MITCHELL HEALTH CARE LEGISLATION
EXECUTIVE SUMMARY
AUGUST 2, 1994

1. EXPANDING COVERAGE

The objective of this health care reform plan is to provide universal coverage through a system of insurance market reforms, voluntary purchasing cooperatives, and incentives and subsidies to those who need them.

The Congressional Budget Office's preliminary estimate is that, if this plan is enacted, 95 percent of all Americans will have health insurance by the year 2000 with no increase in the federal deficit. The plan will further establish a procedure to provide thereafter health insurance to all Americans.

A. Subsidies Under a Voluntary System. Targeted subsidies will be available to encourage certain low income individuals and some firms to purchase insurance. These subsidies would be targeted to people who do not have health insurance coverage today.

For low income individuals:

- Low-income families. Beginning in 1997, low income individuals and families will receive a subsidy worth a fixed percentage of the average premium in a health care coverage area. For those below 100 percent of the Federal poverty level, the subsidies will cover the full cost of health insurance coverage. The value of the subsidy will be phased out between 100 percent and 200 percent of poverty.

- Low income pregnant women and children. Beginning no later than 1997, pregnant women and children under 19 with incomes up to 185 percent of poverty will be eligible to receive subsidies equal to 100 percent of the premium. The subsidies will be phased out between 185 percent of poverty and 300 percent of poverty. Community rated health plans will be required to offer two additional categories of coverage: single child and multiple child, so that child only policies are available in the market.

- Cash assistance recipients. Beginning with the January 1, 1997 abolishment of the acute care portion of Medicaid for AFDC, all AFDC cash assistance recipients will receive subsidies equal to 100 percent of the premium.

- Former non-cash Medicaid eligibles. Beginning in 1997, individuals who would be medically needy or other non-cash recipients under the current Medicaid program (except pregnant women, infants and children) will receive subsidies covering 100 percent of the premium for six months, then will be treated the same as others based on income.

- o Outreach and enrollment. To maximize health insurance coverage, low income individuals eligible for full subsidies (below 100% of poverty generally, and below 185% of poverty for pregnant women and children) will be permitted to enroll in a health plan at any time of the year (others may enroll only during the 30 day enrollment period). Any pre-existing exclusion rules that apply to the newly insured will be waived for these individuals, and a new system will be developed to sign up such individuals for health insurance coverage when they seek health care service at a hospital or clinic.

- o Temporarily unemployed, uninsured. Beginning in 1997 individuals who were full time employees, ~~insured for at least six months~~ will be eligible for enhanced income protection subsidies to purchase insurance. Under this program, unemployment insurance benefits and wages earned in a month up to 75 percent of the poverty level, will be disregarded for purposes of determining eligibility for low income subsidies. Individuals will be eligible for this program for up to six months or until they find other full time work. This assists temporarily unemployed individuals purchase insurance by disregarding a portion of their income for the year so that they are eligible for the low income subsidies.

For employers:

- o Employers who expand coverage to additional workers. Beginning in 1997, employers who expand coverage to all their employees in a specific class (i.e., full time, part time) will receive subsidies to make their employees' premiums more affordable. Employers will pay the lesser of 50 percent of the premium or 8 percent of each newly insured employee's wages. The employee will pay 50 percent of the premium. Workers with incomes under 200 percent of poverty eligible for the individual subsidies described above. This subsidy will be available to employers for a maximum of five years.

B. Trigger to a Requirement. On January 15, 2000, the National Health Care Cost and Coverage Commission will determine whether the voluntary system has achieved 95 percent coverage.

- o First Alternative -- Coverage Target Achieved. If the Commission determines that, on a nationwide basis, at least 95 percent of all Americans had health coverage, it will send recommendations to the Congress on how to insure the remaining uninsured individuals. Congress will consider legislation to insure the remaining uninsured under an expedited process that requires committees to discharge by a certain date and that limits floor debate. The legislation will be fully amendable and require the President's signature. No further action is required.

- o Second Alternative -- Coverage Target Not Achieved. If coverage is below 95 percent, the Commission will send to Congress by May 15, 2000 one or more legislative proposals on how to insure the remaining uninsured individuals. Congress will consider legislation to insure the remaining uninsured under an expedited process that requires committees to discharge by a certain date and that limits floor debate. The legislation will be fully amendable and require the President's signature. If universal coverage legislation is not enacted by December 31, 2000, an employer requirement will go into effect on January 1, 2002 in those states with less than 95 percent coverage.

C. Nature of Requirement. If a requirement is triggered, employers with 25 or more employees will have to pay 50 percent of their employees' premium costs, with the employee paying the remainder. Firms employing fewer than 25 workers will be exempt from an employer requirement. Individuals will be required to have health insurance. Under a requirement, the targeted subsidies available under the voluntary system will be replaced with general subsidies designed to make insurance costs affordable.

- o Employees with Adjusted Gross Income under 200 percent of poverty will be subsidized on their 50 percent share of the premium on a sliding scale basis, so that those with incomes up to 100 percent of poverty will pay no more than about 4 percent of income, rising to no more than 8 percent of income by 200 percent of poverty. No family, regardless of income will pay more than 8 percent of income on their 50 percent share of the premium.

- o Non-workers and those in exempt firms will receive the same subsidies for their 50 percent share of the premium as employees in covered firms. Those below 200 percent of income will receive additional subsidies (on a sliding scale) to make the remainder of the premium affordable.

2. CONTROLLING HEALTH CARE COSTS

A. Premium Assessment. A 25 percent assessment would be imposed on "high cost" health plans to the extent their costs exceed a target cost. The initial target for community rated plans would be based on average per capita health care costs in the particular community rated market area for 1994 trended forward at the rate national health expenditures increase. The target rate of growth thereafter would be CPI plus 3.0 percent for 1987, 2.5 percent for 1988 and 2.0 percent thereafter. The initial target for experience rated plans would be based on each plan's actual experience from 1997-1999, and then will increase generally by the same target growth rate that applies to community rated plans.

Plans in a community rated area where the average premium is less than the target would not be subject to the assessment. The health plan would pay half the assessment and collect the other half from providers in reduced reimbursements. The Secretary of Treasury will have the authority to adjust the reference premium to reflect changes in demographic characteristics and health status. The tax would apply to community-rated plans after 1996 and to experience-rated plans after 1999.

B. National Health Care Cost and Coverage Commission. A National Health Care Coverage and Cost Commission will be established to monitor and make recommendations with respect to trends in health insurance coverage and costs. The Commission will consist of seven members to be appointed by the President and confirmed by the Senate.

Beginning in 1998, the Commission will issue annual reports detailing trends in health care coverage and costs, broken down nationally, by state, and by health care coverage area.

Among other things, the Commission will report 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 households;
- Success of high cost health insurance premium tax in controlling costs;
- Success and adequacy of subsidy program in expanding coverage through employers and households;

The Commission will also issue 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 will 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.

Beginning on January 15, 1999, the Commission will report each year on the affordability of coverage for families and employers and on the success of market incentives and other provisions of this legislation in achieving cost containment. If the Commission finds that coverage is unaffordable or that cost containment efforts are unsuccessful, it will make recommendations for improvements.

If the Commission finds that fewer than 35 percent of those eligible to enroll in the community-rated health plan are able to enroll in a plan with a premium at or below the target premium for the area, then the Commission will consider and recommend to Congress a means of controlling health care cost growth 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 expedited procedures as it considers the Commission recommendation for achieving universal coverage. Consideration of such recommendations under such procedures will not occur more than once in a Congress.

3. INSURANCE MARKET REFORMS

A. Market segments and boundaries. Firms with fewer than 500 workers and individual purchasers (self-employed, nonworkers, AFDC-eligibles) will be in the community rated pool. Firms with 500 or more workers, as well as Taft-Hartley plans and rural cooperatives with 500 or more members, will be permitted to self-insure or purchase experience-rated coverage.

B. Community rating requirements. Community-rated plans could modify their rates based on coverage category (e.g., single, family, etc.), geography, and age (with 2:1 band for population under 65 years of age until 2002). Each community-rated health plan will be required to establish a single set of rates for the standard benefits package applicable to all community-rated eligible individuals and groups within the community rating area.

States draw boundaries for community rating areas. In drawing such boundaries, states cannot subdivide metropolitan areas and must assure that a community rating area contains at least 250,000 individuals.

C. Guaranty fund. States shall be required to establish guaranty funds for all community-rated health plans and in-state, self-insured plans based on federal standards. The Department of Labor would establish standards for and operate a guaranty fund for multi-state self-insured plans.

D. Health Insurance Purchasing Cooperatives (HIPCs). The plan allows for multiple, competing, voluntary HIPCs. States certify HIPCs to serve state-established community rating areas. States may certify more than one HIPC for each such area. HIPCs must be non-profit. States and local governments will be allowed to sponsor or establish HIPCs. If a HIPC is not available in a community rating area, the Federal Employees Health Benefits Program (FEHBP) will be required to establish or sponsor HIPCs in such unserved areas (see FEHBP below).

HIPCs will be responsible for entering into agreements with plans and employers; enrolling individuals in plans; collecting and distributing premium payments; coordinating out-of-coverage with other HIPCs; and providing consumer information on plans' quality and cost.

HIPCs must accept all eligible individuals and firms; provide enrollees a choice of at least 3 plans, including 1 Fee For Service (FFS), 1 Point of Service (POS), and 1 HMO. Requirement of 3 plans could be waived by Governor in rural areas, but FFS must always be available. The Secretary of Health & Human Services will set fiduciary standards for HIPCs. HIPCs will be permitted to negotiate discounts with plans reflecting economies of scale in administration and marketing.

E. Employer Responsibility. Small employers (firms with less than 500 workers) must offer to their employees a HIPC. They may also offer a choice of at least three plans (including a FFS, POS, and HMO) to their employees. These small firms could choose from among the HIPCs in their community rating area.

In order to qualify for an employer premium contribution, employees will be required to purchase health insurance through the three plans or the HIPC chosen by their employer. If an employer chooses to offer a HIPC that is not the FEHBP HIPC in the area, that employer's employees also could choose from the plans offered by the FEHBP HIPC and still qualify for any employer premium contribution.

Large employers (firms with 500 or more workers) must offer a choice of at least three plans (including a FFS, POS, and HMO) to their employees. Large employers can purchase experience-rated health plans or self-insure. Large employers can join together to form large employer purchasing groups, but cannot join HIPCs.

F. Self-insured plans. In general, self-insured plans must comply with the above responsibilities and reforms, including employer and individual premium contribution requirements, coverage of a comprehensive package of benefits, guaranteed issue and renewal, and pre-existing condition limits.

G. FEHBP. The Office of Personnel Management will designate a state-certified health insurance purchasing cooperative in each area as the FEHBP HIPC. If a state-certified HIPC is not available, OPM will be responsible for setting up a HIPC. A HIPC run by OPM would have all of the powers of a state-certified HIPC.

Federal workers will select plans through their local FEHBP HIPC. Premiums for federal workers will be based on the current methodology and will not be age-adjusted. OPM will implement rules to blend premiums for federal workers with premiums for non-federal individuals over time. Federal workers and non-federal individuals will pay the same community-rated premium upon the phase-out of age-rating in 2002.

Workers in firms with less than 500 workers, nonworkers, AFDC recipients, the self-employed can also purchase coverage from the same plans as federal workers through the FEHBP HIPC, but at the age-adjusted community rate. National employees plans (e.g., Treasury) will have a one year transition before they are opened to non-federal individuals.

The federal government and employee and retiree representatives will negotiate to decide whether the federal government will offer and contribute towards supplemental benefits above the standard benefit package for federal workers.

H. Risk Adjustment. Risk adjustment will occur between community-rated health plans to account for differences in health costs that result from differences in their enrollees' health status, demographics, socioeconomic status, and other factors. Community rated health plans must also participate in a mandatory reinsurance program run by the states.

In addition, experienced rated plans will be required to make transfers to the community rated plan pools to adjust for the increased costs in the community rated pools.

I. Family Coverage for Individuals up to Age 25. To further maximize coverage, health plans must allow unmarried children to be covered under parents' policies until they turn 25.

4. NATIONAL HEALTH PLAN STANDARDS

A. State Certification of Plans. States will certify health plans based on federal guidelines. Health plans will be subject to the following market reforms: guarantee issue and renewal, open enrollment, limit pre-existing condition exclusions to six months, and exit from market rules. Supplemental health benefits plans must be priced and sold separately from the standard health plan.

B. Any-Willing-Provider. The plan does not include "any-willing-provider" provisions. The anti-discrimination provision prohibits a provider network from discriminating against providers on the basis of their profession as long as the state authorizes that profession to provide the covered services. However, this provision does not require standard health plans to include in a network any individual provider or establish any defined ratio of different categories of health professionals.

