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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Democratic Members of the House Committee on Energy and Commerce 103rd Congress (7 pages)	nd	P5
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Potential Rockefeller Problem and Jackson Hole Care Meeting Invite (14 pages)	8/18/95	P5

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

FOLDER TITLE:
Undated HSA Files [4]

gf125

RESTRICTION CODES

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THE PRESIDENT'S PLAN:
A SERIOUS STEP TOWARD HEALTH CARE REFORM

OVERVIEW

Savings, Coverage Expansions, and Deficit Reduction

As the President has said, the key to balancing the budget is controlling health care costs through health care reform. Thus, in his plan to balance the budget by 2005, the President presents a serious first step toward reform that helps Americans maintain private insurance coverage, strengthens the Medicare Trust Fund, reforms the insurance market, and reduces the deficit by $284 billion over 10 years.

His proposal:

- strengthens the Medicare Hospital Insurance (HI) Trust Fund by reducing HI spending by $213 billion over 10 years;

- reforms Medicare to make quality managed care options more attractive to beneficiaries;

- improves Medicare by providing beneficiaries with two new benefits that will (1) waive the copayments for Medicare-eligible women who need mammograms, and (2) provide a respite care benefit to families of Medicare beneficiaries who suffer from Alzheimer's disease;

- maintains Medicaid as a safety net for low-income Americans while reforming it to target funds more efficiently and give states more flexibility to manage it;

- provides grants for home-and community-based long-term care for disabled and elderly Americans;

- reforms the insurance market so that Americans are not denied coverage because they get sick;

- makes insurance more accessible and affordable for small businesses;

- expands the self-employed tax deduction to allow self-employed Americans to deduct up to 50 percent of the cost health insurance premiums; and

- saves $284 billion over the next decade.

The President's plan expands coverage, cuts the deficit with less than half the Medicare savings and a third of the Medicaid savings that Republicans propose, and imposes no new cost increases on Medicare beneficiaries. Republicans would raise costs to the average Medicare beneficiary by ~~$3,500~~ 3,100 over the next 7 years.

DETAILED EXPLANATION

1. Reforming the Insurance Market

Insurance reforms, based on proposals that both Republicans and Democrats supported in the last Congress, will improve the fairness and efficiency of the insurance marketplace. Provisions include:

- **Portability and Renewability of Coverage** -- Insurance companies will be barred from denying coverage to Americans with pre-existing medical conditions, and plans will have to renew coverage regardless of health status.

- **Small Group Market Reforms** -- Insurance companies will be required to offer coverage to small employers and their workers, regardless of health status, and companies will be limited in their ability to vary or increase premiums on the basis of claims' history.

- **Consumer Protections** -- Insurance companies will be required to give consumers information on benefits and limitations of their health plans, including the identity, location, and availability of participating providers; a summary of procedures used to control utilization of services; and how well the plan meets quality standards. In addition, plans would have to provide prompt notice of claims denials and establish internal grievance and appeals procedures.

2. Helping Working Families Retain Insurance After a Job Loss

Families that lose their health insurance when they lose a job will be eligible for premium subsidies for up to three months. The premium subsidies will be available to families with annual incomes up to about $36,500, and will be adequate to help them purchase health insurance with benefits like the Blue Cross/Blue Shield standard option plan available to Federal employees.

3. Helping Small Businesses Afford Insurance

- **Giving Small Employers Access to Group Purchasing Options:** Small employers that lack access to a group purchasing option through voluntary state pools would get that option through the Federal Employees Health Benefits Program (FEHBP). This would increase the purchasing power of smaller businesses and make the small group insurance market more efficient. Small firms would get coverage from plans that also provide coverage to Federal employees through FEHBP, but the coverage would be separately rated in each state, leaving premiums for Federal and state employees unaffected.

- **Expanding the Self-Employed Tax Deduction:** The President's plan provides a fairer system for self-employed Americans who have health insurance. Self-employed people would get to deduct 50 percent of the cost of their health insurance premiums, rather than 25 percent as under current law.

4. Reforming and Strengthening Medicare

• **Strengthening the Trust Fund:** The President's plan would reduce spending in Medicare's Part A by $80 billion over 7 years to ensure the solvency of the Medicare HI Trust Fund to 2005. The plan finds such savings by reducing provider cost growth, not raising beneficiary costs.

• **Eliminating the CoPayment for Mammograms:** Although coverage by Medicare began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance tap this potentially lifesaving benefit. One factor is the required 20 percent copayment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare copayment.

• **Encouraging Managed Care Enrollment:** To encourage more beneficiaries to choose managed care, the President's plan expands the managed care arrangements available to beneficiaries to include preferred provider organizations ("PPOs") and point-of-service ("POS") plans. The plan also implements initiatives to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal. Also included in his plan are important initiatives to streamline regulation.

• **Combatting Fraud and Abuse:** "Operation Restore Trust" is a five-state demonstration project that targets fraud and abuse in home health care, nursing home, and durable medical equipment industries. The President's budget increases funding for these critical fraud and abuse activities.

5. Long-Term Care

• **Expanding Home and Community-Based Care:** The President's plan provides grants to states for home-and community-based services for disabled elderly Americans. Each state, will receive funds for home-and community-based care based on the number of severely disabled people in the state, the size of its low-income population, and the cost of services in the state.

• **Providing for a New Alzheimer's Respite Program Within Medicare:** The President's plan helps Medicare beneficiaries who suffer from Alzheimer's disease by providing respite services for their families for one week each year.

6. Reforming Medicaid

The President reforms Medicaid, expanding state flexibility, cutting costs, and assuring Medicaid's ability to provide coverage to the vulnerable populations it now serves.

• **Eliminating Unnecessary Federal Strings on States:** To let states manage their Medicaid programs more efficiently, the President's plan substantially reduces Federal requirements.

-- States will be allowed to pursue managed care strategies and other service delivery innovations without seeking Federal waivers; and

-- The "Boren Amendment" and other Federal requirements that set minimum

payments to health care providers will be repealed.

- **Reducing Medicaid Costs:** The President proposes a combination of policies to reduce the growth of federal Medicaid spending, including expanding managed care, reducing and better targeting Federal payments to states for hospitals that serve a high proportion of low-income people, and limiting the growth in federal Medicaid payments to states for each beneficiary. Per-person limits, as opposed to a block grant on total spending, promote efficiency while protecting coverage.

