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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Hillary Clinton Re: Medicare/Medicaid and the Budget (2 pages)	12/14/94	P5

COLLECTION:
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Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
December 1994 HSA

gf122

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

AGENDA

December 1, 1994

Outstanding Issues/Principles of Health Care Reform

I. Introduction

II. Review of Outstanding Issues
- Health Related Tort Reform
- Antitrust
- Fraud & Abuse
- Information Systems

III. Review and Discussion of Draft Health Care Reform Principles
- Pros and Cons of Using Principles
- Presentation of First Cut Menu of Policy Principles

IV. Discussion of How Packages will be Presented to Map Group Participants Next Week
- Review of Basic Assumptions for Modeling

V. Conclusion/Announcements for Next Meeting

HEALTH CARE-RELATED TORT REFORM

THE PROBLEM

Although the evidence is mixed, many doctors and other members of the public believe that the vagaries of the jury system lead to unfair and inconsistent results in medical malpractice cases and that large jury awards drive up health care costs because doctors are forced to purchase expensive malpractice insurance policies and practice "defensive medicine." In addition, some argue that problems in the malpractice system cannot be addressed comprehensively unless products liability litigation is reformed as well.

MEDICAL MALPRACTICE: APPROACHES

HEALTH SECURITY ACT (S. 1757/ H.R. 3600)

Alternative dispute resolution

- Before claim can be brought, ADR (arbitration, mediation, and early offers of settlement) must have been utilized. Mandatory, non-binding.

Attorney's fees

- Contingency fees limited to maximum of 33.3% of the total amount recovered by judgment or settlement. States may impose lower limits.

Punitive damages; Cap on noneconomic damages

- No provisions.

Preemption

- Does not preempt states from imposing more restrictive legislation.

REPUBLICAN INITIATIVES

Republican initiatives in this area included the Dole, House Republican, Chafee, Rowland-Bilirakis, and Cooper-Grandy bills.

Alternative dispute resolution

- The Dole bill has no provision for ADR. Both the House Republican plan and the Cooper-Grandy plan provide for mandatory, non-binding ADR with appeals subject to English rule (in a contested ADR determination, the loser pays fees.) Chafee provides for the same, with mediation available at the request of any party. The Rowland-Bilirakis plan also includes mandatory, non-binding ADR.

Attorney's fees

- All of the bills except the Dole bill include a formula for determining attorneys fees: House Republican plan and Cooper-Grandy plan (25% of first $150,000; 10% of excess); Chafee plan (25% of award or settlement); Rowland-Bilirakis plan (25% of first $100,000; 20% of

next $150,000; 15% of next $250,000; 10% in excess of $500,000).

Punitive damages

- The Dole bill caps punitive damages at two times compensatory damages or $500,000, whichever is less. Other bills provide that a certain percentage of punitive damages be paid to the state (House Republican plan and Cooper–Grandy plan – 100%; Chafee plan – 75%). The Rowland–Bilirakis plan provides, as to manufacturers only, that 50% be paid to the state and that awards be capped at no more than two times the amount of all other damages.

Cap on noneconomic damages

- The Dole bill caps compensable noneconomic damages at $250,000 for the injured party and preempts state law in those states that have set such a cap at a higher figure. The House Republican plan, the Chafee plan, and the Rowland–Bilirakis plan all set a cap at $250,000. The Cooper–Grandy plan caps noneconomic damages at $250,000 but permits future development of alternative limits.

PRODUCTS LIABILITY: APPROACHES

Products liability issues may arise in the context of medical malpractice litigation because malpractice plaintiffs often name a drug or medical device manufacturer or supplier as one of the defendants.

The Health Security Act did not address products liability.

Contract with America

- One of the bills House Republicans intend to introduce within the first 100 days of the new Congress is the "Common Sense Legal Reforms Act."

- Important provisions include the award of attorney's fees to the prevailing party in civil cases brought in federal court under diversity jurisdiction, amending the Federal Rules of Evidence to provide that expert opinion is admissible only if a judge determines that it is based on "scientifically valid reasoning," and the abolition of strict liability for sellers.

- In addition, the bill provides that punitive damages may be awarded against sellers of a product only where there is clear and convincing evidence of malice and caps such damages at no more than the greater of three times the economic damages award or $250,000.

OPTIONS

Status quo: no Administration proposal.

Present last year's policy, making sure to communicate its strengths clearly.

Propose additional malpractice reforms that do not include damage caps.

Propose additional malpractice reforms, including damage caps.

Propose tort reforms that encompass malpractice and products liability reforms.

ANTITRUST

THE PROBLEM

Medical providers such as hospitals are interested in forming integrated health care delivery systems that will allow them to better compete in the evolving health care industry, particularly with managed care plans. The providers believe that their efforts to form such systems are constrained unduly by antitrust laws.

APPROACHES

ADMINISTRATION INITIATIVES

The Health Security Act repealed health insurers' exemption from McCarran-Ferguson Act.

DOJ/FTC Policy Statements

- In 1994, DOJ and FTC issued nine policy statements relating to the health care industry.
- The policy statements delineate safety zones that describe activities that will not be challenged by the agencies, barring extraordinary circumstances.
- Most activity that falls outside of a safety zone, if challenged, will be evaluated under rule of reason analysis.
- The agencies are committed to responding to most requests from the business community for advisory opinions (e.g., whether a proposed activity falls within the safety zone) within 90 days.

REPUBLICAN INITIATIVES

Republican initiatives in this area included Hatch/Archer (introduced in House and Senate); a revised Hatch/Archer incorporated in Dole; and the Canady amendment to H.R. 3600, which was reported out of the House Judiciary Committee.

Safe harbors

- The Republican bills created safe harbors, some of which were broader than the safety zones in the DOJ/FTC policy statements and some of which addressed topics that were not the subject of a policy statement.

- In Hatch/Archer and Canady, the safe harbors were established by statute. In Dole, the safe harbors were to be established through the formal administrative rulemaking process.

- The bills established procedures for the creation of additional safe harbors by the Attorney General.

Certificates of review

- The Hatch/Archer and Dole bills established procedures for the award of certificates of review to cooperative ventures by the Attorney General with the agreement of the Secretary of Health and Human Services.

- Cooperative ventures receiving a certificate of review would be exempt from antitrust laws.

Notification procedures

- Under Hatch/Archer and Dole, cooperative ventures that filed with the Attorney General would receive guaranteed rule of reason analysis of their activities and detrebling of antitrust damages awarded against them.

OPTIONS

Present last year's proposal on this subject.

Continue current administrative approach and do not propose legislation.

Propose more extensive legislation.

FRAUD AND ABUSE

THE PROBLEM

Public perceives that health care problems are largely due to fraud and abuse, and according to the GAO estimates, the annual costs of health care related to fraud and abuse could be as high as 10% of total U.S. health care expenditures, or almost $100 billion. Although fraud and abuse is a significant problem that must be addressed, it is the consequence of a larger systemwide problem (e.g. multi-payors, no cost-containment, the uninsured). Without a comprehensive reform, it would be extremely difficult to seriously address fraud and abuse, and thus the collection of $100 billion. However, a number of steps can be made to strengthen federal authority to prevent and monitor fraud and abuse activities, e.g. formalizing coordination activities between agencies and expanding Federal statutes to private payors.

APPROACHES

ADMINISTRATION'S INITIATIVES

All-Payor Fraud and Abuse Control Program and Account

Extension of certain criminal and civil authorities to all payors

Revision of controls on health care kickbacks and extension to all payors

Revision of certain administrative Civil Monetary Penalties (CMPs) and administrative exclusion authorities and extending some to all payors

REPUBLICAN'S INITIATIVES

The Dole bill and the Mainstream bill paralled the fraud and abuse provisions advocated through HSA, with the following key exceptions.

- No provisions to revise physician self-referral law and extension to all payors.
- Do not create a new false statement, bribery, grand jury disclosure, or a new theft and embezzlement statutes. Both however, authorize forfeiture of property.

The Rowland/Bilirakis/Cooper bill strategy for fraud and abuse was relatively limited, and contained provisions that could create serious loopholes in the system and do more damage than good. Problems identified include:

- Limits deposits to the All-Payor Fraud and Abuse Trust Account only penalty amounts collected through certain administrative authorities. The bill also requires a 60% set-a-side of the disbursements for "education" of providers (as opposed to using the money to pay for increased enforcement).

- Does little in the way of expanding Federal authority (e.g. the bill does not create or extend any CMP authorities to all payors.)

- Provisions relating to kickback and self-referral create serious loopholes.

Other Republican approaches include the creation of a provider guidance/advisory options, Medicare Beneficiary Reporting Program of fraud and abuse, and final adverse action data base of providers found guilty of committing fraud and abuse.

OPTIONS FOR FUTURE ADMINISTRATION ACTION

Option A: Avoid addressing Fraud and Abuse problems in the next session of Congress.

Option B: Re-introduce HSA Fraud and Abuse provisions

Option C: Adapt the Health Security Act provisions as is to the current political environment:

(1). Minimize the regulatory nature of HSA provisions while strengthening Federal authority with respect to fraud against private health plans (all payor approach).

(2). In addition to above, expand Federal authority to take on some politically tough provider-related issues that are likely to be well received by some Republicans.

ADMINISTRATIVE SIMPLIFICATION

THE PROBLEM

The health care system continues to be burdened by large volumes of paperwork and red tape. Over 1500 private and public health plans, each using their own systems and forms for claims and medical review, consume time and money and divert attention away from patient care. Substantial savings can be achieved by standardizing forms and making multiple use of data that are recorded once, i.e. by using data generated during enrollment and during visits to doctors, hospitals, or other providers for other health-related purposes.

An electronic health information system would streamline paperwork and its costs significantly. National standards for data elements and transmission are needed to assure compatibility among participants in the electronic system. Rules to protect the privacy of data within the network also would be needed for patients and providers to trust it with sensitive information about them.

APPROACHES

The Health Security Act's provisions on administrative simplification were developed with significant guidance from the Vice President's national information infrastructure initiative (NII). The HSA provided for private sector development of an electronic health information system, guided by federal standards which would be developed with representation from affected private and public interests. Privacy of information in the network would be protected.

The Congressional health reform process produced compatible legislative language in the Mitchell, Dole, and Senate "mainstream" bills. The primary sponsors of the "mainstream" legislation, Sen. Bond (R-MO) and Sen. Leahy (D-VT), have expressed interest in pursuing the topic further next year.