C. Balance Billing. Each standard health plan must have arrangements with a sufficient number and mix of health professionals that will accept the plan's payment rates as full.

D. Access to Specialized Treatment Expertise. Standard health plans that use gatekeeper or similar process must ensure that such a process does not create an undue burden for enrollees with complex or chronic health conditions. Each standard health plan must demonstrate that enrollees have access to specialized treatment expertise.

E. Utilization Management. Each standard health plan must disclose the protocols and financial incentives which they are using to control utilization and costs.

5. BENEFITS PACKAGE

A. The Benefit Package. There are 16 legislatively-defined categories of covered services in a "standard" benefits package, including:

1. Hospital services;
2. Health professional services;
3. Emergency and ambulatory medical and surgical services;
4. Clinical preventive services;
5. Mental illness and substance abuse services;
6. Family planning and services for pregnant women;
7. Hospice services;
8. Home health services;
9. Extended care services;
10. Ambulance services;
11. Outpatient laboratory, radiology and diagnostic services;
12. Outpatient prescription drugs;
13. Outpatient rehabilitation services;
14. Durable medical equipment, prosthetics and orthotics;
15. Vision, hearing, and dental care under 22 years of age;
16. Investigational treatments.

The scope and duration of services are not specified in legislation, but will be defined by a National Health Benefits Board. For mental illness and substance abuse, the board is instructed to seek parity (same copays, coinsurance, deductibles). If the Board cannot initially design a benefit package with parity, it is permitted to place limits, first on hospitalizations and subsequently on outpatient psychotherapy for adults. No copayment will be required for clinical preventive and prenatal services.

B. Cost sharing schedules. The value of the standard benefits package will be equivalent to the actuarial value of the Blue Cross/Blue Shield standard option under FEHBP. The Benefits Board will specify three cost sharing schedules:

- o A low cost sharing schedule, resembling an HMO.
- o A high cost sharing schedule, resembling fee-for-service.
- o A combination cost sharing schedule, resembling a point-of-service plan, in which in-network services would have lower cost sharing schedules similar to an HMO or PPO, and out-of-network services would have higher cost sharing schedules like fee-for-service.

C. The "alternative standard" benefits package. Individuals will have the option of purchasing an alternative benefits package. With a higher deductible, this plan will be offered at a lower actuarial value than the standard plan. While it resembles a catastrophic plan in the size of the deductible, it differs in that it must cover all 16 categories of services. It will not be offered through employers, and supplemental policies will not duplicate services or pay for cost sharing below the deductible. Enrollees selecting this plan will be included in the community rating pool. These provisions are designed to limit the potential for risk selection.

D. National Health Benefits Board. The seven member National Health Benefits Board will determine the scope and duration of services and the details of each cost sharing schedule. In addition, the Board will develop criteria and procedures for defining medical necessity and appropriateness. Members will be appointed by the President, with the advice and consent of the Senate, to staggered six year terms.

E. Cost Sharing Subsidies. AFDC recipients enrolling in a lower or combination cost sharing plan at or below the average premium in the area will pay only 20 percent of the regular cost sharing schedule (e.g., instead of a $10 copay, they pay only $2). If no such plan is available, they can get a cost-sharing reduction in a higher cost-sharing plan (e.g., instead of a 10 percent copay on an doctor's visit, they pay only $10).

For people who are under 150 percent of poverty and are not receiving AFDC, cost sharing is only available if they cannot buy a lower or combination cost sharing plan. If such a plan is unavailable, the person can enroll in a higher cost sharing plan and have their cost sharing reduced to the lower cost sharing level.

For people under 150 percent of poverty and not working, cost sharing is only available if they cannot buy a lower or combination cost sharing plan. If such a plan is unavailable, the person can enroll in a higher cost sharing plan and have their cost sharing reduced to the lower cost sharing level.

For people under 150 percent of poverty who enroll in a plan through an experience-rated employer, no cost sharing is available if the person can enroll in any lower or combination cost sharing plan offered by their employer through which they enroll. Otherwise, the person can enroll in a higher cost sharing plan and have their cost sharing reduced to the lower cost sharing level.

6. EXPANDED BENEFITS FOR THE ELDERLY AND DISABLED

A. Long Term Care. The plan includes several new initiatives to provide long term care services to the elderly and disabled. New programs include:

- o New Home and Community Based Care Program. The plan provides a capped federal entitlement to states to provide home and community-based services to individuals with 3 or more deficiencies in Activities of Daily Living (ADLs), severe mental retardation or severe cognitive or mental impairment regardless of age or income. Funding over the 1995-2004 period totals $48 billion.

- o Long Term Care Insurance Standards. Private long term care insurance policies will be subject to Federal model standards to be developed by the Secretary of HHS in consultation with the National Association of Insurance Commissioners within one year of enactment.

- o Tax Clarification for Long Term Care Insurance. Expenses for long term care services and insurance premiums shall be treated as medical expenses. Other tax clarifications are also included.

- o Life Care Program. The plan establishes a voluntary public insurance program to cover the costs of extended nursing home stays. Individuals will be given the option of purchasing coverage when they reach the age 35, 45, 55, or 65. The program is self-financed and pre-funded.

- o PACE Program. The plan expands Medicaid's Program of All-Inclusive Care for the Elderly (PACE), increasing authorized demonstration sites from 15 to 40. The Secretary of HHS is required to develop provider and service protocols.

B. Medicare Drug. This initiative gives Medicare beneficiaries three drug benefit options: a fee-for-service plan, a Prescription Benefits Management (PBM) option, and an HMO option -- all effective January 1, 1999. Under this new program, beneficiaries will have an annual deductible to be determined by the Secretary of HHS; a 20 percent copay; and an annual out-of-pocket limit of $1,275 in 1999. Medicare Part B premium would be increased by 25 percent of the cost of the drug benefit - estimated to be about $10 in 1999, with Medicare paying the remaining 75 percent.

Drug manufacturers will sign rebate agreements with HHS in exchange for no formulary under the fee-for-service option. Drugs used as part of HMOs or capitated drug plans and drugs for the working aged will not be subject to rebates.

Rebates for single source and innovator multiple source drugs will be 15 percent; rebates for generic drugs would be 6 percent; the Secretary could establish a sliding scale from 2 percent to 15 percent for generic drugs as long as the effect was equal to a 6 percent. From 1999-2004, this program will cost $94.4 billion.

C. Enrollment of Medicare Beneficiaries into Managed Care Plans. Individuals who become eligible for Medicare may choose to remain in their current health plans if such plan is a Medicare Risk Contracting plan under section 1876 of the Social Security Act, or is eligible to become such a risk contract. Payments will be made beginning in the first month in which the individual is Medicare eligible. Payments under this provision shall be the sole Medicare payment to which the beneficiary is entitled.

7. MEDICAID PROGRAM

A. Integration of Medicaid Recipients. (See Coverage section above) Under this plan, the AFDC and non-cash population will be integrated into the general health care reform program and treated like other low-income people eligible for federal subsidies and enrollment in certified health plans. States will be required to make general maintenance of effort payments for services covered under the standard benefit package.

AFDC. Cash Medicaid recipients (AFDC) will be eligible for full premium subsidies as will other families with incomes less than 100 percent of poverty;

Non-cash. Full premium subsidies will be available to all pregnant women and children up to age 19 with incomes up to 185 percent of poverty.

B. Cost sharing for Integrated Medicaid recipients. AFDC recipients in HMOs will pay only 20 percent of the cost sharing amount otherwise required. If no HMO is available, AFDC recipients will pay the cost sharing amount that would apply in an HMO, but not reduced to 20 percent. Noncash recipients will receive cost sharing subsidies like all other low-income individuals -- up to 150 percent of poverty.

C. State and Federal Premium Payments for Integrated Recipients. The federal government will pay all of the premium subsidies for integrated Medicaid recipients. States will pay the federal government maintenance of effort payments for these integrated recipients. Specifically:

- Cash: States will be required to pay an amount equal to: (1) the adjusted, fiscal year 1994 per capita cost of services covered (based upon the state's current Medicaid payment rates) under the standard benefits package for AFDC recipients multiplied by (2) the number of AFDC recipients receiving a subsidy in a given year. Disproportionate Share (DSH) payments attributed to Cash recipients are not included in the calculation of a state's per capita cost of covered services. The per capita cost of services in fiscal year 1994 will be adjusted for future years by the growth in per capita national health expenditures.

- Non-cash: States will be required to make general maintenance of effort payment for services (based upon the state's current Medicaid payment rates), in fiscal year 1994, covered under the standard benefits package for non-cash recipients. State DSH payments which are attributable to the noncash population will be included in the calculation of general maintenance of effort payment. Such MOE payments will increase at the same growth rate as national health expenditures.

D. SSI/Disabled Medicaid Recipients. SSI/Medicaid recipients will not be included in the community rated market. Medicaid will be retained as a separate program, with current rules, for SSI and long-term recipients. States will have the option to pay a per capita amount for each SSI/Medicaid recipient (who is not enrolled in Medicare) that chooses to enroll in a certified health plan. States shall negotiate with certified health plans for rates for the SSI population that are separate from the community rate. No certified plan can have more than 50 percent of its enrollment composed of SSI/Medicaid recipients.

E. Dual Eligible Recipients. Dual eligibles -- persons eligible for Medicare and Medicaid -- will remain under Medicaid and not be enrolled in health plans.

F. Non-SSI, Non-Dual Eligible Recipients aged 18-64 years. These individuals will remain under Medicaid, but as the low-income subsidies phase-in (e.g., 100 percent to 125 percent), these recipients (currently about 240,000) shall be integrated and treated like other low-income individuals.

G. Supplemental Services. Current Medicaid rules governing covered services and recipient eligibility will be retained to cover services not otherwise provided through certified health plans. The current flexibility provided to States to determine the optional services and groups it will cover will also be retained.

H. Miscellaneous Medicaid. In addition, the plan:

- o allows states to expand eligibility for home-based Medicaid long term care services for single persons by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option.
- o eliminates the institutionalization requirement as a condition of eligibility for habilitation services under a home and community based waiver.
- o eliminates the "cold bed" rule for home and community based waiver programs.
- o requires State Medicaid programs to reimburse directly for services by certified registered nurses and anesthetists or clinical nurse specialists that are authorized to practice under State law, whether or not they operate under the supervision of a physician or other health care provider.

8. HEALTH WORKFORCE AND EDUCATION/RESEARCH

A. Graduate Medical Education/Graduate Nurse Training/Academic Health Centers/Medical Schools

- o Creation of an all-payer account. Currently, only Medicare supports graduate medical education. By supplementing this with a 1.5 percent premium assessment, and allocating the total pool to residency training programs and academic health centers, this plan spreads medical education costs across all of the insured.

- Health professional workforce policy. This initiative consists of: (1) phasing in primary care residency positions from 39 percent in 1998 to 55 percent in 2001; (2) reducing the number of total residency positions from 134 percent of US medical school graduates in 1998 to 110 percent in 2001; (3) creating a National Council on GME to implement these policies and modify the goals beginning in 2001; and (4) providing transitional funding to residency programs which reduce their number of residency positions.

- Creation of funding accounts. Funding by account is as follows:

  - GME Account: $27 billion over 5 years;
  - AHC Account: $42 billion over 5 years;
  - Medical School Account: $2 billion over 5 years;
  - Graduate Nurse Training Account: $1 billion over 5 years;
  - Dental School Program: $250 million over 5 years;
  - Public Health School Program: $150 million over 5 years.

B. Biomedical and Health Services Research Fund

- Creation of Biomedical and Health Services Research Fund. This fund is designed to supplement National Institutes for Health and Agency for Health Care Policy and Research funding, which is currently sufficient to finance only a fraction of the peer-reviewed grant submissions.

- Funding levels. The plan's premium assessment will provide additional funding for the NIH and AHCPR.

9. HEALTH INFRASTRUCTURE

A. Public Health Service. To strengthen our public health infrastructure, the following programs receive new or additional funding:

- Core Public Health. Grants to states to improve and monitor the health of population.

- Health Promotion and Disease Prevention. Grants to eligible providers to develop and implement innovative community-based strategies to provide health promotion and disease prevention activities.

- Mental Health and Substance Abuse. Grants to help integrate state MH/SA services with those provided by health plans.

- Comprehensive School Health Education. Grants to state education agencies to integrate comprehensive education programs in schools.

- o School-Related Health Services. Grants to develop school-based or school linked health service sites.

- o Other initiatives. Other initiatives include domestic violence and womens' health; occupational safety and health; and border health improvement.

B. WIC. The bill supplements existing appropriations for the supplemental food program for women, infants and children (WIC) with $2.4 billion in direct appropriations which will allow the program to serve all of the pregnant women, infants and children eligible for WIC benefits.