CLOSE HOLD

PRESIDENT'S HEALTH REFORM INITIATIVE

SAVINGS, REINVESTMENT, AND DEFICIT REDUCTION PHILOSOPHY

With less than one-half the Medicare savings and one-third the Medicaid savings the Republicans have proposed, the President's health care plan strengthens the Medicare Trust Fund, reinvests savings for long-term care and coverage expansions, and makes a solid contribution to deficit reduction. **What is more, his plan achieves this feat without adding any new cost increases to Medicare beneficiaries.**

The President's proposals make the programs more efficient and more responsive to the beneficiaries and taxpayers they serve. Moreover, as he has consistently stated, the President believes any significant changes in the Medicare and Medicaid program MUST be done in the context of reform. To this end, his vision of reforming the health care system includes:

REFORMING THE INSURANCE MARKET

Insurance market reforms, based upon proposals supported by both Republicans and Democrats in the 103rd Congress, would improve the fairness and efficiency of the insurance marketplace. Provisions include, but are not limited to:

- **Portability and Renewability of Coverage,** including banning plans from excluding coverage for pre-existing medical conditions and requiring plans to renew coverage regardless of health status.

- **Small Group Market Reforms,** including requiring plans to offer coverage to small employers and their workers regardless of health status and limiting the amount by which health plans can vary or increase premiums because of claims history.

- **Consumer Protections,** including requirements that plans provide information to consumers about the plan's benefits and limitations; the identity, location, and availability of the plan's participating providers; a summary description of the procedures used by the plan to control utilization of services; and how well the plan meets quality standards. In addition, plans would be directed to provide prompt notice of claims denials and to establish internal grievance and appeals procedures.

HELPING WORKING FAMILIES KEEP INSURANCE WHEN LAID OFF

As part of the effort to assure portability of coverage, families that lose their insurance because of temporary unemployment would be eligible for premium subsidies for up to six months. The program would build on the current COBRA program, which allows most people who lose their jobs to keep their coverage, but requires them to pay the full cost (including the share previously paid by the employer).

HELPING SMALL BUSINESSES AFFORD INSURANCE

- **Giving Small Employers Access to FEHBP Plans**: The Federal Employees Health Benefit Program (FEHBP) would be made available to states that wish to make group purchasing available to small employers. This would increase the purchasing clout of smaller businesses and make the market for small group insurance more efficient. Small firms would obtain coverage from FEHBP plans, but the coverage would be separately rated in each state so the premiums for federal and state employees would be unaffected.

- **Expanding the Self-Employed Tax Deduction**: The health insurance tax deduction for the self-employed would be expanded so that self-employed people could deduct X% of the cost of their health insurance premiums. The self-employed currently can deduct only 25% of the cost of their premiums.

REFORMING AND STRENGTHENING THE MEDICARE PROGRAM

- **Strengthening the Medicare Trust Fund**: Savings in Part A of Medicare would delay the insolvency of the Part A Trust Fund to 2005. New savings initiatives would not increase beneficiary costs.

- **Eliminating the Co-Payment for Mammograms**: To remove financial barriers from woman seeking preventive mammograms, the Medicare copayment would be waived.

- **Encouraging Managed Care Enrollment**: To encourage more beneficiaries to choose managed care options, the type of managed care arrangements available to beneficiaries would be expanded to include preferred provider organizations ("PPOs") and point-of-service ("POS") plans. Initiatives to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal, would be implemented.

- **Combatting Fraud and Abuse**: Operation Restore Trust is a five-state demonstration project targeting fraud and abuse in home health care, nursing home and durable medical equipment industries. Increased funding would be available for fraud and abuse activities.

LONG-TERM CARE

- **Expanding Availability of Home and Community-Based Care:** Grants would be made available to states to provide home and community-based services to disabled people. Funds would be distributed to each state based on the number of severely disabled people in the state, the size of its low-income population, and the cost of services in the state.

- **Providing for a New Alzheimer's Respite Program Within Medicare:** All Medicare beneficiaries who have Alzheimer's Disease would be eligible for respite services for their families for one week each year.

- **Encouraging Purchase of Private Long-Term Care Insurance:** To encourage people to protect themselves against the costs of long-term care, long-term care expenses and insurance premiums would receive the same favorable tax treatment as other health insurance. To be eligible, long-term care insurance policies would have to meet minimum consumer protection standards to assure that they provide a reasonable return to purchasers. In addition, a tax credit would be available for disabled working persons for one-half of their work-related personal assistance expenses. The maximum credit would be $7,500 each year.

REFORMING THE MEDICAID PROGRAM

The Medicaid program would be reformed to expand state flexibility and reduce costs while assuring the program's ability to provide coverage to the vulnerable populations it serves today. Federal savings would be reinvested to expand health insurance coverage.

- **Eliminating Unnecessary Federal Strings on States:** To enable states to manage their Medicaid programs more efficiently, federal requirements on how states manage their Medicaid programs would be substantially reduced.

  - States could pursue managed care strategies and other service delivery innovations without seeking waivers from the federal government.
  - Federal restrictions that set minimum levels for state payments to health care providers would be eliminated.

- **Reducing Medicaid Costs:** A combination of policies would be implemented to reduce the growth of federal Medicaid spending, including expanding managed care, reducing federal contributions to states for disproportionate share hospitals, and limiting the growth in federal Medicaid payments made to states for each beneficiary. Limits made on a per-person basis, as opposed to a block grant on total spending, promote efficiency while protecting coverage.

STRENGTHENING COMMUNITY PRIMARY AND PREVENTIVE CARE PROGRAMS

To expand the availability of primary and preventive care services in underserved areas, grants would be awarded to states to expand the service capacity of Federally Qualified Health Centers, county and city health departments, and other safety–net providers. Funds would be used primarily to develop new service sites and broaden the types of available services, including outreach services and case management for vulnerable populations.

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Tot. meetings = 345
tot. people = 147

Cong. Gephardt - 12
Sen. Mitchell - 8 + 1 meeting with is staff
Sen. Rockefeller - 9
House Democratic Leadership - 3
Sen. Wofford - 3
Cong. Rostenkowski - 4
Cong. Ford- 1
Cong. Dingell - 4
Cong. Caucus on Women's Issues - 1
Cong. Stark - 2
Cong. Waxman - 3
Sen. Moynihan - 5
Sen. Sasser - 1
Sen. Riegle - 4
Sen. Wellstone - 6
Cong. Black Caucus - 2
Cong. Hispanic Caucus - 1
Sen. Johnston - 2
Sen. Breaux - 2
Cong. Jefferson - 1
Cong. McDermott - 4
House Energy and Commerce Committee - 4
Cong. Wyden - 4
Sen. Veterans Affairs - 1
Cong. Montgomery - 1
Cong. Rowland - 1
House Veterans Affairs - 1
Sen. Graham - 1
Cong. Gibbons - 2
Sen. Harkin - 1
Cong. Smith - 1
House Ways and Means Committe - 4
Cong. Brooks - 1
Sen. Iouye - 2
Cong. Glickman - 1
Cong. McCurdy - 3
Cong. Cooper - 3
Cong. Stenholn - 1
Cong. Payne - 2
Cong. Andrews - 4
Cong. Reynolds - 2
Sen. Bob Kerrey - 4
House Ways and Means Health Subcommitte - 2
Senate Finance Committee - 5
Cong. Moakley - 3
Senate Bipartisan Leadership - 2
Sen. Comm. on Labor/Human Resources - 4
Sen. Special Comm. on Aging - 1
Pacific-American Members of Congress - 1
Sen. Mikulski - 4
Cong. Cardin - 2
Cong. Mfume - 3
Sen. Ford - 1
Cong. Dickey - 1