Some of the major issues on which consensus was reached or was being developed included:

- Standards for an electronic health information network should build on what exists.
- Private and public sector interests must be represented in the new system.
- Privacy is critical.
- Efficiency is critical.

CURRENT ENVIRONMENT

Next year's proposals for administrative simplifications must take into account the concurrent development of insurance reforms to limit risk selection and additional consumer protections should be considered. The ongoing involvement of this Administration in this debate is desirable for many reasons, including the opportunity for bipartisan cooperation.

OPTIONS

Because the new political and health care reform environment will require further refinement of administrative simplification policies, the Administration has two options for proceeding.

- Interact with the bipartisan Congressional process as it continues.
- Include in the budget an affirmative statement of Administration support for the development of an electronic health information network, consistent with the four principles noted above, and for bipartisan cooperation with the Congress to achieve this goal.

CONSUMER PROTECTIONS

1. Reform should promote the broad spreading of risk, rather than encourage risk selection.

2. Businesses and families should be protected from unfair or discriminatory insurance practices. Families who have insurance should be able to keep it, even if they get sick or change jobs.

3. People should be able to choose their own physician or hospital.

4. Individuals and businesses should have better information about health plans and providers to make health care decisions.

5. Reforms should encourage health plans and providers to improve the quality of health care.

AFFORDABILITY

1. Our goal should be to control the cost of health care for businesses, families and the government.

2. Cost containment measures should promote the efficient delivery of health care, not cut back people's benefits.

3. Cost containment should seek to enhance competition and market forces, not supplant them.

4. At a minimum, reform should not increase the federal budget deficit.

5. There should be no significant savings in the Medicare program without expansions in coverage.

6. Small businesses and individuals should have the same opportunities to obtain affordable coverage that larger businesses have.

7. Steps should be taken to simplify administration of the health care system and to reduce fraud and abuse.

8. Better information should be available to private and public purchasers so that they can evaluate cost containment efforts.

COVERAGE

1. Any reform legislation must provide for progress that puts us on the path towards universal coverage. Any interim measures should be consistent with, and move us towards, universal coverage.

2. Any investments should benefit middle income Americans.

3. Reform should maintain a safety net for those who cannot obtain or afford private insurance.

4. Reform should increase access to preventive care and promote health.

5. Federal laws and regulations should not stand in the way of state initiatives that significantly expand coverage or state efforts to administer existing public programs in innovative ways.

6. Reform should not be paid for by taxing health benefits.

ASSUMPTIONS FOR COVERAGE OPTIONS

I. We assume the rejection of subsidy options that are significant (e.g., the Mainstream proposal cost $600–$800 billion).

II. We are focusing on private sector–oriented expansions for all options (except Welfare to Work and State Flexibility).

III. We assume subsidies should benefit middle income Americans.

PRESIDENT'S PRINCIPLES ON HEALTH CARE REFORM

Security

Savings

Simplicity

Quality

Choice

Responsibility

Reg FA4

December 2, 1994

MEMORANDUM FOR CAROL RASCO

FROM: Paul Weinstein
Brian Burke

SUBJECT: **Regulatory Review Initiative**

Per your request from this week's DPC staff meeting, the following are our recommendations for how we should proceed to accomplish this enormous undertaking. Our suggestions are discussed below.

Goals

At the meeting of regulatory advisers, the Vice President described the purpose of this exercise as an attempt to reform, not roll-back regulations. Nevertheless, it is clear that one of the purposes of this process is to reduce regulatory burdens on individuals, the private sector, and state, local, and tribal governments.

In the past, attempts to eliminate regulations have focused on line-by-line review of the Code of Federal Regulations (CFR). The Reagan, Bush, and Clinton Administrations have all done such reviews -- and while they have been partially successful in improving the regulatory scheme and in reducing the number of duplicative and unnecessary regulations, the fundamental problems inherent in regulatory philosophy remain. (e.g. EPA has a Water office, an Air office, a Waste office, a Drinking water office, and other offices which have overlapping responsibilities but are not designed to coordinate, often leading to duplicative and self-defeating regulations.) In order for this review to be successful in reducing the number of regulations, the working groups should focus on regulatory philosophy and systems. More specifically, the working groups should develop recommendations for moving to market incentives such as tradeable permits, voluntary regulatory structures, multi-media regulation, streamlining agency responsibilities, increasing waiver authority, fostering regulatory simplicity including one-stop shopping and single forms for a series of regulations, and establishing a presumption against issuing new regulations. In the end, however, what is really needed, is a review of conflicting statutory requirements, that are driving the creation of unnecessary regulations, and a legislative proposal from the Administration that would reduce such requirements.

Next Steps

Below you will find a list of DPC staff who we recommend to serve as chairs or on the other working groups. If you approve of the list of staff assignments, we will convene a meeting next week with the DPC chairs of the regulatory working groups as well as DPC staff who will serve on the other working groups, to discuss the following: 1) The objectives

of this exercise; 2) a methodology for reviewing regulations; and 3) what the final product should look like. Other possible issues to discuss at the meeting include timelines for the chairs to complete their tasks, and procedures for interaction with the executive branch departments and possibly outside organizations. A discussion memorandum would be prepared for you from this group that reflects our conclusions. Shortly thereafter, we would convene a meeting for DPC chairs and staffers to meet with Elaine Kamarck to discuss how we can fully utilize NPR's resources in this project.

Procedures For Chairs

We recommend that each chair set up an interagency working group of the relevant agencies and EOP offices. Prior to setting up the working groups however, we suggest you send a memorandum to the relevant agency heads to ask for their assistance in this endeavor. In addition, we suggest that one NPR staffer be dedicated to work with each co-chair (with regards to Workplace safety and labor group, Mike Schmidt has indicated that he will work closely with Ellen Seidman of NEC). The first task for each chair should be to provide you with a schedule of timetables that will insure the working groups meet the Vice President's deadline.

One issue you should raise with Jack Quinn is Chris Jenning's proposal to merge the Food and Drug group into the Health Industry Regulation group. We concur with Chris' recommendation.

Suggested Staff Assignments

<u>DPC Chairs</u>

Health Industry Regulation/Food and Drug -- Chris Jennings — to consult on
Workplace Safety and Labor Issues -- Mike Schmidt
Education -- Bill Galston (Gaynor McCown)

<u>DPC Staff On Non-DPC Working Groups</u>
Unfunded Mandates, Takings, Risk -- Paul Weinstein, Brian Burke
General Regulatory and Cross-cutting Regulatory Issues -- Paul Weinstein
Environment, Energy, and other Natural Resources -- Brian Burke
NEC Financial Institutions -- Paul Weinstein
CEA Business Regulation -- Paul Weinstein
OSTP Information Technology -- Jose Cerda
Customer Service in the regulatory environment -- Paul Weinstein
NEC Transportation -- Mike Schmidt
Council Equal Opportunity -- Steve Warnath
Agriculture -- Brian Burke
OSTP Biotechnology -- Mickey Levitan
OSTP Research -- Mickey Levitan
CEQ Consumer Products and Safety -- ~~Lynn Margherio or~~ Gaynor McCown