C. Indian Health Service. The programs of the Indian Health Service are strengthened with grants and loans to improve and expand services. Greater flexibility allows the programs of the IHS to contract with health plans to provide services and receive third party reimbursement. Furthermore, IHS health programs are eligible to apply and receive funding under the public health programs.

10. UNDERSERVED/ESSENTIAL COMMUNITY PROVIDER

A. Access to Care for the Underserved Population

- o Community Health Plan and Network Development. Grants and contracts are awarded to eligible health providers to develop community health groups to provide the standard benefit package in health professional shortage areas or directly to medically underserved population. Grants and contracts are also made to expand existing health delivery sites and services, and to develop new ones.

- o Capital Development. Grants and loans are awarded for the capital costs of developing community health groups and expanding or developing new health delivery sites.

- o Enabling and Supplement Services. Grants and contracts are awarded to eligible entities to assist in providing enabling and supplemental services to the underserved population.

B. Essential Community Providers. Designed to ensure that vulnerable populations enrolling in health plans have access to traditional, safety-net providers (e.g. community health centers and AIDS providers), the essential community provider provision requires that health plans offer a contract or agree to pay essential community providers in their service area.

The plan creates two categories of essential community providers and requires all plans to contract with every essential community provider listed in Category I and one from each category listed in Category II.

- Category I include Migrant Health Centers, Community Health Centers, Family planning grantees, Homeless Program Providers, Ryan White grantees, State HIV drug programs, Black Lung Clinics, Hemophilia Centers, Urban Indian programs STD and TB Clinics, Nonprofit and public DSH hospitals, Native Hawaiian Health Centers, School Based Health Service Centers, Public and nonprofit mental health/substance abuse providers, Runaway homeless youth centers and transitional living programs for homeless youth Public and nonprofit Maternal and Child Health providers, Rural Health Clinics, and Programs of the Indian Health Service.

- Category II providers include Medicare dependent small rural hospitals and Children's hospitals.

In 5 years, the Secretary will make recommendations to Congress on whether or not the program should continue; and if so, with what changes. Congress would then vote up or down on the recommendation.

11. STATE OPTIONS

States that want to move ahead early with the implementation of Federal health care reforms will be allowed do so on a fast track. The bill will also allow states to implement a single payer system. Existing state waivers will be grandfathered.

12. QUALITY AND CONSUMER PROTECTION

A. Quality

- National Quality Council. This 15 member Council, comprised of consumers, health plans, purchasers, States, health care providers and quality researchers, will set national quality goals/standards and establish regional and State-based organizations to implement the goals.

- Performance Measures for Health Plans. The National Council will establish performance measures for health plans, including measures of access (waiting times, patient/provider ratios), consumer satisfaction, health plan report cards for consumers and quality improvement. The Council will conduct surveys of consumers and develop quality reports.

- o Research in quality improvement. The Council will make research recommendations to the Agency for Health Care Policy and Research for outcomes studies and guideline development.

- o Quality Improvement Foundations. These non-profit, non-governmental, regional or State-based organizations will get federal grants for quality improvement (involving health plans and practitioners) on the local level. QIFs will look at practice variations between health plans and different geographic regions. They will engage practitioners in lifetime learning techniques and provide technical assistance to health plans to develop their own quality improvement programs.

- o Consumer Information and Advocacy Centers. These State-based, non-profit, non-governmental organizations will disseminate consumer report cards about health plans; open local offices to hear grievances; and provide consumer education. A National Center for Consumer Information and Advocacy will also be established to train local and State-based consumer advocates.

- o The National Practitioner Databank. This Bureau of Health Professions databank will be opened for public access.

B. Simplicity. The enormous amounts of paperwork that insurance companies now generate and process will be reduced through streamlined and computerized systems. Many consumers will no longer have to submit claims to their insurance company, but if they did, they could use one, uniform claim form. Insurance companies will be required to use a standard form to inform consumers of their claim status.

Because benefits will be standardized, consumers will be able, for the first time, to easily compare plan prices. To help consumers compare prices, states will be required to distribute easy-to-read and understand report cards on health plans.

Consumers will also have information about the results of health care provided by each provider and plan in their area which can help consumers make informed choices when selecting providers and plans.

C. Remedies and Enforcement. These provisions require health plans to give notice of benefit denial, reduction or termination and to establish an expeditious appeals process within the plan. They will create State-run claims review offices to provide claimants with options for alternative dispute resolution. State and federal judicial review are also possible.

D. Fraud and Abuse. The bill creates an all-payer fraud and abuse program, including State-based fraud control units funded wholly from settlement revenues.

E. Privacy. Consumers are assured that their individually identifiable health information is protected by a law which prevents inappropriate disclosures and punishes unlawful disclosures severely. Consumers have uniform legal rights to inspect, get copies, and make corrections or amendments to their health records. Patients have the right to restrict disclosure of specific health information.

F. Antitrust. Repeal of the McCarran Ferguson Act with respect to health insurance will subject health insurance companies to antitrust actions. The bill does not include increased antitrust exclusions or safe harbors.

G. Malpractice Reform. Malpractice reforms include: mandatory State-based alternative dispute resolution; a certificate of merit requirement; a limitation on the amount of attorney's contingency fees to 33 percent of the first $150,000; and 25 percent above that amount; and periodic payment of awards. Studies and demonstrations are proposed on medical negligence; the use of practice guidelines; and enterprise liability demonstration project.

13. RELATED ISSUES

A. Veterans Affairs

- Enrollment. The Department of Veterans may offer a VA health plan to veterans, individuals eligible for CHAMPVA, and their family members.

- Eligibility. All compensable, service-connected, disabled veterans, low-income veterans, veterans who are ex-POWs, and veterans who have been exposed to Agent Orange, radiation, or unknown toxins in the Persian Gulf, who chose a VA health plan will receive the standard benefits without a cost-sharing requirement.

- Fiscal Matters. VA will continue to receive appropriations to its medical care account. VA will retain the premiums, copayments and deductibles it receives from higher income, nonservice-connected veterans and dependents, the premiums VA collects from the sale of supplemental health plan, and payments it receives from other plans for the furnishing of care to other plans' patients. It also will retain Medicare reimbursement for care furnished to higher-income, Medicare eligible veterans who have no service-connected disabilities, and dependents. (VA health plans will be considered to be Medicare HMOs).

- o Administration Flexibility. VA health plans will have expanded authorities to enter into contracts and sharing agreements for the furnishing of services to enrollees. VA facilities not operating as part of a VA health plan will continue to furnish health care services under current law.

NOTE: Because of technical Budget Act requirements, certain VA program changes may have to be made on the floor.

B. Worker's Compensation. The plan creates a Commission on Worker's Compensation Medical Services consisting of 15 members charged to consider a number of issues related to the relationship between health plans and workers compensation medical services. The Commission will report to the President, as well as the House Education and Labor and Senate Labor and Human Resources Committees by October 1, 2000. The plan also authorizes a number of State demonstrations with respect to work related illnesses and injuries.

14. FINANCING

This plan will not increase the federal deficit over the 1994-2004 period.

A. Medicare. Medicare savings total about $54 billion over five years, and $278 billion over 10 years. About $140 billion of that total would finance a new Medicare prescription drug benefit and a long term care entitlement for the elderly and the disabled.

B. Medicaid. The plan eliminates the acute portion of Medicaid and instead provides subsidies for low income individuals to purchase health insurance from private plans (this new subsidy absorbs $387 billion in ten year Medicaid savings). In addition, the plan saves another $129 billion in Medicaid DSH payments by reducing the number of uninsured. Finally, states will be contributing about $232 billion in subsidy payments over the ten year period which represents their existing Medicaid costs, grown each year at national health expenditures. Since states' existing Medicaid costs are growing at a much higher 12 percent, this MOE represents substantial savings for the states.

C. Revenues.

- o Increase in excise taxes on tobacco products. The plan will increase the excise tax rate on small cigarettes by 45 cents per pack (for a total of 69 cents per pack), phased in over five years on the following schedule: 15 cents in 1995 and 1996, 25 cents in 1997, 35 cents in 1998, and 45 cents in 1999 and thereafter. The excise tax on other currently taxable tobacco products would be increased proportionately.

- Premium assessment. The proposal will impose a 1.75 percent assessment on health care premiums. The net revenues derived from the imposition of this premium assessment would be used to fund the Graduate Medical Education and Academic Health Centers Trust Fund and the Biomedical and Behavioral Research Fund. The assessment would be effective after December 31, 1995.

- High cost premium assessment. As discussed earlier, a 25 percent assessment would be placed on health plans to the extent they exceed the target rate of growth.

- Cafeteria plans. The proposal will eliminate the exclusion for employer-provided accident or health benefits provided through a cafeteria plan or flexible spending arrangement, effective on and after January 1, 1997, with a delayed effective date for collectively bargained plans.

- Finance Committee provisions. The following provisions are taken from the Finance Committee bill.

    - Additional Medicare Part B premiums for high-income individuals.

    - Increase excise tax on certain handgun ammunition.

    - Modification to self-employment tax treatment of certain S corporation shareholders and partners.

    - Extending Medicare coverage of, and application of hospital insurance tax to, all state and local government employees.

    - Modify exclusion for employer-provided health care.

    - Repeal of volume cap for 501(c)(3) bonds.

    - Self-employed deduction.

      The 25-percent deduction for health insurance expenses of self-employed individuals will be reinstated and extended for taxable years beginning after December 31, 1993, and before January 1, 1996. Beginning January 1, 1996, self-employed individuals who are not eligible for employer-subsidized health coverage will be entitled to deduct up to 50 percent of the cost of the standard benefits package. In the case of a self-employed individual with at least one full-time employee who has been employed for at least 6 months, the 50-percent deduction will be reduced based on the contributions the self-employed individual makes with respect to coverage of the individual's employees.

- o Limitation on prepayment of medical insurance premiums.
- o Tax treatment of voluntary employer health care contributions.
- o Tax treatment of organizations providing health care services and related organizations.
- o Tax treatment of long-term care insurance and services.

  In addition, reserves for long-term care insurance contracts that constitute noncancellable accident and health insurance generally will be determined in accordance with the reserve method prescribed by the National Association of Insurance Commissioners (NAIC).
- o Tax treatment of accelerated death benefits under life insurance contracts.
- o Definition of Employee.
- o Increase in penalties for failure to file correct information returns with respect to non-employees.
- o Nonrefundable credit for certain primary health services providers.
- o Expensing of medical equipment used in health professional shortage areas.
- o Tax treatment of funding of retiree health benefits.
- o Tax credit for the cost of personal assistance services required by individuals.
- o Disclosure of taxpayer return information for administration of health subsidy programs.

15. CONTROLLING FEDERAL COSTS -- FAIL SAFE

The bill's fail safe guards against future unanticipated deficit increases due to this legislation. After enactment, OMB will publish an initial health care baseline including its most up-to-date estimate of the net outlays and revenues from the health reform bill, as well as all Medicare and Medicaid spending. Starting with fiscal year 1997, the President's budget will include an updated version of the initial health baseline. If the updated baseline (excluding non-health-reform-related differences) exceeds the initial baseline, reform spending (with the exception of the subsidies for pregnant women and children) would be cut back to eliminate the overage. Changes made by the sequester order would not be permanent, and the sequester would be suspended during a recession.

Why the Mitchell Bill Gets Us To Universal Coverage

"The [Mitchell] bill says that we will use voluntary mechanisms -- the marketplace, the beneficial effects of managed competition, insurance reform, and some subsidies to those who are uninsured-- to reach a level of 95 percent of coverage by the year 2000, and then there will be recommendations by a commission to the Congress on which Congress must act to go the rest of the way" -- Sen. George Mitchell, Aug 2, 1994

The Mitchell plan has a guaranteed path to universal coverage. Senator Mitchell's bill does not set 95% as a goal -- it sets 95% as a yardstick to measure how quickly we are heading toward universal coverage, and what other steps are then needed to finish the job. Under the Mitchell bill, the Congress does not rest until every American is covered.

Voluntary measures and incentives

Senator Mitchell's bill uses a voluntary approach with market incentives to increase the number of Americans with health coverage. A combination of subsidies, new incentives for employers not now providing coverage, and the better rates that come with purchasing in big groups should increase the number of employers who provide insurance and the number of families who enroll.

Fairer insurance laws and special subsidies for people out of work will mean that people won't have to worry about losing insurance when they change jobs or lose their job. Senator Mitchell believes -- and the Congressional Budget Office agrees -- that this combination of incentives and special protections will dramatically increase the number of Americans with insurance, extending coverage for more than 25 million people who don't now have coverage in four years.