Sen. Exon - 1
Cong. Rush - 2
Cong. Sangmeister - 1
Sen. Pryor - 1
Sen. Leahy - 2
Sen. Jeffords - 2
Cong. Sanders - 2
Cong. Conyers - 1
Single Payer Group - 1
Sen. Nunn - 1
Cong. Rose - 2
Cong. LaFalce - 3
Sen. Bumpers - 3
Sen. Leadership - 2
House Small Business Committee - 1
Sen. Daschle - 7
Joint House Congressional Message Group - 2
Senate Malpractice Focus Group - 1
Cong. Clay - 1
House Education and Labor Committee - 4
House Leadership - 2
Senate Small Business Focus Group - 1
Sen. Small Business Group - 1
Sen. Kennedy - 7
Democratic Leadership - 1
House Democratic Leadership - 1
Cong. Lancaster - 1
Cong. Kaptur - 1
Sen. Harkin - 1
Cong. Sabo - 1
Sen. Durenberger - 4
Cong. Grams -1
Cong. Ramstad - 1
Cong. Vento - 1
Bipartisan Health Care University - 1
Sen. Pell - 1
Cong. Reed - 2
Cong. Collins - 1
Congress - 1
Cong. Picle - 1
Cong. Richardson - 1
Cong. Wheat - 2
Cong. Danner - 1
Sen. Glenn - 1
Cong. Strickland - 1
Cong. Klink - 1
Cong. Murphy - 1
Cong. Wise - 1
Sen. Boxer - 1
Sen. Feinstein - 1
Sen. Murray - 2
Cong. Stokes - 1
Cong. Fingerhut - 1
Cong. Slaughter - 2

88 - 270

Congressional Spouses - 1
Cong. Bachus - 1
Freshman Democrats - 1
Cong. Sharp - 2
Cong. Swett - 1
Cong. Studds - 1
Cong. Frank - 1
Co-sponsors of Health Security Act - 1
Cong. Bonior - 4
Cong. Matsui - 1
Cong. Richardson - 1
Cong. Bilbray - 1
Sen. Reid - 1
Cong. Blackwell - 1
Cong. Marglies-Mezvinsky - 1
Cong. Foglietta - 1
Cong. Borski - 1
Cong. Rangel - 2
Sen. Bradley - 2
Cong. Pallone - 1
Cong. Klein - 1
Cong. Menendez - 1
Sen. Feingold - 2
Sen. Kohl - 2
Sen. Conrad - 2
Cong. Obey - 1
Cong. Pomeroy - 3
Cong. Minge - 1
Cong. Kleczka - 1
Cong. Barcia - 1
Cong. Lambert - 1
Cong. Brewster - 1
Cong. Schenk - 1
Sen. Bingama - 1
Sen. Boren - 1
Sen. Lieberman - 1
Sen. Moseley-Braun - 2
Sen. Biden - 1
Sen. Dorgan - 1
Cong. Bryant - 1
Cong. Daggs - 1
Cong. Shroeder - 1
Cong. Deutsch - 1
Cong. Slattery - 1
Speaker Foley - 2
Democratic Study Group - 1
Sen. Democratic Caucus - 1
Cong. Synar - 1
Cong. Hoagland - 1
Sen. Dodd - 2
North Carolina delegation - 1
Sen. Message Group - 1
Cong. DeFazio - 2
Cong. Cantwell - 1

4Cong. Kreidler - 1
Dem. Senators - 1
Cong. McKinney - 1
Sen. Dole - 2
Rep. Michel - 1
Rep. Task Force - 1
Sen. Republican Health Task Force - 3
sen. Kassebaum - 2
Sen. Danforth - 2
Sen. Burns - 1
Senate Bipartisan Leadership - 1
Cong. Kasich - 2
Sen. Chafee - 2
House Progressive Group - 1
House Republican Task Force - 1
Sen. Specter - 3
Republican Staff - 1
Cong. Machtley - 1
Sen. McCain - 1
Sen. Bond - 2
Sen. Gramm - 1
Cong. Shays - 1
Cong. Houghton - 1
Sen. Cohen - 1
Sen. Pressler - 1
Cong. Barrett - 1

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Chris's Office

A PRELIMINARY ANALYSIS OF SENATOR MITCHELL'S HEALTH PROPOSAL

August 9, 1994

The Congress of the United States
Congressional Budget Office

INTRODUCTION

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared this preliminary analysis of Senate Majority Leader George Mitchell's health proposal, as introduced on August 9, 1994. The analysis is based on the text of S. 2357 as printed on August 3 and on subsequent revisions specified by the Majority Leader's staff. Because the estimate does not reflect detailed specifications for all provisions or final legislative language, it must be regarded as preliminary.

The first part of the analysis is a review of the financial impact of the proposal. The financial analysis includes estimates of the proposal's effects on the federal budget, the budgets of state and local governments, health insurance coverage, and national health expenditures. It also includes a description of the aspects of the proposal that differ from S. 2357, as well as other major assumptions that affect the estimate.

The second part of the analysis comprises a brief assessment of considerations arising from the proposal's design that could affect its implementation. The issues examined in this discussion are similar to those considered in Chapters 4 and 5 of CBO's analyses of the Administration's health proposal and the Managed Competition Act.

FINANCIAL IMPACT OF THE PROPOSAL

Senator Mitchell's proposal aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. If these changes failed to increase health insurance coverage to 95 percent of the population by January 1, 2000, coverage would become mandatory in 2002 in states that fell short of the goal. Individuals in those states would be required to purchase insurance, and employers with 25 or more workers would be required to pay half of the cost of insurance for them and their families.

In CBO's estimation, the proposal would just meet its target of 95 percent coverage without imposing a mandate. Because the actual outcome could easily fall short of the estimate, however, this analysis shows the effects of the proposal both without the mandate and with the mandate in effect nationwide. In both cases, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce the pressure on state and local budgets as well. But the expansion of coverage would add to national health expenditures.