cc: Bill Galston
Bruce Reed

AGENDA
December 6, 1994

I. INTRODUCTION TO SWAP

II. MEDICAID IMPLICATIONS

III. WELFARE IMPLICATIONS

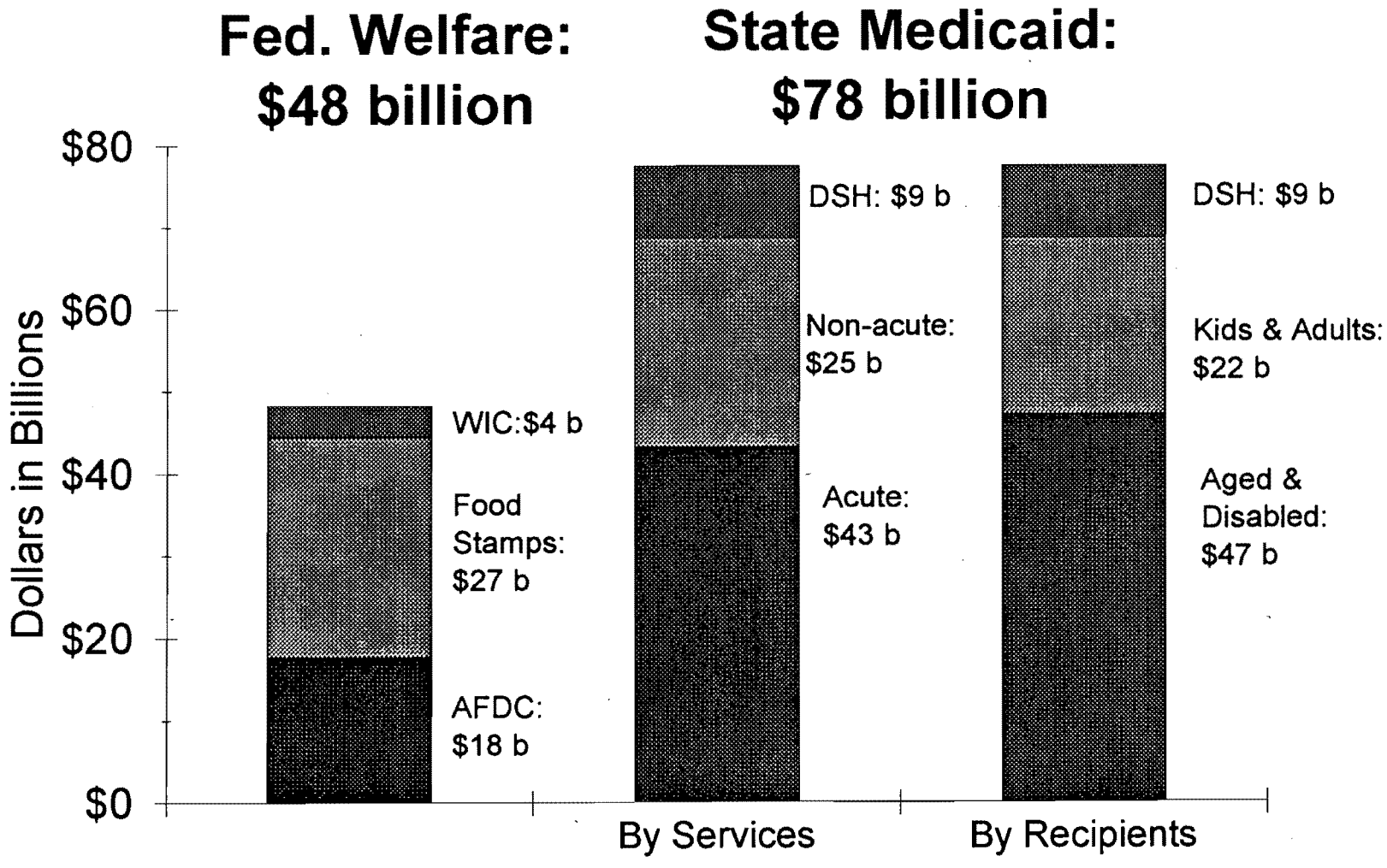
IV. ALTERNATIVE OPTIONS

V. WRAP-UP

MEDICAID FOR WELFARE SWAP

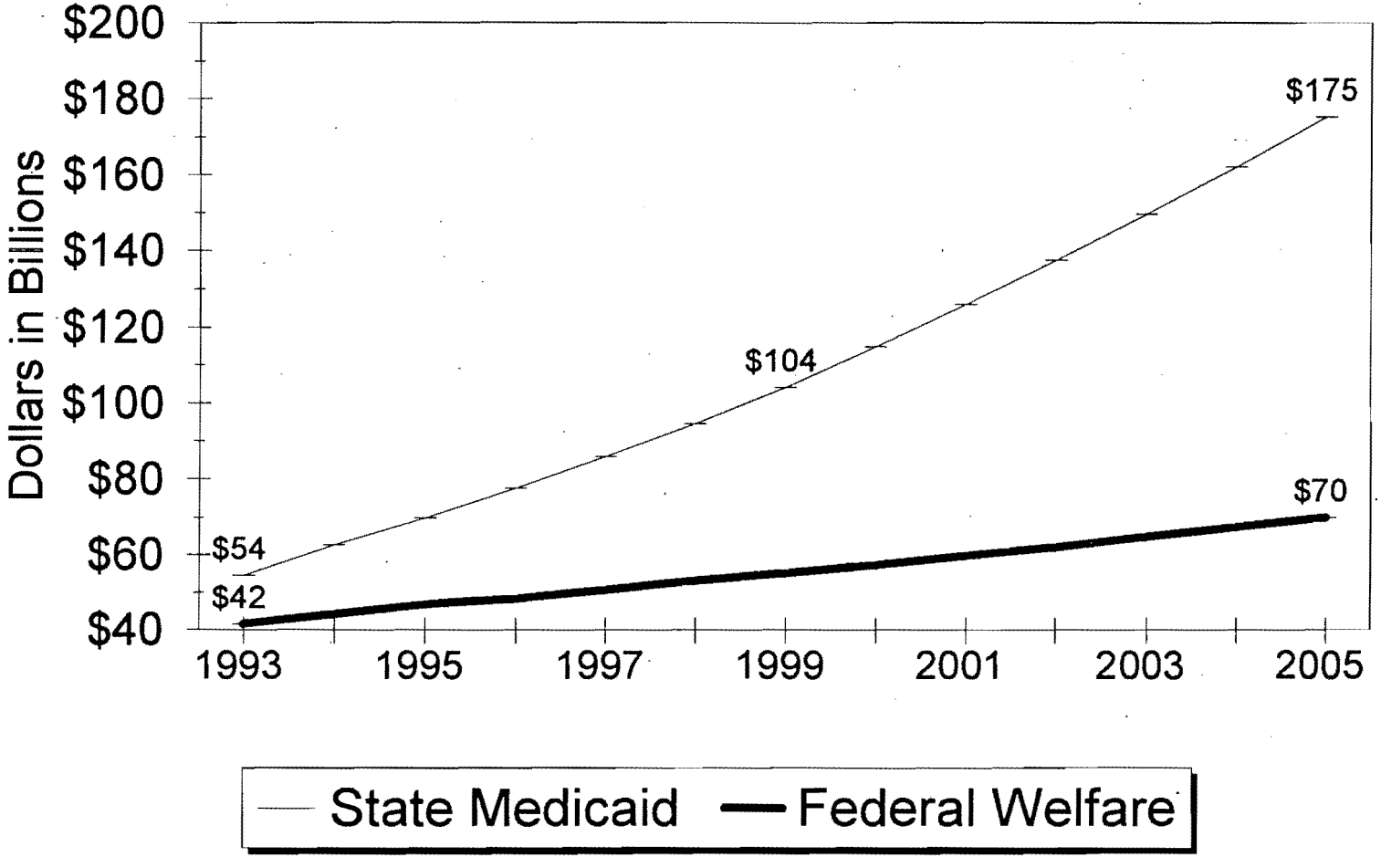
- Impact on Federal and State Budgets
- Trends in Welfare and Medicaid Costs
- Coverage and Cost Issues for Medicaid Program
- Impact / Issues for Welfare

Expenditures For the Swap: 1996



Federal Welfare & State Medicaid

Comparision of Expenditure Trends



Net Effects of Swap Options on the Deficit

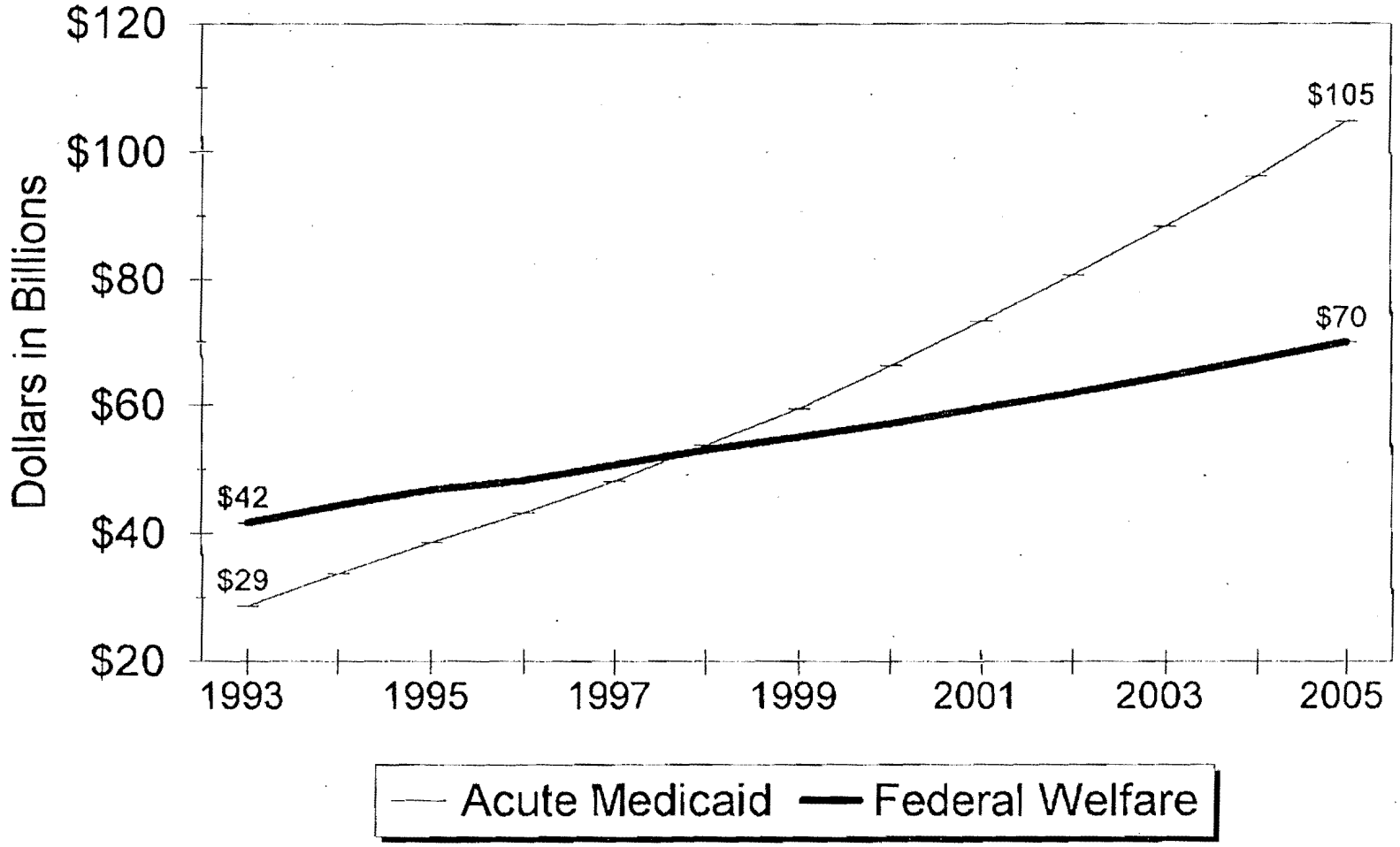
(Fiscal Years, Dollars in Billions)

SWAP FEDERAL AFDC, FOOD STAMPS & WIC FOR:	1996 - 2000	1996 - 2005
All State Medicaid Services for All Current Recipients	$213	$640
All State Medicaid Services for Aged and Disabled	$29	$176
State Medicaid Acute Care Services Only for All Current Recipients	$7	$127
State Medicaid Acute Care Services Only for AFDC and Non-Cash Kids Only	($143)	($278)

Increases in the Deficit indicated by positive numbers. Decreases in the Deficit indicated by negative numbers.

Federal Welfare & State Acute Medicaid

Comparison of Expenditure Trends



Estimated State Fiscal Effects of Medicaid for AFDC/Food Stamps/WIC Swap

(state fiscal effects in millions)

State	Fiscal Year 1996			Fiscal Year 2002		
	Projected State Costs on Acute Care Medicaid	Projected Federal Costs AFDC + FNS	State Gain (Loss)	Projected State Costs on Acute Care Medicaid	Projected Federal Costs AFDC + FNS	State Gain (Loss)
California	$6,941	$6,882	$59	$12,979	$8,838	$4,141
Connecticut	$446	$478	($32)	$835	$614	$221
Indiana	$742	$778	($36)	$1,388	$999	$389
Michigan	$1,584	$2,086	($502)	$2,962	$2,679	$283
Mississippi	$219	$647	($428)	$410	$831	($421)
Texas	$2,048	$3,540	($1,492)	$3,830	$4,546	($716)
U.S. Total	**$43,150**	**$48,297**	**($5,147)**	**$80,700**	**$62,022**	**$18,678**

* Medicaid estimates for 1996 were calculated by HCFA; estimates for 2002 assume the national growth rate for acute care services.