Trigger to a Mandate

The National Health Care Cost and Coverage Commission will determine whether the voluntary system has achieved 95% coverage in a report to Congress on January 1, 2000. If 95% coverage has not been achieved, the Commission is required to submit to Congress implementing legislation that will result in universal coverage. The GAO must certify ***"if implemented, the legislative proposals in such bill would expand health care coverage to cover the remaining uninsured population."*** [Mitchell bill Sec. 10004 (2)] Congress must consider these proposals on a fast-track.

If the Congress fails to enact legislation by December 31, 2000, employers and employees automatically share the premiums under a system of universal coverage.

Additional Efforts Even If 95% Is Reached

If total coverage does increase to 95% by the year 2000, the United States will clearly be heading at a rapid pace toward full coverage. But just to make sure this is the case, the Cost and Coverage Commission will evaluate progress year by year, and make sure we finish the job.

Even if 95% coverage is achieved, the Commission will still send Congress recommendations on how to insure the remaining uninsured. Congress will consider this legislation in an expedited process.

Incentives For States To Achieve Full Coverage On Their Own

The bill also removes federal barriers for states that are ready to implement full coverage right away. Not only does the Mitchell plan allow states to achieve full coverage early; it rewards them financially if they do, by letting the states keep the federal savings to the Medicaid program.

The Mitchell bill sets a clear, definable path to full coverage, and provides businesses, families, and states with incentives to cover everyone as soon as possible.

The Mitchell Bill Provides Affordable Coverage to All America's Children

The Mitchell bill provides affordable coverage for all kids by 1997.

- Children under 19 and pregnant women will be eligible for premium subsidies. Children and pregnant women living in families with incomes below 185 percent of poverty will receive full subsidies. This will cover 6.2 million kids.

- Children and pregnant women with incomes between 185 and 300 percent of poverty will receive subsidies on a sliding scale. This will cover an additional 1.3 million kids.

So that means that a total 7.5 million children will get coverage through premium subsidies.

- In addition, unfair insurance practices that today exclude children in middle-income families from insurance will be eliminated.

By 1997, therefore, the Mitchell bill will provide affordable coverage for the 9 million American children who today have no health insurance. By contrast, under the new Dole bill, fewer than 750,000 children will gain coverage, less than one tenth the number of kids Senator Mitchell's bill covers.

The Mitchell bill provides comprehensive preventive care for kids.

- The benefits package in the Mitchell bill includes important preventive services for children. Immunizations, well-child visits and screenings will be covered at no cost.

The Mitchell bill preserves additional benefits for children with special needs.

- Children who currently qualify for Medicaid will continue to receive the additional services now covered under the Medicaid program. This will ensure, for example, that children with special needs get the additional rehabilitation services that are critical to their development.

The Mitchell bill supports essential nutrition programs .

- The Mitchell bill provides full funding for the WIC Program so that all low-income pregnant woman and children who are currently eligible for the program can be served.

CHILDREN AND HEALTH CARE:
The Problem Today

MILLIONS OF CHILDREN HAVE NO INSURANCE; MILLIONS MORE INSECURE:

- 9 million children and half a million pregnant women have no health insurance. [Census Bureau, CPS, 3/93]

- One out of every ten children under age six are uninsured, perhaps the most critical years of a child's development. [Census Bureau, CPS, 3/93]

- One in five American children had no contact with a doctor in 1992. [Children's Defense Fund]

- 17 million children are uninsured for part or all of the year. [Bureau of the Census, 1990-1992 SIPP for CDF]

- Many thousands of children are locked out of the health insurance system because of pre-existing condition exclusions.

MAJORITY OF UNINSURED CHILDREN IN MIDDLE CLASS FAMILIES

- 58% of uninsured children were dependents of full-time, full year workers. [Subcommittee on Children, 11/16/93]

- Approximately 30% of adolescents without insurance live in middle class families with incomes above 200% of poverty. [Subcommittee on Children, 11/16/93]

BY 2000, ONLY 50% OF CHILDREN WILL HAVE EMPLOYER-BASED COVERAGE:

- If current trends continue, only about half of the nation's children will be covered by employer-provided health insurance by the year 2000. *"For two decades, employer cost-cutting and the rising cost of health insurance have forced millions of children out of the private health insurance system."* [Children Defense Fund, 3/3/94]

- The percentage of children who were covered by employers fell from 64.1 percent in 1987 to 59.6 percent in 1992. Had the coverage percentage stayed at 1987 rates, more than 3 million additional children would have had employer-based insurance in 1992. [Children Defense Fund, 3/3/94]

MILLIONS MORE CHILDREN HAVE INADEQUATE COVERAGE TODAY:

- Millions have private insurance that fails to cover preventive services as well as special treatment needed by children with physical and emotional disabilities.

- Only about a third of health insurance policies in medium and large firms -- typically the most comprehensive plans -- covered well-baby care. [BLS, Employee Benefits Survey, 5/93]

- Only 42% of children with health insurance are covered for routine immunizations. [Subcommittee on Children, 11/16/93]

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The Mitchell Bill Provides Strengthened Protection and New Benefits For Older Americans

- **Preserves Medicare.**
- Under the Mitchell bill, Medicare will be preserved and strengthened. Older Americans will continue to receive the same Medicare coverage -- with guaranteed security. Seniors can keep seeing the doctors they see today, with expanded benefits. And doctors and hospitals will no longer be able to charge more than what Medicare pays.

- **New prescription drug coverage.**
- The Mitchell bill adds prescription drug coverage to Medicare -- providing desperately needed protection for older Americans. Older Americans will get protection against prescription drug prices that represent their highest out-of-pocket medical cost. An annual cap will be placed on out-of-pocket prescription drug costs, and above this amount, drug costs will be fully covered.

- **Helps with home and community-based long-term care.**
- The Mitchell bill takes historic steps toward long-term care coverage, creating a new, $50 billion home and community-based long-term care program. It will help Americans who need long-term care live independently at home and in their communities -- which most older Americans, people with disabilities, and their families and friends prefer.

- **Improves the quality and affordability of long term care insurance**
- The Mitchell bill creates tough new standards that all private insurers selling long-term care policies must meet. It also clarifies tax rules so that long term care services an insurance premiums can be deducted from taxable income. And the plan establishes a federal long term care insurance program to cover the costs of extended nursing home stays. People will have the option to purchase coverage when they reach age 35, 45, 55, or 65.

- **Guarantees security to early retirees.**
- Under the Mitchell bill, American workers who retire early will not have to worry about losing affordable health insurance. Today many of these Americans are vulnerable -- dropped from their coverage and not yet eligible for Medicare. Under the Mitchell bill, insurance will always be secure and affordable..

- **Outlaws insurance company discrimination against older workers.**
- Today, insurance companies pick and choose whom they cover -- and they charge older workers far than younger workers. These practices will be outlawed under Senator Mitchell's bill -- insurance companies can vary premiums by no more than 2:1. And no one can deny coverage to an older worker who's once been sick.

- **Enhances medical research**
- The Mitchell bill creates a special fund for academic health centers and medical research, which should mean increased commitment and research dollars for the fight against Alzheimer's disease.

MEDICARE

- **Preserves and Strengthens Medicare**

  Under the Mitchell bill, older Americans will see little difference in where, how or from whom they receive their health care. And although every health reform proposal before the Congress calls for significant savings from Medicare, the Mitchell bill is the only one that reinvests the savings in two new benefits for older Americans: prescription drugs and a new federal/state program outside of Medicare providing home- and community- based long-term care.

- **Provides Prescription Drug Coverage**

  Medicare beneficiaries will have 80 percent coverage for their medications after they reach a $250 deductible. A $1,000 annual cap will be placed on out-of-pocket prescription drug costs, with costs above this amount fully covered. Patients will receive counseling from their pharmacist on what medications are most appropriate.

- **Increases Choice for Medicare Beneficiaries**

  For Medicare beneficiaries reform will mean more choices among health plans, and the ability to choose a plan which may offer lower copays and deductibles than traditional Medicare coverage offers today.

- **Protects Seniors Against Fraud and Overcharges**

  The Mitchell Bill calls for new penalties to pursue and prosecute those who order unnecessary tests and procedures to defraud Medicare and senior citizens. In addition, the Mitchell Bill controls rising costs in both the private sector and Medicare.

- **Lowers Medigap Premiums**

  For those who currently buy a Medigap policy to cover prescription drugs and overcharges, the Mitchell Bill will mean significantly lower costs. The plan stops doctors or hospitals from charging more than Medicare covers. And it prohibits insurance companies from using pre-existing conditions to exclude people from Medigap coverage.

- **Eliminates Balance Billing**

  The Mitchell bill prohibits doctors and hospitals who participate in Medicare from charging more than Medicare pays.

OLDER AMERICANS: THE CURRENT SYSTEM

No Prescription Drug Coverage. Nearly two thirds of Americans over the age of 65 have no prescription drug coverage. But while people under 65 purchase an average of four prescriptions a year, people over 65 purchase, on average, four times that amount -- 16 prescriptions each year.

This means that many Americans are in a position like Benjamin Gagliani, a 66 year-old retired bookkeeper from Alabama. Each month he must spend $340 of his $594 income on prescription drugs because Medicare provides no prescription drug coverage. With all his prescription drug expenses, he often runs short of money for food and must rely on "Meals on Wheels" for his one daily meal.

Medicine Is Often Priced Out of Reach. Prescription drugs are the highest out of pocket expense for three out of four older Americans. And drug companies charge three times more for prescription drugs made in America here in the United States than they charge for the same drugs overseas, with prices continuing to skyrocket.

The result: more than 8 million Americans over age 55 say they have to choose between food and medicine. And more than 17 million prescriptions each year go unclaimed after pharmacists fill the orders, mostly because consumers cannot afford to pay for them.

Little Help With Long-Term Care At Home. Most older Americans want to stay at home with their families if they become disabled and need long-term care. Many senior citizens just need a visiting nurse or someone to pick up groceries in order to live independently. But in today's system, many are forced into nursing homes because they have no way of getting the help they need.

Older People Discriminated Against By Insurance Companies. Insurance companies today use age and health status as factors in setting the price of insurance premiums. This means that older workers or retirees who don't yet qualify for Medicare often are forced to pay several times what younger people pay for the same insurance. Moreover, older people are often denied coverage because they have a pre-existing condition or simply because they are older.

Little Protection For Early Retirees. 60 percent of the nine million early retirees in the United States are not insured by their former employers. Even those companies who used to provide health benefits to retirees are being forced to pare back their commitments because of rising costs. Early retirees are therefore particularly at risk of being without adequate coverage. Because they are older, on their own, and may have experienced health problems, they have a difficult time getting quality insurance at an affordable price.

Skyrocketing Costs of Care. In 1965, Congress enacted Medicare to ensure that America's elderly were not driven into poverty by health care costs. Medicare has been a great success. But health care prices are rising so fast that older Americans spend more of their incomes on health care today than they did before Medicare began.

THE DOLE BILL IS BAD FOR STATES

Problems with Medicaid

- **States are on the hook for Medicaid caps.** Before AFDC and non-cash recipients are integrated into the low-income assistance program -- potentially from 1997 until 2000 -- both federal and state payments for these individuals under Medicaid are capped.

  However, states are not permitted to eliminate any category of eligibility under Medicaid. And, an entitlement to services under Medicaid remains in effect.

  So if Medicaid costs rise faster than the caps (which is likely):

  - States would inevitably be subject to lawsuits requiring them to provide services and make up any funding shortfall.
  - States would come under enormous pressure -- from both providers and advocates for recipients -- to fund any shortfalls.
  - As they are generally the health care providers of last resort, state and local governments would likely bear the financial burden of reductions in access under a capped Medicaid program.

- **States have no control over maintenance of effort payments.** After AFDC and non-cash recipients are integrated into the low-income subsidy program -- as early as 1997 at state option, and no later than 2000 -- states are required to make maintenance of effort payments.

  Maintenance of effort payments increase each year based on the increase in premiums under the Federal Employees Health Benefits Program (FEHBP). Since states have no control over how fast FEHBP premiums rise, they are left with no control over a substantial portion of their state budgets.

- **Disproportionate Share Payments are Cut 25%.** The Dole Bill cuts DSH payments by 25%, without substantial expansion in coverage or reductions in uncompensated care.

Problems with the New Low-Income Subsidy Program

- **States would be on the hook if subsidies are underfunded.** If subsidies are underfunded -- which is likely without any effective cost containment in the Dole Bill -- then eligibility for subsidies is cut off.

If subsidies are eliminated for a large number of low-income people, states would be under pressure -- both from providers at risk for uncompensated care and from interest groups for the disabled and low-income populations -- to continue coverage at full state expense.

- **Uncompensated care burden on states continues.** Because few people would get coverage under the Dole Bill, uncompensated care would continue to be a problem for employers, families, and state governments.

- **No funding for start-up costs.** States are expected to establish new programs to deliver low-income subsidies, but they are provided no money for planning or start-up costs.