The estimated effects of the proposal are displayed in the six tables at the end of this document. Tables 1 and 2 show the effects on federal outlays, revenues, and the deficit. Tables 3 and 4 show the effects on the budgets of state

and local governments. Tables 5 and 6 provide projections of health insurance coverage and national health expenditures, respectively.

Like the estimates of other proposals for comprehensive reform--such as the single-payer plan, the Administration's proposal, the Managed Competition Act, and the bills reported by the Committees on Finance and Ways and Means--CBO's estimates of the effects of this proposal are unavoidably uncertain. Nonetheless, the estimates provide useful comparative information on the relative costs and savings of the different proposals. In estimating Senator Mitchell's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

Senator Mitchell's proposal would establish a standard package of health insurance benefits, whose actuarial value would be based on that of the Blue Cross/Blue Shield Standard Option under the Federal Employees Health Benefits program. The Congressional Research Service and CBO estimate that such a benefit package would initially be 3 percent less costly than the average benefit of privately insured people today and 8 percent less costly than the benefit package in the Administration's proposal.

The proposal adopts the four basic types of health insurance units included in the Administration's proposal--single adult, married couple, one-parent family, and two-parent family. In addition, separate policies would be available for children eligible for subsidies, as explained below.

In general, workers in firms with fewer than 500 full-time-equivalent employees (and their dependents) and people in families with no connection to the labor force would purchase health insurance in a community-rated market. Firms employing 500 or more workers would be experience-rated. States would operate a risk-adjustment mechanism covering both community-rated and experience-rated plans, thereby narrowing the differences between the average premiums in the two insurance pools. The estimated average premiums in 1994 for

1. For descriptions of CBO's estimating methodology, see Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994), and *An Analysis of the Managed Competition Act* (April 1994).

the standard benefit package for the four types of policies in both pools are as follows:

Single Adult	$2,220
Married Couple	$4,440
One-Parent Family	$4,329
Two-Parent Family	$5,883

Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

Subsidies

Starting in 1997, the proposal would provide subsidies for low-income people and certain firms to facilitate the purchase of health insurance. The system of subsidies would change somewhat if a mandate to purchase insurance went into effect. States would determine eligibility for subsidies and distribute subsidy payments to health plans.

Without a Mandate in Effect. The proposal would make low-income families eligible for premium subsidies. Recipients of Aid to Families with Dependent Children (AFDC) and families with income below 100 percent of the poverty level would be eligible for full subsidies, and those with income between 100 percent and 200 percent of poverty would be eligible for partial subsidies. For children and pregnant women, full subsidies would extend to 185 percent of the poverty level and partial subsidies to 300 percent of poverty. In addition, workers who become temporarily unemployed would be eligible for special subsidies for up to six months. Families could become eligible for more than one type of subsidy at the same time. Families could use the special subsidies for children and pregnant women to help purchase coverage for the entire family, or they could purchase coverage only for the eligible individuals.

States would be required to establish and administer a program of enrollment outreach that would allow people eligible for full subsidies of their premium to sign up for health insurance with health care providers whenever they sought health care services. People eligible for health insurance under this provision would be counted as insured in determining whether the target of 95 percent coverage is met.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty level for that family's size. The maximum amount of the subsidy would be based on family income relative to the poverty level and on the weighted average premium for community-rated health plans in

the area. The estimate assumes that a family's subsidy could not exceed the amount it paid for coverage in a qualified health plan. Therefore, if an employer paid a portion of the premium, the subsidy could at most equal the family's portion of the premium.

People with income up to 150 percent of the poverty level, as well as AFDC recipients, would be eligible for reduced cost sharing if they were unable to enroll in a plan providing a low or combination cost-sharing schedule. AFDC recipients in low or combination cost-sharing plans would also be eligible for cost-sharing assistance. The amount of assistance would vary slightly for the two groups. In both cases, health insurance plans would be required to absorb the cost of the reduced cost sharing.

Employers who voluntarily expanded health insurance coverage to classes of workers whom they previously did not cover could also receive temporary subsidies. Employers would become eligible for a subsidy if they began paying at least 50 percent of the cost of coverage for an additional class of worker. In the first year, the amount of the subsidy for each worker would equal the difference between half of the average insurance premium in the area (or in the worker's plan, if lower) and 8 percent of the worker's wage. Over the following four years, the subsidy would be gradually phased out.

With Mandate in Effect. If a mandate to purchase insurance went into effect in a state, the system of subsidies would change. Subsidies for families with income up to 200 percent of the poverty level would remain, as would subsidies for people who were temporarily unemployed. The special subsidies for children and pregnant women would be eliminated, however, as would the subsidies for employers who voluntarily expanded coverage.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income or Medicare would be integrated into the general program of health care reform and would be eligible for federal subsidies in the same way as other low-income people. For these people, Medicaid would continue to cover services not included in the standard benefit package. For children, Medicaid would also continue to cover services whose scope or duration exceeded that in the standard package. States would be required to make maintenance-of-effort payments to the federal government based on the amount by which their Medicaid spending was reduced in the first year. The proposal would phase out federal Medicaid payments to disproportionate share hospitals and replace them with a program to make payments to financially vulnerable hospitals.

The proposal would expand Medicare by adding a prescription drug benefit for outpatients starting in 1999. The Secretary of Health and Human Services would set the deductible so that the net incurred cost of the benefit would total $13.4 billion in the first year. In CBO's estimation, the initial deductible would be about $700. The deductible would be indexed in later years so as to hold constant the proportion of Medicare beneficiaries receiving some drug benefit.

Reductions in Medicare spending would provide a major part of the funding for the proposal. The growth in reimbursement rates for hospitals covered by Medicare's prospective payment system would be reduced by 1 percentage point in 1997 and by 2 percentage points each year from 1998 through 2004. Payments to disproportionate share hospitals would be cut in half. Reimbursements to physicians and other providers of health care services would also be restrained. Beneficiaries would be required to pay higher premiums for Supplementary Medical Insurance (SMI) and part of the cost of laboratory services and home health care.

Other Spending

The proposal would restructure the system of subsidies for medical education and academic health centers. Current payments from Medicare for direct and indirect medical education would be terminated. New programs would provide assistance for academic health centers, graduate medical education, graduate training for nurses, medical schools, schools of public health, and dental schools.

The proposal would create several additional mandatory spending programs. A capped entitlement program would help states finance home- and community-based care for the severely disabled; spending for this program would be limited to $48 billion over the 1998-2004 period. A biomedical and behavioral research trust fund would be financed by a portion of the assessment on private health insurance premiums starting in 1997. The proposal would also provide direct spending authority for a variety of public health initiatives totaling almost $10 billion in the 1996-1999 period and almost $15 billion in the 1996-2004 period.