** Food & Nutrition Services program estimates past 2000 were calculated by ASPE staff.

Issues for a Federal Medicaid Acute Care Program

- Reimbursement
- Services
- Eligibility
- Administration

Trends in Maximum Benefit Levels Over the Past 25 Years

(Percentage changes reflect changes in real dollars)

100% Federally Funded Programs	
Food Stamps	3%
Basic SSI	6%
Shared State and Federal Programs	
AFDC	-47%
100% State Funded Programs	
SSI Supplement	
elderly individuals	-63%
elderly couples	-75%
General Assistance	NA

BENEFIT VARIATION ACROSS PROGRAMS

AFDC and Food Stamp Monthly Benefits
For a one-parent family of three persons, July 1994

State	AFDC Benefit Only	Food Stamp Benefit Only	AFDC & Food Stamps Combined (State Contribution) *	% of Total Benefit Provided By State
Mississippi	$120	$295	415 (25)	6%
Texas	$188	$295	483 (67)	14%
Indiana	$288	$278	566 (105)	19%
Michigan	$459	$227	686 (200)	29%
California	$607	$183	790 (304)	38%
Connecticut	$680	$161	841 (340)	40%

* AFDC is a program where federal share varies from 50% to 80%

* Food Stamps is a program with 100% federal share (except administrative costs).

State programs for a single person in FY 1993

State	Maximum GA Benefit Able Bodied	Average State SSI Supplement
Mississippi	No GA	No SSI Supp.
Texas	No GA	No SSI Supp.
Indiana	Case by Case	NA
Michigan	No GA	$29
California (LA Cty)	$303	$180
Connecticut	$314	NA

* General Assistance is 0% federal share
* "NA" indicates not available

AGENDA

DECEMBER 8, 1994

COVERAGE PACKAGES

I. Introduction and Description of Meetings with the President

II. Overview of Assumptions and Coverage Packages

III. Coverage Options: Costs and Distribution

IV. Sources of Funding

V. Examples of Packages

VI. Closing Remarks

ASSUMPTIONS FOR COVERAGE OPTIONS

I. We assume the rejection of subsidy options that are significant (e.g., the Mainstream proposal cost $600–$800 billion).

II. We are focusing on private sector–oriented expansions for all options (except Welfare to Work and State Flexibility).

III. We assume subsidies should benefit middle income Americans.

COVERAGE OPTIONS

I. COVERAGE FOR CHILDREN

Description

- Beginning in 1997, children who have been uninsured for at least six months and do not have other coverage available would be eligible to receive an insurance package similar to Blue Cross/Blue Shield package for federal employees.

- Coverage would be through private health plans, administered either through vouchers (with comprehensive insurance reforms) or through state contracts with health plans.

- Children in families with income under 185% of the poverty level would receive fully subsidized coverage. One option would phase out subsidies between 185% and 240% of poverty. Another would phase out subsidies between 185% and 300% of poverty.

- For the purposes of determining eligibility, income would be measured on a monthly basis.

Implications

- Politically appealing.

- Middle class benefit.

- Dropping.

- Annual versus monthly income issue.

- Marginal tax rate issue.

II. COVERAGE FOR THE TEMPORARILY UNEMPLOYED

Description

- Beginning in 1997, people receiving unemployment compensation who do not have other insurance coverage available would be eligible to receive an insurance package similar to the Blue Cross/Blue Shield package for federal employees.

- Coverage would be through private health plans, administered either through vouchers (with comprehensive insurance reforms) or through state contracts with health plans.

- For the purposes of determining eligibility, income would be measured on a monthly basis. One option excludes unemployment compensation from income, while another includes it.

- People with income under 100% of the poverty level would be eligible for a full subsidy, and the subsidy would be phased out between 100% and 200% of poverty. Since most middle class citizens do not have high monthly incomes when they are unemployed, they would in large numbers qualify for this benefit.

Implications

- Worker-oriented structure has political appeal.

- Extending insurance to previously insured.

- COBRA relief for business.

- Limiting coverage to unemployment compensation has mixed effects.

- Potential for some unintended employment disincentives.

III. COVERAGE FOR THOSE LEAVING WELFARE FOR WORK

Description

- Beginning in 1997, people leaving welfare for work would be eligible to continue receiving Medicaid for two years. Under current law, one year of continued Medicaid is available.

- Eligibility does not depend on income.

Implications

- Mixed impact on breaking welfare/health link.

Projected Federal Budget Deficit

Fiscal Years (billions $)

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
-176	-201	-217	-213	-237	-253	-256	-263	-271	-281

Source: NEC

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1996-2000	Total 1996-2000
OUTLAYS													
Kids' Program (1)													
Full Coverage 1997													
240% Phase-Out													
No Employer Dropping Assumed	0.0	0.0	6.4	8.8	9.2	9.7	10.1	10.7	11.3	11.9	12.6	34.1	90.8
Higher Employer Dropping Assumed (2)	0.0	0.0	7.8	10.8	11.3	11.8	12.3	13.0	13.7	14.5	15.3	41.6	110.4
300% Phase-Out													
No Employer Dropping Assumed	0.0	0.0	6.9	7.2	10.0	10.5	11.0	11.6	12.2	12.9	13.7	34.7	96.1
Higher Employer Dropping Assumed (2)	0.0	0.0	9.2	12.7	13.2	13.8	14.5	15.2	16.1	17.0	18.0	48.8	129.5
Temporarily Unemployed													
UI Included in Income	0.0	0.0	3.0	4.2	4.5	4.9	5.3	5.7	6.2	6.7	7.2	16.6	47.6
UI Excluded in Income	0.0	0.0	4.0	5.7	6.1	6.6	7.1	7.7	8.3	9.0	9.7	22.4	64.4
Welfare to Work	0.0	0.0	1.4	1.5	1.6	1.7	1.8	1.9	2.1	2.3	2.4	6.2	16.7
Kids + Temporarily Unemployed													
UI Included; Kids Phase-Out at 240% (5)	0.0	0.0	9.0	12.5	13.2	14.0	14.9	15.9	16.9	18.1	19.3	48.7	133.7
UI Excluded; Kids Phase-Out at 300% (6)	0.0	0.0	12.0	16.6	17.5	18.6	19.8	21.1	22.5	24.0	25.6	64.8	177.8
Kids + Temporarily Unemployed + Welfare to Work													
UI Included; Kids Phase-Out at 240% (3)	0.0	0.0	10.0	13.6	14.4	15.3	16.3	17.5	18.6	19.9	21.3	53.3	146.8
UI Excluded; Kids Phase-Out at 300% (4)	0.0	0.0	13.0	18.1	19.1	20.3	21.6	23.0	24.6	26.3	28.0	71.0	194.5
Public Health/ FQHC	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
Long Term Care Program													
Expand Home & Community Based Services													
Low Option	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
High Option	0.0	0.0	0.0	1.8	2.9	3.6	5.0	7.9	11.4	15.4	17.3	8.3	65.3
REVENUES													
Self-Employed Deduction (5,6)													
Extend 25% deduction	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2	-3.8	-8.8
100% deduction in 1995	-0.9	-2.2	-2.4	-2.7	-2.9	-3.2	-3.5	-3.8	-4.1	-4.5	-4.8	-14.3	-35.0
Long Term Care													
Long-Term Care Insurance Tax Incentives (5)	0.0	0.0	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-1.0	-2.8
Personal Assistance Services Tax Credit (5)	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume employer or employee dropping of insurance, which would result in increased tax revenues of approximately $2.2 billion between FY 1997 and FY 2000 and $5.8 billion between FY 1997 and FY 2005.

(3) Uses kids' program estimate assuming no dropping.

(4) Uses kids' program estimate assuming higher dropping.

(5) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue.

(6) These totals include FY 1995 losses in revenue.

Coverage Of Children Under Proposed Programs
(Persons in millions)

SELECTED PROGRAMS	Total Uninsured	Total Participants	Participants Who Were Formerly Uninsured
Kids' Program (Full Coverage in 1997)			
240% Phase-Out			
Assuming No Employer Dropping	9.0	7.5	4.1
Assuming Higher Employer Dropping	9.0	11.8	4.1
300% Phase-Out			
Assuming No Employer Dropping	9.0	8.1	4.3
Assuming Higher Employer Dropping	9.0	14.1	4.3

Distribution of Federal Funds and Participants
By Income Quintile: 1997
(Persons in millions, dollars in billions)

SELECTED PROGRAMS		Income Quintiles 1st	2nd	3rd	4th	5th	Total
Kids' Program (Full Coverage in 1997)							
240% Phase-Out							
Assuming No Employer Dropping	*Participants*	1.3	3.0	2.2	0.8	0.1	7.5
	Subsidies	22%	49%	26%	3%	0%	$8.5
Assuming Higher Employer Dropping	*Participants*	1.4	3.4	4.1	2.5	0.4	11.8
	Subsidies	17%	40%	34%	8%	1%	$10.4
300% Phase-Out							
Assuming No Employer Dropping	*Participants*	1.3	3.0	2.3	1.2	0.2	8.1
	Subsidies	20%	45%	28%	6%	0%	$9.2
Assuming Higher Employer Dropping	*Participants*	1.4	3.4	4.4	4.2	0.7	14.1
	Subsidies	15%	35%	36%	14%	1%	$12.3
Temporarily Unemployed							
UI Included	*Participants*	0.9	2.4	2.6	1.8	0.4	8.2
	Subsidies	22%	38%	26%	11%	2%	$4.0
UI Excluded	*Participants*	1.0	2.7	2.9	2.3	0.7	9.5
	Subsidies	18%	35%	29%	15%	3%	$5.3
Kids + Temporarily Unemployed							
UI Included, Kids Phase-Out at 240%	*Participants*	2.2	5.2	4.7	2.5	0.6	15.2
	Subsidies	22%	49%	26%	3%	0%	$12.0
UI Excluded, Kids Phase-Out at 300%	*Participants*	2.1	5.2	6.4	5.7	0.9	20.4
	Subsidies	16%	36%	34%	13%	1%	$17.6
Kids + Temporarily Unemployed + Welfare to Work							
UI Included, Kids Phase-Out at 240%	*Participants*	2.3	5.4	4.8	2.6	0.6	15.6
	Subsidies	22%	45%	27%	6%	1%	$12.5
UI Excluded, Kids Phase-Out at 300%	*Participants*	2.1	5.3	6.6	5.8	1.0	20.8
	Subsidies	16%	38%	32%	13%	1%	$18.9
Long Term Care Program							
High Option (1)	*Participants*	0.2	0.2	0.1	0.0	0.0	0.5
	Subsidies	60%	26%	13%	2%	1%	$1.8