- **No relief from administrative burdens.** Anyone who would be eligible for Medicaid under current eligibility rules would automatically be eligible for a subsidy under the Dole Bill. So states receive no relief from the burdensome Medicaid eligibility process.

<u>No Real State Flexibility</u>

- **Not only does the Dole Bill fail to achieve universal coverage, but it prevents states from doing so.** ERISA preemption of state reform efforts would continue under the Dole Bill. The federal government would continue to stand in the way of states that want to move towards universal coverage. And, the Dole Bill does not include a state single payer option.

- **The Dole Bill is contrary to welfare reform.** Since the Dole Bill provides little if any subsidies for low-income workers -- and, in fact, imposes an enormous marginal tax rate on these workers -- it does little to aid state and federal welfare reform efforts to move people from welfare to work.

<u>Problems with Insurance Market Reforms</u>

- **The Dole Bill Undermines State Insurance Regulation.** The Dole Bill permits any small employer to self-insure, and permits associations of small employer associations to escape state regulation and choose regulation under ERISA.

  These provisions fundamentally undermine the ability of a state to establish and regulate a viable community-rated market.

- **The Dole Bill Gives States Little Authority Over Insurance Reforms.** At best under the Dole Bill, states have the authority to regulate only the insurance market for businesses with 50 or fewer employees. And if many small businesses join self-insured associations, states would be left with a shrinking insurance market within their regulatory authority.

CBO VALIDATES THE MITCHELL BILL

CBO SAYS THE MITCHELL BILL WILL....

Meet Its Goal of Universal Coverage

CBO confirms that the Mitchell bill will *"meet its target of 95 percent coverage"* by 1997, using market forces and subsidies, with a Commission to recommend how to cover the remaining uninsured. However, CBO confirms that if the market does not reach universal coverage on its own, the system of shared responsibility that would trigger into effect will reach universal coverage in 2002. [CBO, p. 1, Table 5]

In contrast, preliminary analysis has concluded that the Dole bill -- which has not yet been analyzed by CBO -- *will guarantee coverage to less than one million more people in 1997, leaving nearly 39 million Americans uninsured.*

Pay for Itself, with Money Left over for Deficit Reduction

CBO says that the Mitchell bill -- with subsidies for individuals with incomes up to 200 percent of poverty, children and pregnant women up to 300 percent of poverty, employers expanding coverage and the temporarily unemployed -- will be fully funded, yet still generate *$14 billion in deficit reduction by 2004.* The Mitchell bill will yield short term deficit reduction of $3.7 billion by 1999. [CBO Analysis of Senator Mitchell's Health Proposal, Table 1]

In contrast, the Dole bill has no deficit reduction and only has enough funding to guarantee coverage to less than one million people.

Allow Job Creation to Continue on its Expected Upward Path

CBO says that under Mitchell's backup system of shared responsibility the rate of job creation -- which is currently moving forward at more than 2 million jobs per year -- will continue on its upward path. While critics may claim otherwise, CBO states the effect of the plan on the rate of expected job creation *"would likely be very limited."* [CBO p.18]

In contrast, the Dole plan barely reduces the number of uninsured, leaving over 20 million Americans in working families to continue to go without coverage.

Lower the Growth of Health Costs

The Mitchell plan will inject market forces into the health care system by forcing insurance companies to compete on quality and price. Furthermore, insurance companies will face incentives to keep their premiums down because insurance companies that spike up premiums excessively will be taxed. CBO estimates that the cost containment in the Mitchell plan will lower the future rate of growth of health spending in the nation. [CBO p. 13, Table 6]

In contrast, the Dole plan lacks any form of scorable private sector cost containment.

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Net Effect of Senate Proposal on Average Payments for Private Health Insurance, Relative to Current System

	1997			2004		
	Community Rated Pool	Experience Rated Pool	Private Sector Average	Community Rated Pool	Experience Rated Pool	Private Sector Average
Medicaid Cost Shift (1)	2.2%	-1.8%	0.2%	3.0%	-1.1%	0.9%
Medicare Cost Shift	0.0%	0.0%	0.0%	0.5%	0.5%	0.5%
Non-Worker Cost Shift	2.9%	0.0%	1.4%	2.9%	0.0%	1.4%
Cross Pool Risk Adjustment (2)	-1.3%	1.3%	0.0%	-1.3%	1.3%	0.0%
High Cost Plan Assessment (3)	0.2%	0.0%	0.1%	0.4%	0.1%	0.3%
Universal Coverage (4)	-6.0%	-6.0%	-6.0%	-6.0%	-6.0%	-6.0%
Gains from Group Purchasing (5)	-12.7%	0.0%	-6.4%	-12.7%	0.0%	-6.4%
Academic Health Centers	1.75%	1.75%	1.75%	1.75%	1.75%	1.8%
Cafeteria Plan Limitations	0.1%	0.4%	0.2%	0.5%	2.1%	1.3%
Net Total Additions	-14.0%	-5.0%	-9.5%	-11.7%	-1.4%	-6.5%

Notes:

(1) Includes payment rate differences, demographic effects, and growth rate effects.
(2) CBO estimate
(3) Includes incidence of assessment and effect on growth rate of premiums.
(4) Quantifies reductions in uncompensated care.
(5) Reductions in administrative costs expressed as weighted average across firm sizes.

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Change in National Health Expenditures By Source ($ billions)		
Source	2000	2005
National Health Expenditures	+ $33	+ $27
Federal	+ $38	+ $31
State and Local	-$3	- $6
Private	- $2	+ $2

NATIONAL GOVERNORS' ASSOCIATION

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August 9, 1994

M E M O R A N D U M

To: Robert M. Rozen
Legislative Counsel
Office of Senator George Mitchell

From: Raymond C. Scheppach

Re: Preliminary Concerns about the Health Security Act

Thank you for meeting with us yesterday to discuss some of the Governors' concerns about the Health Security Act as proposed by Senator Mitchell. As you requested, the following is a description of the issues that were discussed with you. I believe that many Governors are likely to oppose Senator Mitchell's bill if substantial changes are not made to the Medicaid provisions.

MEDICAID STRUCTURE

Problem. We support integrating AFDC and non-cash categorical Medicaid beneficiaries into the new low income subsidy program. However, because your plan requires states to maintain existing benefits and existing benefit levels for this population above the levels offered in the standard benefits package, we believe that there will be no streamlining for states, and in fact, states can expect increases in Medicaid complexity and administrative expenditures as a result of the plan. We cite three examples.

- If the health plan offering the standard benefits package offers a service that is less in amount, duration, and scope than offered under Medicaid, the state must pay for coverage up to the Medicaid's amount, duration, and scope provisions. This will result in states developing complex administrative systems to pay for this "wrap around" for standard benefits. Moreover, this provision will give health plans an incentive to limit amount, duration, and scope provisions in the standard benefits package in order to shift costs to states.
- AFDC and non-cash categorical beneficiaries will remain eligible for all other acute care benefits that are not part of the standard benefits package. This requires states to maintain all eligibility systems for these populations with eligibility requirements that go beyond eligibility for the new low income subsidy program. Moreover, this provision maintains inequities in benefits among poor people using categorical criteria that are not based on need.

- It will be more difficult to place Medicaid beneficiaries in managed care. No more than 50 percent of total enrollees in a HMO can be Medicaid beneficiaries. This is a rollback from current law which is 75 percent. This will take Medicaid individuals out of managed care in a number of states. Fee-for-service is more expensive to administer than managed care.

Alternatives:

- The provision that requires states to pay for differences in the amount, duration, and scope of services in the standard benefits package should be deleted. All subsidized beneficiaries should have the same benefits package.
- The supplementary Medicaid benefits beyond the standard benefits package should be changed from an individual entitlement to AFDC and non-cash categorical beneficiaries and should be restructured as an entitlement to states using the new home and community based care program as a model. (See attached low income subsidy paper.)
- There is no need to limit the number of Medicaid beneficiaries in managed care. The "75/25" rule was implemented as a proxy for assessing quality, and the Mitchell plan now has national quality standards that preclude the need for this requirement. Not only should the test not be reduced to "50/50" but it should be eliminated altogether.
- Moreover, with the advent of the new low income subsidy program and the development of community rating areas, states should be given all opportunities to move their Medicaid beneficiaries into managed care. We suggest that states be permitted to enroll beneficiaries in primary care case management systems and partially or fully capitated systems of care without the need for a waivers. This should be established within 6 months of enactment of the legislation and is particularly important if there are any delays in the implementation of the new low income subsidy program.
- States should be allowed a window of three years after January 1997 in which they can integrate their Medicaid populations into the new low income subsidy program.

MEDICAID MAINTENANCE OF EFFORT

Problem: We support using 1994 as a base for the calculation of maintenance of effort. However, we cannot support annual growth in that amount based on the rate of increase in either per capita or national health care spending.

Such an approach is entirely unacceptable for the following reasons.

1. The rate of increase in total national health care is composed of four major components as follows: a) health care inflation; b) changes in population; c) increases in benefits; and, d) increases in the quantity of health care services, which are driven largely by the aging of the population. While states do not mind having an adjustment factor that reflects health care inflation and changes in population, they should not be held accountable for national changes in benefits or quantity changes such as those associated with the aging of the population.
2. The extension of health care benefits to all low-income individuals will substantially increase total and per capita national health care spending in the future and should not be reflected in a state maintenance-of-effort contribution.
3. The rate of increase in Medicaid acute care has been decreasing the last several years and as states are allowed to use managed care, most states now believe that this rate will continue to decrease and be below that projected for total national health care spending growth.

From a financial standpoint the states would be better off with the current Medicaid program as opposed to this proposal. Currently, spending on Medicaid is averaging about 18 percent of state budgets, with some states as high as 35 percent. Your maintenance-of-effort will force states to pay a rate of increase over time that is equal to double their current projected revenues over the next several years. Within the next three to five years this would make the Medicaid maintenance-of-effort over 25 percent of all state spending. It is wrong to place such a new huge additional unfunded mandate on states to pay for health care reform.

Alternative: We suggest the following for each state. Calculate the baseline for the AFDC and non-cash categorical populations as proposed n the Health Security Act. Sum the aggregated amounts for both AFDC and non-cash so that there is one baseline dollar amount for each state. This total would then be increased annually by the annual percentage increase in the states' medical inflation and the annual percentage increase in the state's general population.

Such an approach would provide a strong incentive for states, through other policies, to develop cost control strategies in their respective states. For stability to state budgets, the annual increase could be a five year rolling average of the percentage increases. Since annual medical inflation is not calculated on a state-by-state basis, CPI plus a declining percentage add-on (starting at 2 percent) could be used until the state medical inflation index is developed and reliable.

DELIVERY SYSTEMS

Problem: The states will take on significant new responsibilities in restructuring and overseeing the private health care delivery system as a result of the Health Security Act. While states have a lot of additional responsibilities, the overall philosophy of the bill is very much a federally determined system. Virtually all decisions are made by the federal government and states administer the program. States have limited authority to make decisions and little flexibility. Moreover, rigid federal standards are called for unnecessarily in areas where states have made significant progress in improving health care delivery systems. While we agree that complete state flexibility would undermine a national system, federal standards should be used as a minimum, above which, states could impose more restrictive criteria.

Alternative: The appropriate balance between national conformity and state flexibility is critical both to an efficient health care delivery system and to timely implementation of the plan. A more efficient approach than that incorporated into the Health Security Act would be to set standards only in those areas where it is critical to compare across health plans or to ease the problems for multi-state firms. In other areas broad guidelines are important but states would establish standards within federal guidelines while other areas states should set standards. Such a system would look for like the following.

Federal Standards

- Quality improvement and assurance.
- Medical record keeping.
- Health information and data requirements.
- Other measures which are critical to compare health plans, e.g., health outcomes.

Federal Guidelines with State Standards

- Comparative consumer information.
- Marketing materials.
- Grievance procedures.

State Standards

- Financial standards.
- Solvency requirements.
- Liquidity requirement.
- Accounting and reporting.
- Guarantee fund participation.
- Capital requirements.

OTHER ISSUE AREAS

Funds to Administer the New Low-income Subsidy Program. States will assume the administrative responsibilities for a new low-income subsidy program and there are no federal funds to help pay for administration of this new program. Currently Medicaid administration costs $7 billion annually, serving about 30 million beneficiaries. This new program could have more that 80 million participants. In the Mitchell bill, states are given the ability to impose up to a 1 percent premium tax to generate funds for administration. It is not up to the states to have to impose a tax to fund a new federal program. The federal government should impose the tax or find an alternative financing mechanism.

1.75 Premium Tax. This provision needs to be clarified. It is unclear for the new low-income population and Medicaid, who pays the premium tax. Also, this has been a traditional tax source for states that it not only be preempted, but states are being charged 1.75 percent for state employees. They should be exempt.