The assurance of access to health insurance and the provision of subsidies to low-income families would encourage some older workers to retire earlier and would raise outlays for Social Security retirement benefits. Over the long term, Social Security would incur no additional costs, because benefits are actuarially reduced for early retirement.

Revenues

The Joint Committee on Taxation has estimated the impact of the provisions of the proposal that would affect federal revenues. The bulk of the additional revenues would stem from an increase in the tax on tobacco, a 1.75 percent excise tax on private health insurance premiums, and a tax on health plans whose premiums grew by more than a specified rate. The proposal would also increase SMI premiums for single individuals with income over $80,000 and couples with income over $100,000.

Fail-Safe Mechanism

The proposal would scale back eligibility for premium subsidies, increase the deductible for the Medicare drug benefit, and reduce every other new direct spending program as necessary to offset an increase of more than $10 billion in the cost of the bill and the Medicare and Medicaid programs compared with the initial estimate. Because the reductions would be applied proportionately, to the extent possible, to all the direct spending programs in the proposal, the bulk of any savings would have to come from limiting eligibility for subsidies. As a result, application of the fail-safe mechanism could make previously eligible people ineligible for subsidies and would, in the absence of a mandate, reduce the extent of health insurance coverage.

Budgetary Treatment of the Mandate

A mandate requiring that individuals purchase health insurance would be an unprecedented form of federal action. The government has never required individuals to purchase any good or service as a condition of lawful residence in the United States. Therefore, neither existing budgetary precedents nor concepts provide conclusive guidance about the appropriate budgetary treatment of a mandate. Good arguments can be made both for and against including in the federal budget the costs to individuals and firms of complying with the mandate. It is only appropriate, therefore, for policymakers to resolve the issue through legislation.

Some budget analysts argue that the costs of the mandate should be included in the federal budget because these transactions would be predominantly public in nature. A second argument for inclusion, closely related to the first, is that the premiums that people would have to pay to comply with the mandate would be compulsory payments and should therefore be recorded as governmental receipts. A third argument is that including these costs in the budget would

preserve the federal budget as a comprehensive measure of the amount of resources allocated through collective political choice at the national level.

There are also cogent arguments against including the costs of complying with the mandate in the budget. First, the costs would not flow through federal agencies or other entities established by federal law. Unlike the Administration's proposal, this proposal would not require participation in federally mandated health alliances. Second, this approach would be consistent with the current practice of excluding from the budget the costs to private firms of federal regulatory mandates. Third, the costs of compliance could not be directly observed and would not flow through the federal Treasury.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, Senator Mitchell's would require many changes in the current system of health insurance. For the proposed system to function effectively, new data would have to be collected, new procedures and administrative mechanisms developed, and new institutions and administrative capabilities created. In preparing the quantitative estimates presented in this assessment, the Congressional Budget Office has assumed not only that all those things could be done but also that they could be accomplished in the time frame laid out in the proposal.

There is a significant chance that the substantial changes required by this proposal--and by other systemic reform proposals--could not be achieved as assumed. The following discussion summarizes the major areas of potential difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

Most health care proposals that would create community-rated markets for health insurance also incorporate provisions to adjust health plans' premiums for the actuarial risk of their enrollees. These provisions are intended to redistribute premium payments among health plans, compensating them for differences in risk. Although effective risk-adjustment mechanisms would be essential for the functioning of community-rated markets, the feasibility of developing and implementing such mechanisms successfully in the near future is highly uncertain.

The risk-adjustment mechanism in this proposal is more complex than those in other proposals analyzed by CBO. Most other proposals would restrict risk adjustment to the community-rated market; in Senator Mitchell's proposal, risk adjustment would operate in both the community-rated and the experienced-rated

markets in each community-rating area. The risk-adjustment mechanism would attempt to recompense plans for the higher costs associated with certain groups of enrollees. It would also adjust payments to health plans to reflect the cost-sharing subsidies for low-income participants that health plans would have to absorb. Such transfers would ensure that plans enrolling large numbers of low-income people were not placed at a cost disadvantage. As discussed below, implementing the risk-adjustment process would be a major undertaking for the states.

States' Responsibilities

Most proposals to restructure the health care system incorporate major additional administrative and regulatory functions that new or existing agencies or organizations would have to undertake. Like several other proposals, this one would place significant responsibility on the states for developing and implementing the new system. It is doubtful that all states would be ready to assume their new responsibilities in the time frame envisioned in the proposal.

Under the voluntary system, the states' primary responsibilities would fall into four major areas:

- o determining eligibility for the new subsidies and the continuing Medicaid program;
- o administering the subsidy and Medicaid programs;
- o establishing the infrastructure for the effective functioning of health care markets; and
- o regulating and monitoring the health insurance industry.

States would also have to prepare for the possibility that mandates requiring firms with 25 or more employees to provide insurance and all individuals to obtain coverage might be invoked in 2002. If that occurred, those states with coverage rates below 95 percent would need to have the necessary infrastructure already in place. In addition, they would have to be prepared to expand their regulatory and monitoring functions considerably.

Determining Eligibility for Subsidies and Medicaid. As with other proposals, determining eligibility for subsidies would be an enormous task for the states, made more complicated by the three different subsidy programs for premiums that would be in effect: regular subsidies for low-income individuals and families; special subsidies for children and pregnant women; and special subsidies for

people who were temporarily unemployed. The eligibility criteria would be different for each of these programs and would also differ from those of the Medicaid program. (The role of the Medicaid program in paying for acute care services would be significantly reduced. The program would, however, cover wraparound benefits for those subsidized families who would be eligible for Medicaid under current law. It would also pay for emergency services for illegal aliens and would continue to cover beneficiaries of the Supplemental Security Income program and Medicare beneficiaries who qualified for Medicaid.) Some families would be eligible to participate in more than one subsidy program concurrently, and this proposal would allow them to do so in certain circumstances. They might also be entitled to receive Medicaid wraparound benefits.

States would bear the responsibility for the required end-of-year reconciliation process in which the income of a subsidized family was checked to ensure that the family received the appropriate premium subsidy. Reconciliation would be a major undertaking since, even if federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Tracking people who moved from one state to another during the year would also be difficult and would require extensive cooperation among the states.

Administering the Subsidy and Medicaid Programs. The states would have other major administrative responsibilities for the subsidy and Medicaid programs. In particular, they would make payments for premium subsidies to health plans and would be required to develop and implement a complex outreach initiative to expand enrollment.

The outreach program would be designed to ensure that people eligible for full subsidies would be able to enroll in health plans on a year-round basis and would not be denied coverage for preexisting conditions. They would also be able to have their eligibility for subsidies established presumptively by certain health care providers at the point of service, enabling them to enroll in health plans and receive full premium subsidies for a period of 60 days during which they could apply for continuing assistance. States would not be held responsible for premium assistance provided to low-income families on a presumptive basis, if those families subsequently proved to be ineligible for full subsidies. Instead, the federal government would bear those costs.