Income Quintiles are Annual Cash Income (1994$):
1st Quintile: $0 - 9,400
2nd Quintile: $9,400-20,400
3rd Quintile: $20,400 - 35,000
4th Quintile: $35,000 - 57,500
5th Quintile: $57,500

NOTE: The 1997 costs represent a full year of subsidies; in the "Uses Table", only 75% of these subsdies are displayed since the programs begin on January 1, 1997.
(1) Assumes implementation in FY 1998

Possible Sources of Funds

Fiscal Years, Billions of Dollars

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1996-2000	Total 2001-2005	Total 1996-2005
Medicare Savings Options	1/													
Extensions of OBRA 1993 Baseline Savings		-0.1	-0.4	-0.6	-3.1	-6.0	-8.7	-11.9	-15.9	-19.4	-23.2	-10.2	-79.1	-89.3
Extensions of OBRA 1993 Savings Policies		-1.0	-1.1	-1.5	-2.2	-2.8	-3.6	-4.6	-5.6	-6.7	-7.8	-8.7	-28.2	-36.9
Additional Medicare Savings and Receipt Proposals		-1.6	-3.3	-2.7	-3.3	-3.9	-4.9	-6.3	-7.8	-9.7	-11.5	-14.8	-40.3	-55.1
Medicaid Savings Options														
Managed Care AFDC/NC Kids, 5% One-time Reduction	1/	0.0	0.8	0.4	0.5	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	1.0	-4.7	-3.7
Potential Republican Caps:														
-- AFDC/NC Kids Growth Only (AFDC/NC Pop. + CPI)	2/		-0.7	-1.5	-2.4	-3.4	-4.6	-5.8	-7.0	-8.2	-9.2	-8.0	-34.9	-42.8
-- Total Program Growth (Medicaid Population + CPI)	2/		-3.3	-8.1	-13.1	-19.1	-26.1	-33.2	-40.3	-47.2	-53.9	-43.6	-200.6	-244.3
Target DSH Offsets for Coverage Expansions	3/													
Kids to 240% of Poverty	4/		-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-1.9	-2.0	-2.1	-5.3	-9.4	-14.7
Welfare to Work			-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.3	-2.3	-3.6
Combined: Kids + Unemployed + Welfare to Work			-1.5	-1.7	-1.8	-2.0	-2.1	-2.3	-2.5	-2.7	-2.8	-7.0	-12.4	-19.4
Tobacco Tax	5/													
Phased $0.45 Increase		-1.9	-3.5	-4.9	-6.2	-6.6	-6.5	-6.4	-6.4	-6.3	-6.2	-23.1	-31.9	-55.0
$0.75 Increase		-8.2	-10.4	-10.3	-10.3	-10.2	-10.1	-10.0	-9.9	-9.8	-9.7	-49.4	-49.5	-98.9
Medicare Savings from Health Care Reform Bills	6/													
Dole		-1.8	-3.5	-7.4	-12.2	-17.0	-21.0	-26.2	-32.1	-37.6	-43.9	-41.9	-160.8	-202.7
Mainstream		-4.0	-8.2	-14.1	-21.1	-28.3	-34.4	-41.8	-50.2	-59.2	-68.6	-75.7	-254.2	-329.9

NOTES:

1/ Estimates from HCFA and OMB/HFB.
2/ Estimates from OMB/HFB.
3/ Estimates from HHS/ASPE.
4/ Estimates assume no dropping of private ESI, assume full dropping of private non-group insurance.
5/ Estimates from Department of the Treasury.
6/ Estimates from HCFA.

Caveats and Assumptions in "Possible Sources of Funds" Table

General Caveat

- Use of the FY 1996 President's Budget baseline will have an impact on all Medicare and Medicaid savings estimates.

Medicare Savings Options

- Proposals that had effective dates in 1995 (physician fee update cut, FDO elimination, and moratorium on LTC hospitals) have been pushed back one year for more realistic estimates. However, effective dates for these and other proposals may have to be reconsidered. Later effective dates will reduce savings within the budget window.

- The Medicare Savings Options, Dole bill, and Mainstream bill contain "beneficiary proposals." These proposals are 25% Part B premium extension (all three packages); income-related Part B premium (Mainstream and Medicare Options); and HI tax extended to all State and local employees (Mainstream and Medicare Options).

Medicaid Managed Care Savings Options

- The managed care estimate assumes a phase-in to 100 percent managed care enrollment in FY 1999.

- Per capita expenditures for managed care recipients are assumed to be 5 percent less than fee-for-service. The growth rate in per capita expenditures does not change.

- Per capita expenditures include services for cash adults and children and Medicaid-only children.

Target DSH Offsets for Coverage Expansions

- In addition to considering DSH cuts that are proportional to coverage increases, limiting States' ability to use DSH as a financing tool could also be considered.

- Given States' varied use of the DSH program, and given the varying effects of State DSH allotments and OBRA 1993 DSH payment restrictions, it may be difficult to design a policy that achieves the desired level of savings.

FOR ILLUSTRATIVE PURPOSES ONLY

"KIDS FIRST"*

Initiatives

KIDS (THROUGH 18) UP TO 300%

25% SELF EMPLOYED TAX DEDUCTION

DEFICIT REDUCTION, 2001–2005

Sources of Funds

$0.75 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

	1996–2000	1996–2005
Kids up to 300%	48.8	129.5
25% Self-Employed	3.8	8.8
TOTAL COSTS:*	52.6	138.3
$0.75 Tobacco Tax	49.4	98.9
OBRA I Medicare	10.2	89.3
TOTAL FINANCING:*	59.6	188.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKERS"*

Initiatives

TEMPORARILY UNEMPLOYED (WITH UI INCLUDED)

25% SELF EMPLOYED TAX DEDUCTION

WELFARE TO WORK

DEFICIT REDUCTION, 2001–2005

Sources of Funds

$0.45 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

OBRA II MEDICARE EXTENDERS

	1996–2000	1996–2005
Temporarily Unemployed	16.6	47.6
25% Self-Employed	3.8	8.8
Welfare to Work	6.2	16.7
TOTAL COSTS:*	26.6	73.1
$0.45 Tobacco Tax	23.1	55.0
OBRA I Medicare	10.2	89.3
OBRA II Medicare	8.7	36.9
TOTAL FINANCING:*	42.0	181.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"BUILDING THE FOUNDATION FOR UNIVERSAL COVERAGE"*

Initiatives

KIDS (THROUGH 18) UP TO 300%

TEMPORARILY UNEMPLOYED (WITH UI EXCLUDED)

25% SELF EMPLOYED TAX DEDUCTION

WELFARE TO WORK

LONG TERM CARE TAX INCENTIVES, TAX CREDIT

DEFICIT REDUCTION, 2001-2005

Sources of Funds

$0.75 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

OBRA II MEDICARE EXTENDERS

ADDITIONAL MEDICARE SAVINGS

	1996-2000	1996-2005
Kids up to 300% + Temporarily Unemployed + Welfare to Work	71.0	194.5
25% Self-Employed	3.8	8.8
Long Term Care	1.4	4.1
TOTAL COSTS:*	76.2	207.4
$0.75 Tobacco Tax	49.4	98.9
OBRA I Medicare	10.2	89.3
OBRA II Medicare	8.7	36.9
Additional Medicare	14.8	55.1
TOTAL FINANCING:*	83.1	280.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

ESTIMATED CBO SCORING of MEDICARE SAVINGS PROPOSALS

Fiscal years, dollars in billions

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-yr Total 1996-2000	10-yr Total 1995-2004	10-yr Total 1996-2005
Extensions of OBRA 1993 Baseline Savings													
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-2.4	-3.0	-11.4	-13.8
Part B Offset	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	0.7
Reduce Routine Cost Limits for HHAs	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.6	-0.7	-0.7	-1.7	-4.2	-4.9
Extend OBRA93 SNF Update Freeze	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.8	-1.8	-2.1
Permanent 25% Part B Premium	0.0	0.0	0.0	-1.3	-3.6	-6.1	-9.2	-12.9	-16.2	-20.0	-4.9	-49.3	-69.3
Subtotal	**-0.1**	**-0.4**	**-0.6**	**-3.1**	**-6.0**	**-8.7**	**-11.9**	**-15.9**	**-19.4**	**-23.3**	**-10.2**	**-66.1**	**-89.4**
Extensions of OBRA 1993 Savings Policies													
Hospital PPS Update (MB-0.5%, 1997-2004)	0.0	0.0	-0.3	-0.8	-1.3	-1.9	-2.7	-3.6	-4.6	-5.6	-2.4	-15.2	-20.8
1995 Physician Update -3% (-0% primary care)	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-2.5	-5.6	-6.2
Part B Offset	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4	1.6
ASC Payment Update Freeze (1996-1999)	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.8	-1.0
Part B Offset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3
Clinical Lab Payment Update Freeze (1996-99)	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.9	-2.9	-3.5
Part B Offset	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.7	0.9
Reduce Hospital Capital (-7.31%/-10.41%)	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.1	-1.2	-3.7	-7.8	-9.0
HI Interactions	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.7	0.9
Subtotal	**-1.0**	**-1.1**	**-1.5**	**-2.2**	**-2.8**	**-3.6**	**-4.6**	**-5.6**	**-6.7**	**-7.9**	**-8.7**	**-29.3**	**-36.9**
Additional Medicare Savings and Receipt Proposals													
Extend HI Tax to All State & Local Employees	-1.6	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.1	-1.0	-7.6	-12.6	-13.6
Income-Related Part B Premium ($90K/$115K)													
Net New Receipts and Program Savings	0.0	-1.7	-1.2	-1.7	-2.0	-2.5	-3.0	-3.7	-4.5	-5.2	-6.6	-20.4	-25.6
Eliminate MVPS Upward Bias	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-7.1	-0.8	-14.2	-21.3
Part B Offset	0.0	0.0	0.0	0.1	0.2	0.4	0.7	1.0	1.4	1.8	0.2	3.6	5.3
Subtotal	**-1.6**	**-3.3**	**-2.7**	**-3.3**	**-3.9**	**-4.9**	**-6.3**	**-7.8**	**-9.7**	**-11.5**	**-14.8**	**-43.6**	**-55.1**
TOTAL SAVINGS	**-2.7**	**-4.9**	**-4.8**	**-8.6**	**-12.7**	**-17.2**	**-22.7**	**-29.3**	**-35.8**	**-42.7**	**-33.8**	**-139.0**	**-181.5**

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Hillary Clinton Re: Medicare/Medicaid and the Budget (2 pages)	12/14/94	P5

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

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Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
December 1994 HSA

gf122

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

EXAMPLES OF STATE LAWS WITH ERISA COMPLICATIONS

Except where noted, the following state laws are either clearly preempted by ERISA or are likely to be vulnerable to a colorable claim that they are preempted by ERISA.