Medicaid Home- and Community-based Care. The maintenance-of-effort requirement in the existing Medicaid and community-based care program should be eliminated or at least indexed by the growth in the national population.

Mental Illness and Substance Abuse Services. The provision that requires states to integrate their public mental illness and substance abuse systems into the private delivery system by year 2001 needs to be eliminated. It is inappropriate to require that states funds are used to offset premium costs of the general population to oversee an unlimited mental illness and substance abuse benefit.

Planning and Start Up Funds. While $100 million for planning grants may be sufficient to plan for the system, a 50 percent state match for start up funds is too high. This is a new federal system and therefore the federal government needs to pay 90 percent of start up funds. Otherwise the system will take a very long time to operationalize.

Mandates and Advocacy Funding. Throughout the bill there are a significant number of federal mandates that will be very costly to states. These need to be eliminated from the bill. In addition, there is a substantial amount of federal funds for advocacy groups that can be used for litigation against states. These funds need to be eliminated from the bill. It is the role of the federal government, not the advocacy community, to have oversight of state implementation.

Section 5534. This section of the Act gives individuals a private right to enforce state responsibilities. This right to sue should be eliminated from the legislation.

Malpractice. The malpractice provisions are too limiting for states and would actually weaken provisions currently enacted is some states. The Act needs to be revised to set federal minimum standards and allow states to include stronger requirements.

Thank you for your interest in our issues. If you have any questions please do not hesitate to call me at 624-5320 or Carl Volpe of my staff at 624-7729.

Some Talking Points on the Mitchell Bill and the Private Sector

- The two most important consequences of the Mitchell bill are:

  (1) it extends coverage to 27 million Americans, allowing us to reach 95% coverage through voluntary measures alone.

  (2) it reduces the deficit over 1995-2004.

- On average, private health insurance premiums will cost about 9% less than baseline in 1997 and about 6% less than baseline in 2004. The two most important reasons for these gains are:

  (1) reductions in uncompensated care from expanding coverage. Today, providers shift the unreimbursed cost of services delivered to the uninsured into higher charges for private payors, which pushes up premiums for the insured. Expanding coverage will permit these extra private charges to decline.

  (2) administrative savings from pooling individuals and small groups into purchasing cooperatives. Some pay administrative costs or "loads" of up to 40% today. CBO assumes and recent California experience suggests that loads closer to 13.5% are achievable under Mitchell-like conditions.

- The community-rated sector (individuals and firms with fewer than 500 employees) gains the most from the Mitchell bill, but the large firm sector gains as well, primarily from uncompensated care.

- While the community-rated sector does very well under the Mitchell bill, bringing the uninsured, nonworkers, and most under-65 Medicaid recipients into the community rated pool does increase costs slightly. The Mitchell bill has a mechanism to share the costs of demographic differences across the community-rated and experience-rated pools, which serves to equalize the average premiums in each pool by increasing experience rated premiums and decreasing community rated premiums. CBO estimates the required adjustment to be about 1.25%.

- If the mandate is not triggered, aggregate private health spending will be virtually equal to what it would have been in the absence of reform as 27 million more people would be insured with coverage that costs less than today.

- If the mandate is triggered, aggregate private health spending would be about 2% higher than baseline in 2004 as we add the remaining 14 million Americans to private health insurance coverage.

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Net Effect of Senate Proposal on Average Payments for Private Health Insurance, Relative to Current System

	1997			2004		
	Community Rated Pool	Experience Rated Pool	Private Sector Average	Community Rated Pool	Experience Rated Pool	Private Sector Average
Medicaid Cost Shift (1)	2.2%	-1.8%	0.2%	3.0%	-1.1%	0.9%
Medicare Cost Shift	0.0%	0.0%	0.0%	0.5%	0.5%	0.5%
Non-Worker Cost Shift	2.9%	0.0%	1.4%	2.9%	0.0%	1.4%
Cross Pool Risk Adjustment (2)	-1.3%	1.3%	0.0%	-1.3%	1.3%	0.0%
High Cost Plan Assessment (3)	0.2%	0.0%	0.1%	0.4%	0.1%	0.3%
Universal Coverage (4)	-6.0%	-6.0%	-6.0%	-6.0%	-6.0%	-6.0%
Gains from Group Purchasing (5)	-12.7%	0.0%	-6.4%	-12.7%	0.0%	-6.4%
Academic Health Centers	1.75%	1.75%	1.75%	1.75%	1.75%	1.8%
Cafeteria Plan Limitations	0.1%	0.4%	0.2%	0.5%	2.1%	1.3%
Net Total Additions	-14.0%	-5.0%	-9.5%	-11.7%	-1.4%	-6.5%

Notes:

(1) Includes payment rate differences, demographic effects, and growth rate effects.
(2) CBO estimate
(3) Includes incidence of assessment and effect on growth rate of premiums.
(4) Quantifies reductions in uncompensated care.
(5) Reductions in administrative costs expressed as weighted average across firm sizes.

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SPECIFICATIONS FOR COST CONTAINMENT AMENDMENT

REMAINING POLICY ISSUES THAT NEED TO BE RESOLVED

1. Need to establish the growth index for triggering and applying premium affordability guarantees (e.g., wages, CPI, etc.).

2. Need to determine whether the growth rate is initially lower after the cost containment trigger in order to bring premium back down to a "reference premium." Note that these specifications are not written with that in mind.

3. Need to establish the policy for experience rated plans.

4. Need to determine whether premium affordability guarantees could be "un-triggered" (either nationally or in a community rating area).

SECTION 10003 CHANGE

Change section 10003(c) as follows (in general, the test for affordability and subsequent recommendations are structured similarly to the coverage trigger):

(a) The Commission submits annual affordability reports, with the first affordability report for 1999 (submitted by January 1, 2000).

(b) Coverage is considered unaffordable for a year if the average premium increase (using final community rates for plans for each year) for the standard benefits for community rated health plans over the two year period (ending with such year) exceeds the average increase in X [!need growth rate!] over the same period.

(c) If the affordability test is not met for a year, then the Commission shall recommend to Congress a means of controlling health care costs.

The recommendations of the Commission shall include one or more legislative proposals to ensure that the growth in premiums nationwide is held prospectively to X [!need growth rate!] (as certified by GAO).

(d) If Congress fails to enact legislation (as in 10004(c)), then premium affordability guarantees are automatically triggered beginning in the following year as described below. The first year for which premium affordability

guarantees can be triggered is 2000.

NEW SUBTITLE ON PREMIUM AFFORDABILITY GUARANTEES

1. Definitions and special rules:

(a) The "target growth rate" for a year is X [!need growth rate!], adjusted for a community rating area under 2(b)(3).

(b) The "weighted average annual filed premium" for a community rating area for a year is the average of the final community rates for all the community rated health plans in the community rating area, weighted for each health plan by the total number of families enrolled in such plan for all classes of enrollment.

(c) The "weighted average annual initial premium" for a community rating area for a year is the average of the initial community rates for all the community rated health plans in the community rating area, weighted for each health plan by the total number of families enrolled in such plan for all classes of enrollment.

(d) The "actual national average premium increase" for a year is the average premium increase from the preceding year to the current year for all community rated health plans in all community rating areas (using final community rates, weighted for each health plan by the total number of families enrolled in such plan for all classes of enrollment).

(e) For the purposes of this subtitle and for the purposes of section 10003, initial and filed community rates shall include any applicable marketing fees.

2. Trigger of premium affordability guarantees and determination of affordable premium target.

(a) (1) If premium affordability guarantees are triggered nationally beginning in a year:

(A) In the case of a community rating area that was a non-competitive community rating area for the year preceding the year of the national trigger, premium affordability guarantees would apply as of such year.

(B) In the case of a community rating area that becomes a non-competitive community rating area for any year after the year of the national trigger, premium affordability guarantees would apply as of the year succeeding the year in which the area first becomes a non-competitive community rating area.

(2) A community rating area is considered a non-competitive community rating area for a year if the average premium increase (using final community rates, weighted for each health plan by the total number of families enrolled in such plan for all classes of enrollment) for the standard benefits for community-rated plans in the area over the two year period (ending with such year) exceeds the average increase in X [!need growth rate!] over the same period.

(b) (1) In general, the "affordable premium target" for a community rating area for a year is the affordable premium target for the previous year, increased by the target growth rate.

(2) The affordable premium target for the first year in which premium affordability guarantees apply in a community rating area is the average of:

(A) The weighted average annual filed premium for the preceding year, increased by the target growth rate for the first year in which premium affordability guarantees apply to the community rating area;

(B) The weighted average annual filed premium for the second preceding year, increased by the actual national average premium increase for the preceding year and the target growth rate for the first year in which premium affordability guarantees apply to the community rating area; and

(C) The weighted average annual filed premium for the third preceding year, increased by the actual national average premium increase for the preceding year, the actual national average premium increase for the second preceding year, and the target growth rate for the first year in which premium affordability guarantees apply to the community rating area.

(3) The target growth rate for a community rating area for a year shall be adjusted by _____ as follows:

(A) The target growth rate for a year for a community rating area shall be adjusted for material changes in the demographic characteristics of those enrolled in community rated health plans in the community rating area in comparison with the average change in such characteristics nationwide. The adjustment must be neutral across community rating areas. [**Note:** See Senate Labor Bill, section 6001(c)(2).]

(B) If the employer and individual requirements under Title X are triggered in a state for a year, then the target growth rate for each community rating area in the state shall be reduced to reflect the increase in coverage and the resulting decrease in uncompensated care, and further adjusted to reflect any expected change in the demographic characteristics of those enrolled in community rated plans as a result of expanded coverage.

(4) (A) If the actual weighted average annual filed premium for a community rating area for a year (as determined by _____ based on actual enrollment in the first month of such year) exceeds the affordable premium target for the community rating area for the year, then the affordable premium target shall be reduced, by one half of the excess percentage described in (B) for the year, for each of the two succeeding years.

(B) The excess percentage described here is the percentage by which the actual weighted average annual filed premium for a community rating area for a year exceeds the affordable premium target for the area for the year.

3. Administration of premium affordability guarantees.

(a) Submission of information by plans to states. Each state shall provide for a process by which community rated health plans submit initial and final community rates.

(1) Each rate submitted by a community rated health plan shall be conditioned upon the plan's agreement to accept any premium reduction that may be imposed.

(2) All rates submitted must be legally binding with respect to the plan involved.

(b) Submission of information by states to _____. If premium affordability guarantees apply in a community rating area in a state, the state shall submit by not later than September 1 of each year the following information about such community rating area:

(1) Information on initial community rates for community rated health plans.

(2) Any information requested by _____ concerning:

(A) The actual distribution of families enrolled in community rated health plans across such plans.

(B) Limitations on capacity of community rated health plans.

(c) For each year in which premium affordability guarantees apply in a community rating area, the _____ shall determine a weighted average annual initial premium for such community rating area (subject to rules regarding treatment of enrollment in plans that are discontinued or newly offered).

(d) Notice to certain states.

(1) By not later than October 1 prior to each year in which premium affordability guarantees apply in a community rating area, the _____ shall notify the state in which the community rating area is located if the weighted average annual initial premium for the year exceeds the affordable premium target for the area for the year.

(2) If notice is provided to a state under (1), the _____ shall notify the state and direct the state to notify each noncomplying plan of any premium reduction and of the opportunity to voluntarily reduce the initial community rate filed under (3)(a) in order to avoid the premium reduction.

(e) Voluntary reduction of initial community rates. A noncomplying plan that has received a notice under (d) shall have an opportunity to voluntarily reduce its initial community rate by the amount of the premium reduction calculated under 4.

(1) The reduction shall not affect the amount of the premium reduction for any other plan for the year.

(2) The final community rate for the plan is the initial community rate, less any voluntary reduction.

4. Plan premium reductions. Each noncomplying plan for a year is subject to a premium reduction under this section.

(a) Noncomplying community rating area. The term "noncomplying community rating area" means, for a year, a community rating area in which premium affordability guarantees apply and for which the weighted average annual initial premium exceeds the affordable premium target for the community rating area for the year.

(b) Noncomplying plan. The term "noncomplying plan" means, for a year, a community rated health plan in noncomplying community rating area if the plan's initial community rate exceeds the affordable premium target for the community rating area for the year.

(c) Premium reduction amounts.

(1) (A) The amount of the premium reduction, for a noncomplying plan offered in a noncomplying community rating area in a year, is the area-wide reduction percentage of the excess premium amount.

(B) The final community rate for a plan is equal to its initial community rate, less the amount of any premium reduction.

(2) Area-wide reduction percentage.

(A) The term "area-wide reduction percentage" means, for a noncomplying plan offered in a community rating area for a year:

(i) The amount by which the weighted average annual initial premium for the community rating area for the year exceeds the affordable premium target for the area for the year, divided by

(ii) The sum, for noncomplying plans offered in the community rating area for the year, of the plan proportions of excess premium amounts for the year.