The program would guarantee that poor families, as well as children and pregnant women with income up to 185 percent of the poverty level, had financial access to the health care system when they needed care. It would, however, be difficult to administer, and its success in enrolling low-income families in health plans on a permanent basis would depend on extensive outreach efforts by the states to ensure that people declared presumptively eligible completed the full process for determining eligibility. The program would be considerably more

complex than the current presumptive eligibility programs for pregnant women that are operated by Medicaid programs in about 30 states. Those programs are dealing with a clearly defined target population of individuals and only one health plan--the Medicaid program. By contrast, the system envisioned under the proposal would be dealing with the enrollment of individuals plus their families in their choice of health plan.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would designate the geographic boundaries for the community-rating areas as well as the service areas for carrying out the provisions regarding essential community providers. They would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include developing and implementing the complex risk-adjustment and reinsurance system and providing information and assistance to consumers.

Each state would be required to establish a risk-adjustment organization. That agency would determine the adjustments to be made to premiums for all community-rated and experience-rated plans in each community-rating area in the state. The agency would collect assessments from health plans and redistribute the payments to community-rated and experience-rated plans whose expected expenditures exceeded the average for enrollees in standard health plans.

State risk-adjustment organizations would also have to address the special issues raised by multistate plans. When such plans owed risk-adjustment assessments, they would make payments on behalf of all their enrollees in different states to a single state risk-adjustment organization. The designated organization would determine the applicable assessments for the plan's enrollees in each community-rating area across the country and would make payments to other state risk-adjustment organizations as required.

Another responsibility of the states would be to provide consumers with the necessary information to make informed choices among health plans. States would be required to produce annual standardized reports comparing the performance of all health plans in the state, using data from surveys designed and carried out by the federal government. To do so effectively would require states to establish systems for analyzing data and qualitative information. In each state, a private nonprofit organization under contract to the federal government would distribute the reports, educate and provide outreach to consumers, and help them to enroll in health plans. States would also be required to establish an office in each community-rating area to provide a forum for resolving disputes over claims or benefits.

Regulating and Monitoring the Health Insurance Industry. Like most other health care proposals, this one would place major new responsibilities on state

health insurance departments. They would have to certify standard health plans and health insurance purchasing cooperatives (HIPCs), establish separate guaranty funds for community-rated and self-insured health plans, monitor variation in the marketing fees of HIPCs and other systems for purchasing insurance, and ensure that carriers met minimum capital requirements. Moreover, the standards that health plans would have to meet would be largely federally determined and would include areas, such as data collection and reporting, that are outside the traditional purview of insurance regulators. It is doubtful that all states could develop the capabilities to perform these functions effectively in the near future.

Preparing for and Implementing Individual and Employer Mandates. If insurance coverage nationwide was below 95 percent in 2000, those states in which the coverage rate was below 95 percent would have to be prepared to implement individual and employer mandates in 2002--the year that those mandates would go into effect. The affected states would have to establish mechanisms--possibly through designated HIPCs--to collect and redistribute premium payments from employers with workers enrolled in other employers' health plans. They would have to set up systems to ensure that employers and families complied with the mandates, and they would have to prepare low-income families for the possibility that their subsidies could change significantly.

The System of Multiple Subsidies

In order to maximize voluntary enrollment in health plans, Senator Mitchell's proposal would establish multiple schedules of subsidies for premiums, targeting special populations as well as low-income families in general. The basic system of subsidies would cover individuals and families with income up to 200 percent of the poverty level. Added to this would be subsidies for children and pregnant women with family income up to 300 percent of the poverty level. In addition, a special initiative would provide subsidies for workers and their families when the workers were temporarily unemployed; the subsidies would be available for a period of unemployment not to exceed six months. Integrating these three subsidies in a sensible and administrable fashion would be extremely difficult, especially as some families could receive subsidies from more than one program.

The subsidies for people who were temporarily unemployed would be particularly hard to administer and monitor. It would be difficult, for example, to determine whether people had left their jobs voluntarily or involuntarily, or whether they could receive employer contributions for health insurance through an employed spouse. Moreover, because of the way these subsidies would be structured, significant horizontal inequities could result. That is, families with similar income could receive quite different subsidy amounts. In determining their eligibility for subsidies, people who were temporarily unemployed could

subtract from their family income the lesser of their gross wages or a flat amount equal to 75 percent of the poverty-level income for an individual for each month the worker was employed. In addition, they could subtract any unemployment compensation they received while unemployed. Consequently, people who were unemployed for several months could receive larger subsidies than year-round workers with similar annual income. Workers in seasonal businesses--construction workers and resort employees, for example--would be particularly favored. The incentives inherent in this subsidy could increase unemployment slightly.

The Tax on High-Cost Health Plans

Like the tax contained in the bill reported by the Committee on Finance, the tax on the premiums of "high-cost" health plans in Senator Mitchell's proposal would be difficult to implement. In addition, its contribution to containing health care costs would be limited, and it might be considered inequitable and an impediment to expanding coverage.

The tax would be a 25 percent levy on the amount by which health insurance premiums for a standard health plan exceeded a "reference" premium. Separate reference premiums would be established annually by the Secretary of the Treasury for each class of coverage in each community-rating area and for each experience-rated plan. These determinations would be extremely complex and difficult to make, requiring adjustments for demographic characteristics (age, sex, and socioeconomic status), health status, current levels of health care expenditures, uninsurance and underinsurance, the presence of academic health centers, and other factors. Little reliable information of this sort is available, and the Secretary would have to collect a mass of new information. With the reference premiums affecting not only tax liability but also premium levels, the process could prove to be quite controversial.

Although the tax would not be imposed on community-rated plans operating in areas where the average premium did not exceed the national average reference premium, few if any areas would meet that test for more than the first year or two because the reference premiums would be constrained to grow far more slowly than the expected growth of health insurance premiums. In community-rating areas, the growth would be 3 percentage points over the consumer price index in 1997, declining to 2 percentage points over the CPI by 1999.

Unlike the taxes contained in the Managed Competition Act and the bill reported by the Committee on Finance, which would not affect the lowest-cost plans, virtually all plans would be subject to the assessment called for in Senator Mitchell's proposal. Such an assessment would increase premiums, and higher

premiums would discourage participation during the voluntary period. The tax would be imposed in 1997 on plans in the community-rated market, in which small firms and most of the uninsured would obtain coverage. In contrast, the experience-rated market would not be subject to the tax until 2000, and that differential treatment might be viewed as inequitable.