Except where noted, these state laws have been enacted but not implemented. The list does not include laws that were seriously considered by a state -- for example, through a task force or interagency commission -- but not proposed in legislation (e.g., payroll taxes in Colorado and Vermont). The list also does not include measures that are part of a governor's health care plan but have not been enacted into law (e.g., global budgets in New York).

"PURE" EMPLOYER MANDATE

- Washington
- Hawaii[1]

PAY OR PLAY

- Oregon
- Massachusetts

"EMPLOYER CONDUIT"
(employers must offer, but need not pay for, insurance)

- Iowa

TAXES ON HOSPITAL SERVICES & GROSS EARNINGS
(to fund uncompensated care)

- Connecticut[2]

PROVIDER TAX
(to fund coverage expansion)

- Minnesota[3]

RATE-SETTING

- New York[4]
- Maryland[5]

GLOBAL BUDGETS
(limits on spending or rate of growth)

- Vermont[6]
- Washington
- Minnesota
- Montana[7]

REQUIREMENT THAT HEALTH PLANS ARBITRATE/MEDIATE MALPRACTICE DISPUTES BEFORE GOING TO COURT

- Washington

DATA COLLECTION[8]

- Washington
- Minnesota
- New York
- Vermont

BASIC INSURANCE REFORMS SUCH AS MODIFIED COMMUNITY RATING, RESTRICTING PREEXISTING CONDITION EXCLUSIONS, RESTRICTING MEDICAL UNDERWRITING, AND PORTABILITY

One or more of these types of reforms has been enacted (for fully-insured plans) and/or implemented in every state except Nevada, Michigan, Pennsylvania, Georgia, Alabama, and Hawaii.[9]

1. Hawaii has been able to implement its legislation because it is the only state to be granted a waiver of ERISA preemption by Congress. However, Hawaii's waiver limits the state to its health plan as it existed in 1974. Currently, Hawaii is seeking an expansion of its waiver to allow it to modify the mandated benefit package, require coverage for dependents, and update its cost-sharing formula for insurance premiums.

2. Connecticut's legislation has been implemented and challenged in court on ERISA grounds. A federal district court judge held recently that the legislation is preempted by ERISA. The system Connecticut previously had in place to pay for uncompensated care, an uncompensated care pool funded by a portion of each insured patient's hospital bill, had also been struck down on ERISA preemption grounds.

3. Implemented; challenged in court on ERISA grounds.

4. New York's legislation has been implemented and challenged in court on ERISA grounds. The Court of Appeals for the Second Circuit held recently that the legislation is preempted by ERISA. The United States Supreme Court has agreed to hear the case.

5. Maryland's all-payer hospital rate-setting system has been implemented; although it may be vulnerable to a court challenge on ERISA grounds, no lawsuit has been brought at this time. Maryland has announced that it is interested in changing its rate-setting system to finance uncompensated care and medical education more equitably and that it has not yet done so because it does not want to defend a lawsuit brought against the state on ERISA grounds.

6. Implemented for public and private hospital spending only.

7. Montana's legislation establishes a commission charged with developing two health care reform plans; both plans must include a global budget.

8. The data collection laws in these and other states are not preempted by ERISA because they do not apply to self-insured plans. The four states listed here have expressed a desire to obtain data from such plans; currently, they request the self-insured plans to contribute data voluntarily.

9. These laws are not preempted by ERISA because they do not apply to self-insured plans.

HEALTH CARE AND THE BUDGET:
POLICY AND STRATEGY MEETING

AGENDA
DECEMBER 22, 1994

I. Introduction

II. Revised Deficit Post Changes in Medicare and Medicaid Baseline

III. Sources of Financing for Health Reform

IV. Options for Coverage Expansions

V. Illustrative Packages: Pairing Financing Sources with Options for Coverage Expansion and Deficit Reduction

VI. Discussion of Health Reform Strategic Options:

- Whether, and if so, How Presented in the Budget
- Positioning Strategy Relative to the Republicans

Secretary Bentsen

POSSIBLE SOURCES OF FUNDING

Fiscal Years, Billions of Dollars

MEDICARE/MEDICAID SOURCES WILL BE REDUCED WITH NEW BASELINE CHANGES

		1996	1997	1998	1999	2000	1996–2000
Medicare Savings Options							
Extensions of OBRA 1993 Baseline Savings	1/	-0.8	-1.1	-1.3	-3.9	-6.8	-13.8
Extensions of OBRA 1993 Savings Policies	1/	-0.3	-0.5	-0.9	-1.5	-2.2	-5.4
HHS Desired Programmatic Changes (All Provider Cuts)	2/	-0.8	-1.5	-2.0	-3.5	-4.9	-12.6
Additional Medicare Savings and Receipt Proposals	2/	-1.7	-4.9	-5.7	-6.8	-7.6	-26.8
Medicaid Savings Options							
Managed Care AFDC/NC Kids, 5% One-time Reduction	2/	0.0	0.8	0.4	0.5	-0.7	1.0
Potential Republican Caps							
Total Program Growth (Medicaid Population + CPI)	3/		-3.3	-8.1	-13.1	-19.1	-43.6
Target DSH Offsets for Coverage Expansions							
Freeze Federal DSH Payments at FY 1995 Level	4/	-1.1	-2.2	-3.4	-4.6	-6.0	-17.4
Tobacco Tax							
$0.45 Phased Increase	5/	-1.9	-3.5	-4.9	-6.2	-6.6	-23.1
$0.75 Increase		-8.2	-10.4	-10.3	-10.3	-10.2	-49.4
$1.00 Increase		-10.2	-13.0	-12.9	-12.9	-12.8	-61.8
Medicare Savings from Health Care Reform Bills							
Dole	6/	-1.8	-3.5	-7.4	-12.2	-17.0	-41.9
Mainstream		-4.0	-8.2	-14.1	-21.1	-28.3	-75.7

NOTES

All estimates are preliminary. Totals may not add due to rounding. Baseline re-estimates for FY 1996 President's Budget will affect all savings estimates.

***Medicaid sources will be reduced by a greater percentage than Medicare sources.**

1/ Estimates from HCFA and OMB/HFB. Unclear of availability for health care uses.

2/ Estimates from HCFA and OMB/HFB.

3/ Estimates from OMB/HFB.

4/ Estimates from OMB/HFB. A large downward re-estimation of the FY 1996 President's Budget baseline may significantly reduce estimates of DSH expenditures relative to the rest of the program.

5/ Estimates from Department of the Treasury.

6/ Estimates from HCFA.

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	Total 1995-2000
OUTLAYS							
Kids' Program (1,2)							
Free to 133%, Phase-Out to 240%	0.0	0.0	3.8	5.2	5.4	5.6	20.0
Free to 133%, Phase-Out to 300%	0.0	0.0	4.7	6.5	6.8	7.1	25.1
Temporarily Unemployed (3)							
Free to 100%, Phase-Out to 250%	0.0	0.0	3.0	4.2	4.5	4.9	16.6
Welfare to Work (4)	0.0	0.0	0.0	0.0	1.2	1.3	2.6
Kids + Temporarily Unemployed (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	6.2	8.6	8.9	9.4	33.1
Free to 133%, Phase-Out to 300%	0.0	0.0	7.2	9.9	10.4	10.9	38.3
Kids + Temporarily Unemployed + Welfare to Work (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	6.2	8.6	9.9	10.4	35.2
Free to 133%, Phase-Out to 300%	0.0	0.0	7.2	9.9	11.3	11.9	40.3
Public Health/ FQHC	0.1	0.2	0.2	0.2	0.2	0.2	0.9
Long Term Care Program							
Expand Home & Community Based Services							
Low Option	0.0	0.0	1.5	1.5	1.6	1.6	6.2
High Option	0.0	0.0	0.0	1.8	2.9	3.6	8.3
REVENUES (5)							
Self-Employed Deduction							
Extend 25% deduction	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-3.8
100% Deduction Phased In (6)	-0.5	-0.5	-0.9	-1.4	-2.0	-2.2	-7.5
Long Term Care							
Long-Term Care Insurance Tax Incentives	0.0	-0.2	-0.4	-0.5	-0.6	-0.7	-2.4
Personal Assistance Services Tax Credit	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.4

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

(3) Assumes that unemployment compensation is included in income determinations

(4) Extension of Medicaid transition benefit after FY 1998 sunset

(5) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue. Prepaed by Treasury.

(6) Phase in: 25% in 1994, 25% in 1995, 50% in 1996, and 75% in 1997 and 100% in 1998. Assumes the self-employed must provide health coverage to their employees in

Coverage of Children Under Medicaid Expansions and Proposed Children's Health Insurance Program, Millions of Children,1997

Total Uninsured Children in 1997	**8.6**
Uninsured Children Over 240% of Poverty and Not Eligible for a Premium Subsidy	1.8
--Currently Uninsured Children Eligible for a Premium Subsidy or Coverage Through Medicaid Expansions	6.8
Uninsured Children That Will Be Covered Through Current Law Expansions Of Medicaid	1.8
Remaining Uninsured Children Under 240% of Poverty Eligible for a Premium Subsidy	5.0
Uninsured Children Likely To Participate in New Kids Program	2.0
Previously Uninsured Children Covered By Medicaid and New Children's Program	3.8

**Children In Families Under 133% of poverty receive full premium subsidy. Premium subsidy phases out at 240% of poverty.