(B) The "plan proportion of excess premium amount" for a noncomplying plan is the product of:

(i) The excess premium amount for the plan for the year, and

(ii) The total enrollment of families in community rating area in the plan for the year, expressed as a percentage of total enrollment in all community-rated health plans in the community rating area for the year. Such amount shall be computed based on the same information used to compute the weighted average annual initial premium.

(3) Excess premium amount. The "excess premium amount," with respect

to a noncomplying plan for a year, is the amount by which:

(A) The initial community rate for the plan for the year (not taking into account any voluntary reductions), exceeds

(B) The affordable premium target for the community rating area in which the plan is offered.

5. Provider payment reductions.

(a) Provider networks.

(1) Each community-rated health plan that is a network plan, as part of its contracts or agreements with any providers or groups of providers participating in its provider network, shall:

(A) Include a provision that provides that if the plan is a noncomplying plan for a year and does not provide for a voluntary reduction in the amount of its premium reduction under 3(e), payments to the provider (or group) shall be reduced by the applicable network reduction percentage for the year.

(B) No include any provision that the state determines otherwise varies the payments to such providers (or group) because of, or in relation to, a premium reduction or otherwise is intended to nullify the effect of (A).

(2) Applicable network reduction percentage.

(A) Subject to (B), the "applicable network reduction percentage," with respect to providers that are part of the provider network of a noncomplying plan for a year, equals:

(i) The amount of the premium reduction for the plan for the year, divided by

(ii) The filed community rate for the plan for the year.

(B) Induced volume offset. [**Note:** See Senate Labor Bill, section 6012(a)(2)(B).]

(b) Other providers.

(1) Each community-rated health plan that is a noncomplying plan in a

year that does not provider for a voluntary reduction in the amount of any premium reduction under 3(e) shall provide for a reduction in the amount of payments to providers (or groups of providers) that are not part of the plan's provider network under the applicable fee schedule under _____ by the applicable nonnetwork reduction percentage for the year.:

(2) Applicable nonnetwork reduction percentage.

(A) Subject to (B), the "applicable nonnetwork reduction percentage," with respect to providers that are not part of the provider network of a noncomplying plan for a year, equals:

(i) The amount of the premium reduction for the plan for the year, divided by

(ii) The filed community rate for the plan for the year.

(B) Induced volume offset. [**Note:** See Senate Labor Bill, section 6012(b)(2)(B).]

(c) [**Note**: Probably need to add language like Senate Labor Bill, section 6012(c) and fee schedule language from section 1523 of Senate Labor Bill, and also ban balance billing if premium affordability guarantees are triggered.]

TITLE V CHANGE

New section: There shall be no administrative or judicial review of any determination by the _____ respecting any matter under subtitle _____ of title X. [**Note:** Similar to section 5232 of Senate Labor Bill.]

FEHBP FILE

Some Members of Congress may be eligible for immediate annuities with a combination of congressional service and previous government service. However, since there are no reliable public records which identify all government service for members of Congress, the attached compilation was prepared using information from the Congressional Directory.

Senators eligible for immediate annuity based on congressional service

Democrats = 21
Republicans = 26

Senators not eligible for immediate annuity based on congressional service

Democrats = 35
Republicans = 18

Members who retire on an immediate annuity can retain health benefits coverage if they were covered by FEHB for the five years immediately preceding retirement or from their earliest opportunity.

Stacey - Please copy & send over to Greg L. & Jennifer K. I think they'll find this info interesting and, perhaps, useful?

Thx!

SENATORS ELIGIBLE FOR IMMEDIATE FEDERAL ANNUITY
(Based on Service in the Congress)

Senator	Beginning of Present Service
Robert Byrd (D-WV)*	Jan. 3, 1959
Claiborne Pell (D-RI)	Jan. 3, 1961
Edward Kennedy (D-MA)	Nov. 7, 1962
Daniel Inouye (D-HI)*	Jan. 9, 1963
Ernest Hollings (D-SC)	Nov. 9, 1966
Bennett Johnston (D-LA)	Nov. 14, 1972
John Glenn (D-OH)	Dec. 24, 1974
Wendell Ford (D-KY)	Dec. 28, 1974
Dale Bumpers (D-AR)	Jan. 14, 1975
Howard Metzenbaum (D-OH)	Dec. 29, 1976
Daniel Moynihan (D-NY)	Jan. 3, 1977
Paul Sarbanes (D-MD)*	Jan. 3, 1977
James Exon (D-NE)	Jan. 3, 1979
Howell Heflin (D-AL)	Jan. 3, 1979
Carl Levin (D-MI)	Jan. 3, 1979
David Pryor (D-AR)*	Jan. 3, 1979
George Mitchell (D-ME)	May 19, 1980
Frank Lautenberg (-NJ)	Dec. 27, 1982
Paul Simon (D-Ill)*	Jan. 3, 1985
Richard Shelby (D-AL)*	Jan. 6, 1987
Daniel Akaka (D-HI)*	Apr. 28, 1990

* Served in the House of Representatives previous to service in the Senate.

SOURCE: Congressional Directory

SENATORS ELIGIBLE FOR IMMEDIATE FEDERAL ANNUITY
(Based on Service in the Congress)

Senator	Beginning of Present Service
Strom Thurmond (R-SC)	Nov. 7, 1956
Mark Hatfield (R-OR)	Jan. 10, 1967
Ted Stevens (R-AK)	Dec. 24, 1968
Robert Dole (R-KS)*	Jan. 3, 1969
Bob Packwood (R-OR)	Jan. 3, 1969
Wiliam Roth, Jr. (R-DE)*	Jan. 1, 1971
Pete Domenici (R-NM)	Jan. 3, 1973
Jesse Helms (R-NC)	Jan. 3, 1973
John Danforth (R-MO)	Dec. 27, 1976
John Chafee (R-RI)	Dec. 29, 1976
Orrin Hatch (R-UT)*	Jan. 3, 1977
Richard Lugar (R-IN)	Jan. 3, 1977
Malcolm Wallop (R-WY)	Jan. 3, 1977
Dave Durenberger (R-MN)	Nov. 8, 1978
Nancy Kassebaum (R-KS)	Dec. 23, 1978
Thad Cochran (R-MS)*	Dec. 27, 1978
Alan Simpson (R-WY)	Jan. 1, 1979
John Warner (R-VA)	Jan. 2, 1979
William Cohen (R-ME)*	Jan. 3, 1979
Alfonse D'Amato (R-NY)	Jan. 3, 1981
Charles Grassley (R-IA)*	Jan. 3, 1981
Frank Murkowski (R-AK)	Jan. 3, 1981
Arlen Specter (R-PA)	Jan. 3, 1981
John McCain (R-AZ)*	Jan. 6, 1987
Slade Gorton (R-WA)	Jan. 3, 1989
James Jeffords (R-VT)*	Jan. 3, 1989

* Served in the House of Representatives previous to service in the Senate.

SOURCE: Congressional Directory

SENATORS WHO ARE NOT ELIGIBLE FOR AN IMMEDIATE ANNUITY
(BASED ON SERVICE IN THE CONGRESS)

Sam Nunn
Joseph Biden
Patrick Leahy
Donald Riegle
Dennis DeConcini
Jim Sasser
Max Baucus
David Boren
Bill Bradley
Christopher Dodd
Jeff Bingaman
John Kerry
Tom Harkin
John Rockefeller
John Breaux
Kent Conrad
Thomas Daschle
Bob Graham
Barbara Mikulski
Harry Reid
Richard Bryan
Bob Kerry
Herb Kohl
Joseph Lieberman
Charles Robb
Paul Wellstone
Harris Wofford
Dianne Feinstein
Byron Dorgan
Barbara Boxer
Ben Nighthorse Campbell
Russell Feingold
Harlan Mathews
Carol Moseley-Braun
Patty Murray

SENATORS WHO ARE NOT ELIGIBLE FOR AN IMMEDIATE ANNUITY
(BASED ON SERVICE IN THE CONGRESS)

Larry Pressler
Don Nickles
Phil Gramm
Mitch McConnell
Christopher Bond
Conrad Burns
Dan Coats
Trent Lott
Connie Mack
Robert Smith
Hank Brown
Larry Craig
Robert Bennett
Paul Coverdell
Lauch Faircloth
Judd Gregg
Dirk Kempthorne
Kay Bailey Hutchison

ELIGIBILITY REQUIREMENTS FOR MEMBER ANNUITIES UNDER CSRS

IMMEDIATE ANNUITIES (Must meet age and service requirement at the date of separation)

VOLUNTARY SEPARATION

AGE REQUIREMENT	SERVICE REQUIREMENT
62	5 YEARS OF CIVILIAN SERVICE
60	10 YEARS OF MEMBER SERVICE
55	30 YEARS OF SERVICE

INVOLUNTARY SEPARATION (EXCEPT EXPULSION)

50	20 YEARS OF SERVICE OR 9 CONGRESSES
ANY AGE	25 YEARS OF SERVICE

DISABILITY

ANY AGE	5 YEARS OF SERVICE

DEFERRED ANNUITIES (AGE REQUIREMENT NOT MET UNTIL AFTER SEPARATION)

62	5 YEARS CIVILIAN SERVICE
60	10 YEARS OF MEMBER SERVICE
50	20 YEARS OF SERVICE INCLUDING 10 OR MORE YEARS OF MEMBER SERVICE

MEMBERS WHO RETIRE ON AN IMMEDIATE ANNUITY CAN RETAIN HEALTH BENEFITS COVERAGE IF THEY WERE COVERED BY FEHB FOR THE 5 YEARS IMMEDIATELY PRECEDING RETIREMENT OR FROM THEIR EARLIEST OPPORTUNITY. MEMBERS ENTITLED TO A DEFERRED ANNUITY ONLY DO NOT RETAIN HEALTH BENEFITS COVERAGE.

ELIGIBILITY REQUIREMENTS FOR MEMBER ANNUITIES UNDER FERS

IMMEDIATE ANNUITIES (Must meet age and service requirement on the date of separation)

VOLUNTARY SEPARATION

AGE REQUIREMENT	SERVICE REQUIREMENT
62	5 YEARS OF CIVILIAN SERVICE
60	20 YEARS OF SERVICE
MRA*	30 YEARS OF SERVICE
MRA*	10 YEARS OF SERVICE AND NOT ELIGIBLE UNDER ANY OTHER PROVISION (MEMBER MAY ELECT TO DEFER THE COMMENCING DATE OF THE ANNUITY TO LESSEN OR AVOID THE AGE REDUCTION FACTOR)

INVOLUNTARY SEPARATION (EXCEPT EXPULSION)

50	20 YEARS OF SERVICE
ANY AGE	25 YEARS OF SERVICE

DISABILITY

ANY AGE	18 MONTHS OF MEMBER SERVICE

DEFERRED ANNUITIES (AGE REQUIREMENT NOT MET UNTIL AFTER SEPARATION)

62	5 YEARS OF SERVICE
MRA	10 YEARS OF SERVICE

*MINIMUM RETIREMENT AGE - AGE 55 IF BORN BEFORE 1/1/48; BETWEEN 55 AND 57 IF BORN AFTER 12/31/47.

MEMBERS WHO RETIRE ON AN IMMEDIATE ANNUITY CAN RETAIN HEALTH BENEFITS COVERAGE IF THEY WERE COVERED BY FEHB FOR THE 5 YEARS IMMEDIATELY PRECEDING RETIREMENT OR FROM THEIR EARLIEST OPPORTUNITY. THIS INCLUDES MEMBERS WHO ARE ELIGIBLE FOR AN IMMEDIATE MRA+10 ANNUITY BUT WHO DEFER THE COMMENCING DATE. MEMBERS ENTITLED TO A DEFERRED ANNUITY ONLY DO NOT RETAIN HEALTH BENEFITS COVERAGE.

