.4%	$33,154	$1,615	114.3%	$36,958	$1,691	119.8%	$39,390

2 ADULTS & KIDS

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	AFDC & Non-Cash Per Capita	AFDC & Non-Cash % Change	AFDC & Non-Cash Total Premiums	All Per Capita	All % Change	All Total Premiums
	$1,286			$1,286			$1,286		
All	$1,306	101.6%	$146,826	$1,327	103.2%	$155,129	$1,341	104.2%	$157,165
5000	$1,346	104.7%	$115,977	$1,371	106.6%	$124,279	$1,388	107.9%	$126,315
1000	$1,375	106.9%	$98,704	$1,403	109.1%	$107,007	$1,423	110.6%	$109,043
500	$1,392	108.2%	$91,088	$1,421	110.5%	$99,391	$1,443	112.2%	$101,427
100	$1,451	112.8%	$72,376	$1,483	115.3%	$80,679	$1,511	117.5%	$82,714

SOURCE: HCFA,

06/06/94 20:46 202 401 7321 HHS ASPE/HP 002/003
JUN-06-1994 14:38 FROM HCFA ORCT TO KEN THORPE P.02

ANALYSIS OF REG
CONSTRAINED
Split Families Folio

SINGLE

	AFDC & SSI			AFDC & Non-Cash			All		
Alliance Firmsize	Per Capita	% Change	Total Premiums	Per Capita	% Change	Total Premiums	Per Capita	% Change	Total Premiums
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DRAFT July 8, 1994

POSSIBLE ALTERNATIVE STRUCTURE FOR HIGH COST PLAN ASSESSMENT

- In general, health plans whose premium for the standard benefit package exceeds an annual target would pay an assessment.

  - For community-rated plans, the target would be the projected average premium (or some percentage above the average premium) of community-rated health plans in an area. *Alternatively, there are three additional options for setting the target:*

    Option 1. The target (and its rate of increase) could be established through a formula set in statute (similar to the HSA).

    Option 2. The target could be based on the national average increase in health plan premiums, adjusted for cost-of-living and demographics.

    Option 3. The target could be based on the initial average premiums in each area, increased annually by the average national increase of community-rated health plans.

    Health plans whose premium exceeds the average premium in an area would pay the assessment.

  - For experience-rated employer plans, there are several options for establishing the target:

    Option 1. The target would be the projected average annual rate of increase of health plans in an area. **Option 1a.** *Alternatively, the target rate of increase could be specifically established in legislation (similar to the HSA).*

    Option 2. The target would be based on a blend of the projected average annual increase in area premiums (as in **Option 1**) and the weighted average community rate (adjusted for the demographic characteristics of demographics of the plan's enrollees. For smaller experience-rated employer plans, greater weight is given to the average rate of growth. **Option 2a.** *Additionally, over time, the formula could adjust to give greater weight to the weighed average community rate.*

  Note: The weighted average premium for experience-rated employers contracting with more than one health plan is the weighted average of the premiums charged to that employer by all experience-rated health plans providing coverage to that employer.

  Health plans whose premiums in an area increased faster than the target rate of increase (based on a rolling average of increases over several years) would pay the assessment.

- Separate nationwide targets would be established for community-rated plans.

Alternatively, there could be no national targets.

- The nationwide target for community-rated plans would be the projected average premium of community-rated health plans nationally. The target would be adjusted for cost-of-living and demographic characteristics across community-rating areas.

- Community-rated plans whose premiums were below the nationwide targets (regardless of the area target) would not be assessed).

◆ The area targets would be based on projections of the average premium and average annual premium increase in the each area. The nationwide targets would be based on national projections of premiums and annual premium increases. The projections would be made annually by the Secretaries of Treasury and HHS, pursuant to regulations. *Alternatively, the target formula and target rate of increase could be specified in statute, as in the HSA.*

◆ The targets and assessments would apply only to premiums for the standard benefit package. Experience-rated plans (including self-funded plans) would be required to establish separate premiums (or premium equivalents) for the standard benefits. Regulations would specify how the separate premiums would be calculated for experience-rated plans.

There are several options related to supplemental benefits:

Option 1. Treat supplemental benefits as under the HSA. Generally, employer contributions toward supplemental benefits (other than cost-sharing supplemental benefits) would be included in employee income as of 2004.

Option 2. Apply the assessment to all supplemental plans. The assessment would be collected from insured and self-funded plans, based on the premium (or (premium equivalent) for the benefits.

◆ Targets would need to be adjusted for demographics characteristics of plan enrollees. For experience-rated plans, the adjustment would be based on change in enrollee characteristics between rating periods.

◆ The assessment would be made on the amount of premium that exceeded the target. The level of assessment would be specified in statute.

- For experience-rated employer plans, the assessment would be based on the average of the plan's premium or premium increases over a specified period of years. The period would vary with the number of covered lives (smaller plans would be averaged over a longer period of years).