**Program is assumed to be a capped amount provided to states and not an individual entitlement.

Coverage of Children Under Medicaid Expansions and Proposed Children's Health Insurance Program, Millions of Children, 1997

Total Uninsured Children in 1997	**8.6**
Uninsured Children Over 300% of Poverty and not eligible for a premium subsidy	1.3
--Currently Uninsured Children Eligible for a Premium Subsidy or Coverage Through Medicaid Expansions	7.3
Uninsured Children That Will Be covered Through Current Law Expansions Of Medicaid	1.8
Remaining Uninsured Children Under 300% of Poverty Eligible for a Premium Subsidy	5.5
Uninsured Children Likely To Participate in New Kids Program	2.7
Previously Uninsured Children Covered By Medicaid and New Children's Program	4.5

**Children in families under 133% of poverty receive full premium subsidy. Premium subsidy phases out at 300% of poverty.

**Program is assumed to be a capped amount provided to states and not an individual entitlement.

Distribution of Federal Funds and Participants
By Income Quintile: 1997
(Persons in millions, dollars in billions)

SELECTED PROGRAMS		Income Quintiles 1st	2nd	3rd	4th	5th	Total
Kids' Program (Full Coverage in 1997)							
Free to 133% PL; 240% PL Phase-Out	*Participants*	0.4	1.8	2.7	1.2	0.3	6.4
	Subsidies	10%	44%	39%	6%	1%	$5.1
Free to 133% PL; 300% PL Phase-Out	*Participants*	0.4	1.9	3.2	1.7	0.4	7.6
	Subsidies	8%	38%	43%	9%	1%	$6.3
Temporarily Unemployed	*Participants*	0.9	2.4	2.6	1.8	0.4	8.2
	Subsidies	22%	38%	26%	11%	2%	$4.0
Kids + Temporarily Unemployed							
Free to 133% PL; 240% PL Phase-Out	*Participants*	1.0	3.3	4.5	2.3	0.5	11.7
	Subsidies	15%	42%	34%	8%	2%	$8.3
Free to 133% PL; 300% PL Phase-Out	*Participants*	1.0	3.4	4.9	2.8	0.7	12.8
	Subsidies	13%	38%	38%	10%	2%	$9.6
Long Term Care Program							
High Option (1)	*Participants*	0.2	0.2	0.1	0.0	0.0	0.5
	Subsidies	60%	26%	13%	2%	1%	$1.8

NOTE: The 1997 costs represent a full year of subsidies; in the "Uses Table", only 75% of these subsdies are displayed since the programs begin on January 1, 1997.
(1) Assumes implementation in FY 1998
Income Quintiles are Annual Cash Income (1994$):
1st Quintile: $0 - 9,400
2nd Quintile: $9,400-20,400
3rd Quintile: $20,400 - 35,000
4th Quintile: $35,000 - 57,500
5th Quintile: $57,500

FOR ILLUSTRATIVE PURPOSES ONLY

"BUILDING THE FOUNDATION FOR UNIVERSAL COVERAGE"

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

LONG TERM CARE

PUBLIC HEALTH SERVICES

Sources of Funds

$0.75 TOBACCO TAX

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996–2000	
Kids up to 300% + Temporarily Unemployed + Welfare to Work (Combined)	42.9	
Self-Employed, phased-in to 100%	7.5	
Long Term Care	9.0	
Public Health Services	0.9	
TOTAL COSTS:		$60.3 billion
$0.75 Tobacco Tax	49.4	
Medicaid DSH	17.4	
Provider Medicare Savings	43.5	
TOTAL FINANCING:		$110.3 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKING FAMILIES"

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996-2000
Kids up to 300% of Poverty	25.1
Temporarily Unemployed	16.6
Self-Employed, phased to 100%	7.5
TOTAL COSTS:	$49.2 billion
Medicaid DSH	17.4
Provider Medicare Savings	43.5
TOTAL FINANCING:	$60.9 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKERS"

Initiatives

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.45 TOBACCO TAX

MEDICAID DSH

	1996–2000
Temporarily Unemployed	16.6
Self-Employed, phased-in to 100%	7.5
Welfare to Work	6.2
TOTAL COSTS:	$30.3 billion
$0.45 Tobacco Tax	23.1
Medicaid DSH	17.4
TOTAL FINANCING:	$30.5 billion

FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"KIDS FIRST"*

Initiatives

KIDS (UP TO 300% OF POVERTY)

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.75 TOBACCO TAX

	1996–2000
Kids, up to 300% of poverty	28.1
Self-Employed phased-in to 100%	7.5
TOTAL COSTS:*	$35.6 billion
$0.75 Tobacco Tax	49.4
TOTAL FINANCING:*	$49.4 billion

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

Leon Panetta Files

THE WHITE HOUSE

WASHINGTON

December 12, 1994

MEMORANDUM FOR THE CHIEF OF STAFF

FROM: CHRIS JENNINGS

SUBJECT: Materials from Health Care Meeting on Coverage Packages

Attached are the materials from the health care meeting on December 8th in which we discussed possible coverage options and sources of financing for health care reform. Gene Sperling mentioned that you were interested in taking a look at these materials, and I think that you might find them useful as you proceed in the budget process.

The first table in the attached document shows potential uses of funds, including coverage options. The second table shows potential financing options, with a backup table that provides more detail on the specific Medicare savings options. The next three pages provide examples of combinations of sources and uses of funds that give a sense of the spectrum of coverage packages that we could propose. Please note that although Medicare extenders are used to partially pay for these options, other financing options -- such as additional Medicare savings -- could also be utilized. I have attached the policy descriptions for the coverage options at the end of this document, in case you are interested in having more detail.

I also want to point out a new section in the sources of funds table on Medicaid savings, particularly the line on capped spending at Medicaid population growth plus CPI growth. These numbers are based on a proposal similar to the one that has been discussed in some budget meetings recently. The attached table shows the caps generating $44 billion in savings; if these caps were in place in 1996 they would generate about $70 billion. If this proposal receives serious consideration, I believe it would be important to have the principals briefed on the policy and political implications of such a proposal. We are planning to put together some materials on this for Bob Rubin and Carol Rasco and would be happy to forward them on to you if you are interested.

If you have any questions or are interested in discussing the attachments in more detail, please give me a call at 6-5560.

Attachments

cc: Carol Rasco
Bob Rubin

AGENDA

DECEMBER 8, 1994

COVERAGE PACKAGES

I. Introduction and Description of Meetings with the President

II. Overview of Assumptions and Coverage Packages

III. Coverage Options: Costs and Distribution

IV. Sources of Funding

V. Examples of Packages

VI. Closing Remarks

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1996-2000	Total 1996-2005
OUTLAYS													
Kids' Program (1)													
Full Coverage 1997													
240% Phase-Out													
No Employer Dropping Assumed	0.0	0.0	6.4	8.8	9.2	9.7	10.1	10.7	11.3	11.9	12.6	34.1	90.8
Higher Employer Dropping Assumed (2)	0.0	0.0	7.8	10.8	11.3	11.8	12.3	13.0	13.7	14.5	15.3	41.6	110.4
300% Phase-Out													
No Employer Dropping Assumed	0.0	0.0	6.9	7.2	10.0	10.5	11.0	11.6	12.2	12.9	13.7	34.7	96.1
Higher Employer Dropping Assumed (2)	0.0	0.0	9.2	12.7	13.2	13.8	14.5	15.2	16.1	17.0	18.0	48.8	129.5
Temporarily Unemployed													
UI Included in Income	0.0	0.0	3.0	4.2	4.5	4.9	5.3	5.7	6.2	6.7	7.2	16.6	47.6
UI Excluded in Income	0.0	0.0	4.0	5.7	6.1	6.6	7.1	7.7	8.3	9.0	9.7	22.4	64.4
Welfare to Work	0.0	0.0	1.4	1.5	1.6	1.7	1.8	1.9	2.1	2.3	2.4	6.2	16.7
Kids + Temporarily Unemployed													
UI Included; Kids Phase-Out at 240% (5)	0.0	0.0	9.0	12.5	13.2	14.0	14.9	15.9	16.9	18.1	19.3	48.7	133.7
UI Excluded; Kids Phase-Out at 300% (6)	0.0	0.0	12.0	16.6	17.5	18.6	19.8	21.1	22.5	24.0	25.6	64.8	177.8
Kids + Temporarily Unemployed + Welfare to Work													
UI Included; Kids Phase-Out at 240% (3)	0.0	0.0	10.0	13.6	14.4	15.3	16.3	17.5	18.6	19.9	21.3	53.3	146.8
UI Excluded; Kids Phase-Out at 300% (4)	0.0	0.0	13.0	18.1	19.1	20.3	21.6	23.0	24.6	26.3	28.0	71.0	194.5
Public Health/ FQHC	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
Long Term Care Program													
Expand Home & Community Based Services													
Low Option	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
High Option	0.0	0.0	0.0	1.8	2.9	3.6	5.0	7.9	11.4	15.4	17.3	8.3	65.3
REVENUES													
Self-Employed Deduction (5,6)													
Extend 25% deduction	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.2	-3.8	-8.8
100% deduction in 1995	-0.9	-2.2	-2.4	-2.7	-2.9	-3.2	-3.5	-3.8	-4.1	-4.5	-4.8	-14.3	-35.0
Long Term Care													
Long-Term Care Insurance Tax Incentives (5)	0.0	0.0	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-1.0	-2.8
Personal Assistance Services Tax Credit (5)	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume employer or employee dropping of insurance, which would result in increased tax revenues of approximately $2.2 billion between FY 1997 and FY 2000 and $5.8 billion between FY 1997 and FY 2005

(3) Uses kids' program estimate assuming no dropping.

(4) Uses kids' program estimate assuming higher dropping.

(5) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue.

(6) These totals include FY 1995 losses in revenue.