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EFFECTS OF SENATE HEALTH REFORM BILL
LOW-INCOME VOUCHER PROGRAM

Newly Employed College Graduate

Income: $7,000 (100% of Poverty)

Current Coverage: None; Newly employed in a hospital as a nurses' assistant

Reform Coverage: Community-Rated Pool

Annual Premium Payments:

	Premium	Family Payment:	
TODAY:	$2,220	$2,220	If they purchase insurance
REFORM:	$2,220	$0	

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EFFECTS OF SENATE HEALTH REFORM BILL
LOW-INCOME VOUCHER PROGRAM

Working Couple

Income: $14,900 (150% of Poverty)

Current Coverage: None; husband is an independent construction worker

Reform Coverage: Community-Rated Pool

Annual Premium Payments:

	Premium	Family Payment:	
TODAY:	$4,440	$4,440	If they purchase insurance
REFORM:	$4,440	$2,220	

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EFFECTS OF SENATE HEALTH REFORM BILL
CHILDREN'S VOUCHER PROGRAM

Working Family with Three Children

Income: $20,000 (135% of Poverty)

Current Coverage: None; the working parent is employed by a fast-food chain that does not offer insurance

Reform Coverage: Community-Rated Pool

Annual Premium Payments:

	Premium	Family Payment:	
TODAY:	$5,883	$5,883	If they purchase insurance
REFORM:	$5,883	$1,150	

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EFFECTS OF SENATE HEALTH REFORM BILL
CHILDREN'S VOUCHER PROGRAM

Working Family with Three Children

Income: $35,000 (240% of Poverty)

Current Coverage: None; both parents work in firms that offer but do not pay for coverage

Reform Coverage: Community-Rated Pool

Annual Premium Payments:

	Premium	Family Payment:	
TODAY:	$5,883	$5,883	If they purchase insurance
REFORM:	$5,883	$4,630	

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EFFECTS OF SENATE HEALTH REFORM BILL
JOB TRANSITION PROGRAM

Mother with Two Children

Current Coverage:
- Scenario 1: Mother lost job and insurance due to firm closing, annualized income of $10,000 (80% of poverty)
- Scenario 2: Divorce from husband with insurance; annualized income of $25,000 (205% of poverty)
- Scenario 3: Divorce from husband with insurance; annualized income of $30,000 (245% of poverty)

Reform Coverage: Community-Rated Pool

Annual Premium Payments:

	Premium	Family Payment:	
TODAY: COBRA	$4,415	$4,415	If they purchase a COBRA policy
SCENARIO 1:	$4,329	$0	
SCENARIO 2:	$4,329	$515	
SCENARIO 3:	$4,329	$1,200	

OFFICE OF PUBLIC LIAISON

August 12, 1994

Memo to Harold Ickes
Erskine Bowles
Chris Jennings
Marina Weiss
Mark Iwry

cc: Alexis Herman, Steve Hilton

From: Caren Wilcox

Subject: Self-Employed/Independent Contractors Definition in Mitchell Bill

I attach a letter to Senator Mitchell from Neil Offen, President of the Direct Sellers Association. The DSA has 5 million direct sellers, 10,000 in every Congressional District. He is a friend and is doing all he can to hold off triggering a grassroots campaign against the bill. Direct Sellers, Realtors and others have tried to remain neutral in the health care debate, not joining the NFIB campaign against the bill.

The Realtors also called me and indicated they need to trigger their millions of members unless they receive very prompt indications that this is a misdrafting situation.

I have given their proposed clarifying language, which is also attached, to Chris Jennings and to Mark Iwry for evaluation.

We need a quick turn around on this. There are millions of self-employed and they have a grassroots system in place. All they have to do is trigger it.

DIRECT SELLING ASSOCIATION
1666 K Street, NW, Suite 1010, Washington, DC 20006-2808
202/293-5760 • Fax 202/463-4569

August 11, 1994

The Honorable George Mitchell
United States Senate
Washington, DC 20515-7452

Dear George:

Up until this point in time, the Direct Selling Association (DSA), our 160 member corporations and their over five million-plus grass roots independent contractor salespeople and distributors have been neutral in regard to the various health care measures before Congress. That neutrality is now threatened, inadvertently we believe, by section 1012 of your reform measure, S. 2357 (8/4/94). We ask your immediate help to clarify the situation and eliminate a problem for you, the direct selling industry and perhaps as many as 40 industries which use independent contractors such as ours.

As you know, our member firms include such companies as Avon, Amway, Discovery Toys, Electrolux, Encylopaedia Britannica, NuSkin, Shaklee, Tupperware and numerous others. We have over 10,000 salespeople in every Congressional District.

Specifically, section 1012 defines "employees" to include self-employed individuals. Such a redefinition of these individuals is contrary to the very existence of our industry and the livelihoods or supplemental incomes of our five million-plus salespeople (see enclosed fact sheet). The good news is that in the event that an employer mandate ultimately were to be triggered, section 10111 would in turn not require "employer" premium payments if the employer employed 25 or fewer employees. Thus, as their own "employers" and "employees" (generally as one-person operations), these independent contractors would not be subject to any additional premium payment obligations were the employer mandate to be triggered. (Note: our salespeople are already covered by health insurance through their own policies, through traditional employment they hold, or through their full-time employed spouse.)

The bad news with which we are concerned, however, is the broader implications of equating self-employed independent contractors with "employees" Such "employee" status for direct sellers would be inconsistent with section 3508 of the Internal Revenue Code which treats direct sellers

as independent contractors by statute The first question that arises under S. 2357 is, "who are they deemed to be employees of -- their own businesses or the businesses of the various persons to whom they provide services as independent contractors?" For example, under one potential interpretation, because self-employed individuals are defined as "employees", anyone who engages the services of more than 25 independent contractors (such as all our member firms) might be held responsible for the insurance premiums of these self-employed "employees". Such a result would be disastrous for the direct selling industry, and we trust, unintended. Certainly, in all of our discussions with proponents of health reform over the past months, no one has ever suggested an intent to make direct sellers the "employees" of the companies whose products they sell. No other health care legislation considered would have had this effect.

Second, we are concerned that any statutory provision under the proposed new health care system that effectively equates independent contractors with employees runs the risk of significant misinterpretation and unintended consequences. It could undermine the legitimate use of independent contractors in the marketplace by direct sellers and many other industries. We would note that S. 2357 in the revenue provisions already reflects the ongoing discussions about the need for an effective classification method for independent contractors, and, in section 7501, directs that the Secretary of Treasury make a recommendation to Congress by 1996 providing statutory standards for classification. Consequently, section 1012 is inconsistent with this provision of your bill.

We believe it vital to immediately clarify the language regarding employer obligations and the "employment" status of self-employed individuals. We need to ensure that those who contract for the services of independent contractors not be considered "employers"of those contractors and thus subject to possible employer premium obligations. This could be accomplished with the clarifying amendment which is attached (together with an explanatory statement). Of course, we would be happy to work with you on any possible amendment or report language.

In addition to the above, there is a rumor that, in order to raise revenues, an attempt will be made to impose withholding tax obligations on those utilizing independent contractors. Such an imposition has been and will be vehemently opposed by this industry and numerous others. If an attempt is made to institute withholding, we will be forced to oppose the entire health care reform proposal as a threat to all of our salespersons' and corporations' businesses and mobilize opposition on a grass-roots level. We want to remain neutral on the measures before Congress. Please help us remain so. It is in everyone's interest.

I, my staff and our Independent Contractor Task Force from a dozen of our largest companies are at your service to answer your questions and to work with you. We need a quick response to our concerns and hope to hear from you shortly.

There is no issue more important to direct selling than the independent contractor status of its salespeople. We have worked diligently with the Congress and the President to ensure that any health reform package meets the needs of the country without unfairly burdening the five million people who sell direct or threatening their independent status. In these closing days of the debate, we appreciate your continued understanding of our issue and hope that we can work together to address this concern.

Sincerely,

Neil H. Offen
President

NHO:mlr

Enclosures

cc: Ms. Rima Cohen
Mr. Matt Gorman
Dr. Andrea King
The. Hon. Les Samuels
Mr. William Sollee
Mr. Mike Wessel
Ms. Caren Wilcox

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Proposed Amendment to S. 2357 Regarding
Treatment of Self-Employed Individuals as "Employee"

Amend paragraph (2) (c) (i) of section 1012 (Definitions Relating to Employment and Income) of S. 2357 to read as follows:

"(c) EMPLOYEES. –

"(i) TREATMENT OF SELF-EMPLOYED. –

"(I) IN GENERAL. –The term 'employee' includes a self-employed individual who shall be considered to be an employer of himself or herself.

"(II) EXCLUSION WHERE NO OTHER EMPLOYEES. – Clause (I) shall not apply in the case of a self-employed individual who does not employ other persons as employees (within the meaning of paragraph (1) (B))."

[New language underscored]

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Explanation of Proposed Amendment to S. 2357 Regarding
Treatment of Self-Employed Individual as "Employee"

The proposed amendment makes two changes to section 1012 (2) (c) (i) of S. 2357. Under section 1012 (2) (c) (i) as introduced, for purposes of the Act, "The term 'employee' includes a self-employed individual."

The first change under the proposed amendment would clarify that a self-employed individual would be considered to be an employee of his or her own trade or business (rather than being deemed an employee of some other trade or business such as that of a person for whom the self employed individual performs services as an independent contractor. This proposed clarification reflects what is understood to be the original intent of the provision.

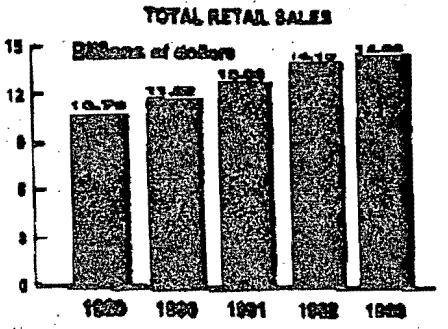
The second change under the proposed amendment would exclude from the proposed rule treating self-employed individuals as employees a self-employed individual who has no other employees. It is understood that the purpose of section 1012 (2 (c) (i) as introduced is to address the situation where a self-employed person operates a business that has other employees and that the provision is intended to operate in a manner similar to I.R.C. § 401 (c) in the pension area which treats the self-employed owner-proprietor as an employee for purposes of eligibility under the employee benefit plan and various statutory requirements of comparable treatment of employees.

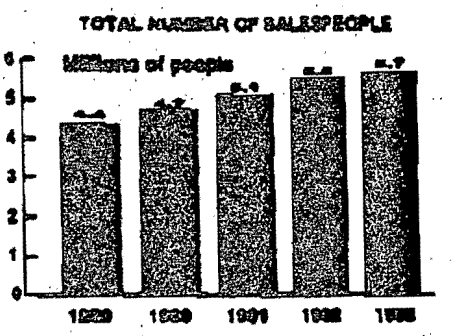
Since these purposes at which section 1012 (2) (c) (i) is understood to be directed in treating a self-employed individual as an employee would be inapplicable in the situation where the self-employed individual has no other employees, the proposed amendment excludes such self-employed individual from the "employee" characterization provision in S. 2357.

FACT SHEET

1994 DIRECT SELLING INDUSTRY-WIDE GROWTH & OUTLOOK SURVEY

Total 1993 U.S. Retail Sales	**$14.98 Billion**
Percent of Sales by Major Product Groups	
Personal care products (cosmetics, jewelry, skin care, vitamins, etc.)	57.1%
Home/family care products (cleaning products, cookware, cutlery, etc.)	35.2%
Leisure/educational products (books, encyclopedias, toys/games, etc.)	6.2%
Services/miscellaneous/other	1.5%
Locus of Sales (reported as a percent of sales dollars)	
In the home	69.7%
In a workplace	19.7%
Over the phone	1.9%
At a public event*	8.3%
Other locations	.4%
**Such as a fair, exhibition, shopping mall, theme park, trade show, etc.*	
Sales Approach (method used to generate sales, reported as a percent of sales dollars)	
Individual/one-to-one selling	74.0%
Party plan/group sales	24.3%
Customer placing order directly with firm	1.7%
Total 1993 U.S. Salespeople	**5.7 Million**
Demographics of Salespeople	
Independent contractors/Employees	99.0%/1.0%
Female/Male	81.7%/18.3%
Part-time/Full-time (30+ hours per week)	77.8/22.2%





For information contact Liz Doherty or Tonya Johnson, 202/293-5760, FAX 202/463-4569.

DIRECT SELLING ASSOCIATION 1666 K Street, NW, Suite 1010, Washington DC 20006-2808 202/293-5760 Fax: 202/463-4569

DRAFT (7/20/94 #2)

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

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

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

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

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

The proposal would establish:

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

DRAFT

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

E. DEFAULT STRATEGY FOR ASSURING UNIVERSAL COVERAGE

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

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

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

- Allow limited flexibility under ERISA: under a waiver process, states will be given limited authority to impose requirements on ERISA plans if they can demonstrate that these requirements would significantly increase coverage. Specifically, states could apply for permission to subject ERISA plans to broad-based premium taxes (up to a capped amount of 1% or 2%) that are used to expand coverage.

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

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

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

- Provide funding for state planning and reporting requirements.

DRAFT

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

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

- Additional flexibility regarding state regulation of ERISA plans under an HHS/DOL waiver process. Options for states include: (1) allowing state-level employer mandates, (2) permitting states to impose all-payer rate systems that include ERISA plans, or (3) easing restrictions on states' ability to establish single-payer systems. (Some provisions to address the concerns of large, multi-state employers must be considered.)

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

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

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

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

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

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

- Possible assumption of additional authorities by HHS.