Although the proposal would provide sponsors of health plans with the right to recover half of the tax from health care providers, providers would incorporate their portion of the expected tax into their charges, so the right of recovery would be unlikely to have any real effect on the cost of health insurance. Moreover, because the mechanics of enforcing the right of recovery are unclear, the provision might lead to costly and unproductive litigation.

The proposal would be, in effect, a tax cap, but one imposed on the providers of health insurance rather than its consumers. A tax cap is an important element in the managed competition approach to controlling health care costs, and a tax on providers could serve this purpose effectively. However, this tax, by exempting cost-sharing and other supplemental policies, would provide much less incentive for containing costs.

Research by the RAND Corporation and others indicates that a tax cap might constrain costs in either of two primary ways: by encouraging consumers to choose health insurance plans with greater cost sharing (that is, higher copayments and deductibles) or by encouraging the use of managed care providers like health maintenance organizations (HMOs) that can control costs more effectively than fee-for-service plans. This tax, however, would not apply to supplemental insurance policies that cover cost sharing. Workers whose employers provided cost-sharing supplements would pay less tax than workers whose employers did not and instead paid higher wages, and the average employee probably would pay lower copayments and deductibles under the proposal than under a tax cap that applied to supplements as well as to basic insurance. Furthermore, HMOs and similar types of managed care arrangements, which build the cost of the low copayments and deductibles into their premiums, would be placed at a tax disadvantage compared with less cost-effective fee-for-service plans in which the cost-sharing supplements would be tax-free.

A final reason that the tax's promise of cost containment would remain far below its potential relates to the method for calculating reference premiums for experience-rated plans. These premiums would be calculated based on actual expenditures during the 1997-1999 period, which could undermine the incentive for experience-rated plans to economize before the tax took effect in 2000.

The Effects of Invoking Mandates

If less than 95 percent of the population had insurance coverage on January 1, 2000, and if the Congress did not enact alternative legislation before the end of that year, mandates on employers and consumers would automatically come into effect in 2002. The proposed mandatory system would be problematic for several reasons.

The mandates would be imposed only in states that had failed to meet the 95 percent threshold for coverage. In those states, all firms with 25 or more workers would be required to contribute to the costs of health insurance for their employees, and all individuals and families would be required to obtain coverage. These requirements would produce inefficient reallocations of business activity. Some firms that did not wish to provide insurance would migrate to states that were not included in the mandate. Furthermore, because the transitional subsidies for employers that voluntarily expanded coverage to additional workers would terminate in mandated states, some firms might be attracted to nonmandated states where these temporary subsidies would still be available.

Moreover, the practical problems of implementing mandates in some states and not in others could be overwhelming, especially in border markets. What, for example, would happen to individuals who lived in mandated states but worked for employers that did not contribute to the cost of insurance in neighboring, nonmandated states?

The system of subsidies for families would also change significantly in the mandated states, raising concerns about affordability and equity. The special subsidies for low-income children and pregnant women would be dropped, making health insurance more expensive for some low-income families without an employer contribution, even though they would now be required to purchase coverage. (For example, a family with income at 150 percent of the poverty level and no employer contribution in a mandated state would have to pay 50 percent of a family premium. A similar family in a nonmandated state might be able to combine regular subsidies and special subsidies and pay far less than 50 percent of the premium for a family policy.) Concerns about the affordability of health insurance under a mandate would be heightened because the incentives to contain costs in this proposal are limited.

Because of the disruptions, complications, and inequities that would result, CBO does not believe that it would be feasible to implement the mandated system in some states but not in others; the system would have to include either all states or none. Accordingly, CBO's cost estimates of the mandated system assume that a nationwide mandate would be in effect.

Reallocation of Workers Among Firms

Senator Mitchell's proposal, like many other reform bills, would encourage a reallocation of workers among firms in ways that would increase its budgetary cost. That process would occur gradually as employment expanded in some firms and contracted in others and as workers sought the jobs that would provide them with the largest combined amount of wages and premium subsidies.

In the voluntary system, this sorting would occur because the family subsidies would be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that did not pay for health insurance would receive a larger subsidy than a worker earning the same wage at a firm that did pay. (In addition to this reallocation, some companies might stop paying for insurance, but the number of firms that would do so would be limited because high-wage workers in those firms would lose the benefit of excluding health insurance from their taxable income.) Some sorting would also occur because firms that expanded insurance coverage to classes of workers not previously covered would be eligible for temporary subsidies; workers employed by those firms could receive higher take-home pay for a few years than could workers at firms that currently provide them with insurance coverage.

In the mandated system, reallocation of workers would occur because some workers would pay less for health insurance if they were employed by small firms excluded from the mandate than they would if they were employed by firms covered by the mandate. For example, many low-wage workers could receive a larger subsidy for their insurance costs in uncovered firms than in covered firms. In addition, married couples with both spouses working would have an incentive under the proposal to have one spouse employed by an uncovered firm, because if both spouses worked in covered firms, they would each have to pay something for insurance. A similar incentive exists in the current system, but by requiring more firms to provide insurance coverage than do now, the proposal would affect more people.

Under both the voluntary and mandated systems, some workers could gain several thousand dollars in higher wages by moving between firms, and over time a significant number of them would probably do so. This reallocation of workers among firms accounts for about $14 billion of the cost of the subsidies in 2004 under the voluntary system and for about $8 billion in 2004 under the mandated system. In addition to raising the government's costs, the reallocation of workers could reduce the efficiency of the labor market.

Finally, the subsidy system would not treat people with similar incomes and family circumstances alike. Under the voluntary system, for example, workers eligible for subsidies who worked at firms that paid for insurance would face

larger costs for their insurance when the reduction in their cash wages is taken into account than similar workers at firms that did not pay.

Work Disincentives

Senator Mitchell's proposal would discourage certain low-income people from working more hours or, in some cases, from working at all, because subsidies would be phased out as family income increased. It is important to note that work disincentives are an inherent element of all health proposals that target subsidies toward the poor and near-poor, and that these subsidies would significantly improve the well-being of many low-income people by assisting their purchase of health insurance.

In both the voluntary and mandated systems, many workers who earned more money within the phaseout range would have to pay more for health insurance, which would cut into the increase in their take-home wage. In essence, these workers would face an implicit tax on their economic advancement. Changing the design of the subsidy systems in this proposal could reduce the marginal levy on some people's income, but it might raise the marginal levy faced by other people or make insurance unaffordable for some people.

The Voluntary System. Estimating the precise magnitude of the implicit tax rates in the voluntary system requires information that is not readily available, but rough calculations suggest that the rates could be extremely high for some families. For workers whose employers did not pay for insurance, the implicit marginal rates from the phaseout of subsidies for low-income families would apply to income between 100 percent and 200 percent of the poverty level, and the phaseout of subsidies for children and pregnant women would apply to income between 185 percent and 300 percent of poverty.