Possible Sources of Funds

Fiscal Years, Billions of Dollars

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total 1996-2000	Total 2001-2005	Total 1996-2005
Medicare Savings Options	1/													
Extensions of OBRA 1993 Baseline Savings		-0.1	-0.4	-0.6	-3.1	-6.0	-8.7	-11.9	-15.9	-19.4	-23.2	-10.2	-79.1	-89.3
Extensions of OBRA 1993 Savings Policies		-1.0	-1.1	-1.5	-2.2	-2.8	-3.6	-4.6	-5.6	-6.7	-7.8	-8.7	-28.2	-36.9
Additional Medicare Savings and Receipt Proposals		-1.6	-3.3	-2.7	-3.3	-3.9	-4.9	-6.3	-7.8	-9.7	-11.5	-14.8	-40.3	-55.1
Medicaid Savings Options														
Managed Care AFDC/NC Kids, 5% One-time Reduction	1/	0.0	0.8	0.4	0.5	-0.7	-0.8	-0.9	-0.9	-1.0	-1.1	1.0	-4.7	-3.7
Potential Republican Caps:														
– AFDC/NC Kids Growth Only (AFDC/NC Pop. + CPI)	2/		-0.7	-1.5	-2.4	-3.4	-4.6	-5.8	-7.0	-8.2	-9.2	-8.0	-34.9	-42.8
– Total Program Growth (Medicaid Population + CPI)	2/		-3.3	-8.1	-13.1	-19.1	-26.1	-33.2	-40.3	-47.2	-53.9	-43.6	-200.6	-244.3
Target DSH Offsets for Coverage Expansions	3/													
Kids to 240% of Poverty	4/		-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-1.9	-2.0	-2.1	-5.3	-9.4	-14.7
Welfare to Work			-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.3	-2.3	-3.6
Combined: Kids + Unemployed + Welfare to Work			-1.5	-1.7	-1.8	-2.0	-2.1	-2.3	-2.5	-2.7	-2.8	-7.0	-12.4	-19.4
Tobacco Tax	5/													
Phased $0.45 Increase		-1.9	-3.5	-4.9	-6.2	-6.6	-6.5	-6.4	-6.4	-6.3	-6.2	-23.1	-31.9	-55.0
$0.75 Increase		-8.2	-10.4	-10.3	-10.3	-10.2	-10.1	-10.0	-9.9	-9.8	-9.7	-49.4	-49.5	-98.9
Medicare Savings from Health Care Reform Bills	6/													
Dole		-1.8	-3.5	-7.4	-12.2	-17.0	-21.0	-26.2	-32.1	-37.6	-43.9	-41.9	-160.8	-202.7
Mainstream		-4.0	-8.2	-14.1	-21.1	-28.3	-34.4	-41.8	-50.2	-59.2	-68.6	-75.7	-254.2	-329.9

NOTES:

1/ Estimates from HCFA and OMB/HFB.

2/ Estimates from OMB/HFB.

3/ Estimates from HHS/ASPE.

4/ Estimates assume no dropping of private ESI, assume full dropping of private non-group insurance.

5/ Estimates from Department of the Treasury.

6/ Estimates from HCFA.

ESTIMATED CBO SCORING of MEDICARE SAVINGS PROPOSALS

Fiscal years, dollars in billions

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-yr Total 1996-2000	10-yr Total 1995-2004	10-yr Total 1996-2005
Extensions of OBRA 1993 Baseline Savings													
Extend OBRA93 Medicare Secondary Payer	0.0	0.0	0.0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3	-2.4	-3.0	-11.4	-13.8
Part B Offset	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6	0.7
Reduce Routine Cost Limits for HHAs	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.6	-0.6	-0.7	-0.7	-1.7	-4.2	-4.9
Extend OBRA93 SNF Update Freeze	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.8	-1.8	-2.1
Permanent 25% Part B Premium	0.0	0.0	0.0	-1.3	-3.6	-6.1	-9.2	-12.9	-16.2	-20.0	-4.9	-49.3	-69.3
Subtotal	-0.1	-0.4	-0.6	-3.1	-6.0	-8.7	-11.9	-15.9	-19.4	-23.3	-10.2	-66.1	-89.4
Extensions of OBRA 1993 Savings Policies													
Hospital PPS Update (MB-0.5%, 1997-2004)	0.0	0.0	-0.3	-0.8	-1.3	-1.9	-2.7	-3.6	-4.6	-5.6	-2.4	-15.2	-20.8
1995 Physician Update -3% (-0% primary care)	-0.4	-0.5	-0.5	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-2.5	-5.6	-6.2
Part B Offset	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4	1.6
ASC Payment Update Freeze (1996-1999)	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.8	-1.0
Part B Offset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3
Clinical Lab Payment Update Freeze (1996-99)	0.0	-0.1	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.9	-2.9	-3.5
Part B Offset	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.7	0.9
Reduce Hospital Capital (-7.31%/-10.41%)	-0.7	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.1	-1.2	-3.7	-7.8	-9.0
HI Interactions	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.7	0.9
Subtotal	-1.0	-1.1	-1.5	-2.2	-2.8	-3.6	-4.6	-5.6	-6.7	-7.9	-8.7	-29.3	-36.9
Additional Medicare Savings and Receipt Proposals													
Extend HI Tax to All State & Local Employees	-1.6	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.2	-1.1	-1.0	-7.6	-12.6	-13.6
Income-Related Part B Premium ($90K/$115K)													
Net New Receipts and Program Savings	0.0	-1.7	-1.2	-1.7	-2.0	-2.5	-3.0	-3.7	-4.5	-5.2	-6.6	-20.4	-25.6
Eliminate MVPS Upward Bias	0.0	0.0	0.0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5	-7.1	-0.8	-14.2	-21.3
Part B Offset	0.0	0.0	0.0	0.1	0.2	0.4	0.7	1.0	1.4	1.8	0.2	3.6	5.3
Subtotal	-1.6	-3.3	-2.7	-3.3	-3.9	-4.9	-6.3	-7.8	-9.7	-11.5	-14.8	-43.6	-55.1
TOTAL SAVINGS	-2.7	-4.9	-4.8	-8.6	-12.7	-17.2	-22.7	-29.3	-35.8	-42.7	-33.8	-139.0	-181.5

FOR ILLUSTRATIVE PURPOSES ONLY

"KIDS FIRST"*

Initiatives

KIDS (THROUGH 18) UP TO 300%

25% SELF EMPLOYED TAX DEDUCTION

DEFICIT REDUCTION, 2001-2005

Sources of Funds

$0.75 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

	1996-2000	1996-2005
Kids up to 300%	48.8	129.5
25% Self-Employed	3.8	8.8
TOTAL COSTS:*	52.6	138.3
$0.75 Tobacco Tax	49.4	98.9
OBRA I Medicare	10.2	89.3
TOTAL FINANCING:*	59.6	188.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Impact Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKERS"*

Initiatives

TEMPORARILY UNEMPLOYED (WITH UI INCLUDED)

25% SELF EMPLOYED TAX DEDUCTION

WELFARE TO WORK

DEFICIT REDUCTION, 2001-2005

Sources of Funds

$0.45 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

OBRA II MEDICARE EXTENDERS

	1996-2000	1996-2005
Temporarily Unemployed	16.6	47.6
25% Self-Employed	3.8	8.8
Welfare to Work	6.2	16.7
TOTAL COSTS:*	26.6	73.1
$0.45 Tobacco Tax	23.1	55.0
OBRA I Medicare	10.2	89.3
OBRA II Medicare	8.7	36.9
TOTAL FINANCING:*	42.0	181.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"BUILDING THE FOUNDATION FOR UNIVERSAL COVERAGE"

Initiatives

KIDS (THROUGH 18) UP TO 300%

TEMPORARILY UNEMPLOYED (WITH UI EXCLUDED)

25% SELF EMPLOYED TAX DEDUCTION

WELFARE TO WORK

LONG TERM CARE TAX INCENTIVES, TAX CREDIT

DEFICIT REDUCTION, 2001-2005

Sources of Funds

$0.75 TOBACCO TAX

OBRA I MEDICARE EXTENDERS

OBRA II MEDICARE EXTENDERS

ADDITIONAL MEDICARE SAVINGS

	1996-2000	1996-2005
Kids up to 300% + Temporarily Unemployed + Welfare to Work	71.0	194.5
25% Self-Employed	3.8	8.8
Long Term Care	1.4	4.1
TOTAL COSTS:*	76.2	207.4
$0.75 Tobacco Tax	49.4	98.9
OBRA I Medicare	10.2	89.3
OBRA II Medicare	8.7	36.9
Additional Medicare	14.8	55.1
TOTAL FINANCING:*	83.1	280.2

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

COVERAGE OPTIONS

I. COVERAGE FOR CHILDREN

Description

- Beginning in 1997, children who have been uninsured for at least six months and do not have other coverage available would be eligible to receive an insurance package similar to Blue Cross/Blue Shield package for federal employees.

- Coverage would be through private health plans, administered either through vouchers (with comprehensive insurance reforms) or through state contracts with health plans.

- Children in families with income under 185% of the poverty level would receive fully subsidized coverage. One option would phase out subsidies between 185% and 240% of poverty. Another would phase out subsidies between 185% and 300% of poverty.

- For the purposes of determining eligibility, income would be measured on a monthly basis.

Implications

- Politically appealing.

- Middle class benefit.

- Dropping.

- Annual versus monthly income issue.

- Marginal tax rate issue.

II. COVERAGE FOR THE TEMPORARILY UNEMPLOYED

Description

- Beginning in 1997, people receiving unemployment compensation who do not have other insurance coverage available would be eligible to receive an insurance package similar to the Blue Cross/Blue Shield package for federal employees.

- Coverage would be through private health plans, administered either through vouchers (with comprehensive insurance reforms) or through state contracts with health plans.

- For the purposes of determining eligibility, income would be measured on a monthly basis. One option excludes unemployment compensation from income, while another includes it.

- People with income under 100% of the poverty level would be eligible for a full subsidy, and the subsidy would be phased out between 100% and 200% of poverty. Since most middle class citizens do not have high monthly incomes when they are unemployed, they would in large numbers qualify for this benefit.

Implications

- Worker-oriented structure has political appeal.

- Extending insurance to previously insured.

- COBRA relief for business.

- Limiting coverage to unemployment compensation has mixed effects.

- Potential for some unintended employment disincentives.

III. COVERAGE FOR THOSE LEAVING WELFARE FOR WORK

Description

- Beginning in 1997, people leaving welfare for work would be eligible to continue receiving Medicaid for two years. Under current law, one year of continued Medicaid is available.

- Eligibility does not depend on income.

Implications

- Mixed impact on breaking welfare/health link.