In 2000, the effective marginal tax on labor compensation (wages and benefits) could increase by as much as 30 to 55 percentage points for workers with family income in the phaseout range. Moreover, those levies would be added to the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, and the phaseout of the earned income tax credit. In the end, some low-wage workers would keep as little as 15 cents of every additional dollar they earned.

For workers whose employers paid some of the costs for insurance, these marginal levies would apply to income in a much smaller range. However, such treatment of employer payments would also create the previously described incentive for workers to move to firms that did not pay for insurance.

The Mandated System. Rough calculations suggest that the implicit marginal rates from the phaseout of subsidies under the mandated system could also be extremely high for some families. These rates would apply to income between 100 percent and 200 percent of the poverty level for workers in uncovered firms. For workers in covered firms, these marginal levies would apply to workers in a smaller income range. In 2002, the effective marginal tax on labor compensation could increase by as much as 35 to 55 percentage points for workers who received subsidies. As in the voluntary system, this new levy would be added to the explicit and implicit marginal taxes that these workers already face, producing total marginal tax rates of more than 95 percent for some workers.

The mandated system would also discourage some people who have spouses working at covered firms from participating in the labor force or at least from taking a job at a firm with more than 25 employees. If those people took a job at a covered firm, their wages would be reduced by the additional cost for insurance but they would receive no additional benefits. The current system also discourages some of these people from working at firms that pay for insurance, but by requiring more firms to provide insurance coverage, the proposal would increase the number of people who were affected.

In the mandated system, the combination of the subsidies and the requirement to purchase insurance would increase the effective income of people who wanted insurance at the net-of-subsidy price, but would reduce the economic well-being of people who would have preferred not to buy insurance. Because the net-of-subsidy price (including employer payments) would be high for many families, the number of people who valued insurance at less than its cost could be large. For example, for a family of two adults (one working in a covered firm) and two children, with income just below the poverty threshold in 2002, the firm contributing 50 percent of the premium would pay more than $5,000 on the worker's behalf for insurance; that would represent roughly one-quarter of the family's income.

Effect on Employment

If the voluntary system in Senator Mitchell's proposal did not result in insurance coverage for 95 percent of the population, mandates would be triggered unless the Congress adopted an alternative approach. Under the mandated system, firms with more than 25 employees would be required to contribute to each worker's health insurance. The imposition of the mandate would raise the cost of employing workers at firms that do not currently provide insurance. Economic theory and empirical research both imply that most of this increased cost would be passed back to workers over time in the form of lower take-home wages. Such shifting would not be possible, however, for workers whose wages

were close to the federally regulated minimum wage. Therefore, the net cost of employing those workers would be raised by the mandate, and some of them would lose their jobs.

Nevertheless, the quantitative effect of the mandate in this proposal would probably be quite small because the mandate would not be implemented until 2002. Market wages for low-income workers will rise over time, reflecting general inflation and, probably, some share of the nation's real economic growth. As a result, few workers will be earning the current minimum wage by 2002. If the Congress did not raise the minimum wage, loss of jobs from this mandate would likely be very limited.

Employment would also be affected by the implicit taxes on work described above. In both the voluntary and mandated systems, some workers would voluntarily withdraw from the labor force in response to the new incentives they faced.

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-23.8	-35.6	-39.7	-44.4	-49.6	-55.2	-61.2	-67.6
2 State Maintenance-of-Effort Payments	0	0	-18.5	-26.5	-28.7	-31.1	-33.6	-36.3	-39.3	-42.4
3 Disproportionate Share Hospital Payments	0	0	-8.8	-13.4	-14.8	-15.6	-18.8	-20.7	-22.9	-25.2
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.7	-1.5	-1.6	-1.9	-2.1	-2.3
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	a	a	-51.4	-76.0	-84.4	-93.2	-104.3	-114.8	-126.2	-138.3
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Part A Interactions	0	0	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Elimination of Balance Billing	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.5	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.2	14.4	15.7	17.5	19.7	21.5
Total - Medicare	-2.4	-6.6	-10.2	-14.1	-14.7	-14.3	-21.1	-28.9	-38.1	-48.4
Subsidies										
12 Persons between 0-200% of Poverty	0	0	66.7	95.4	105.3	116.8	129.3	142.7	157.3	172.3
13 Pregnant Women and Kids 0-300% of Poverty				---------- Included in Line 12 ----------						
14 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	9.0	9.8	10.6
15 Enrollment Outreach	0	0	1.3	3.3	5.2	6.9	8.4	9.9	10.8	11.3
Total - Subsidies	0	0	68.0	103.7	117.6	131.3	146.1	161.6	177.9	194.3
Other Health Programs										
16 Vulnerable Hospital Payments	0	0	0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
17 Veterans' Programs	0	0	-1.4	-1.4	-1.7	-1.8	-1.9	-2.0	-2.0	-2.1
18 Home and Community Based Care ($48 bil. cap)	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
19 Life Care	0	0	-0.6	-1.1	-1.1	-0.3	-0.3	-0.3	-0.3	-0.3
20 Academic Health Centers	0	0	4.7	7.0	8.0	9.1	10.3	11.0	11.5	12.1
21 Graduate Medical and Nursing Education	0	0	2.6	3.9	5.8	6.4	6.6	6.8	7.2	7.5
22 Medicare Transfer - Direct Medical Education	0	0	-1.6	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
23 Medicare Transfer - Indirect Medical Education	0	0	-3.4	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
24 Public Health Schools; Dental Schools	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
25 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	a	0	0	0
26 Administration of Enrollment Outreach	0	0	0.4	0.7	0.9	1.0	1.1	1.3	1.4	1.4
Total - Other Health Programs	0	0.3	1.3	6.7	10.0	12.6	14.1	17.2	20.8	24.6
Public Health Initiative										
27 Biomedical and Behavioral Research Trust Fund	0	0	0.9	1.4	1.5	1.6	1.7	1.9	2.1	2.2
28 Health Professions	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
29 Core Public Health	0	0.1	0.3	0.3	0.4	0.4	0.3	0.2	0.1	0.1
30 Prevention	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
31 Capacity Building and Capital	0	0.3	0.5	0.5	0.4	0.2	0.1	0.1	0.0	0.0

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
32 OSHA and Workforce	0	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.1	0.1
33 Supplemental Services	0	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.0
34 Enabling Services	0	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.1	0.1
35 National Health Service Corps (NHSC)	0	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.0
36 Mental Health & Substance Abuse (CMMH&SA)	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
37 School Clinics	0	0.1	0.2	0.3	0.4	0.4	0.3	0.2	0.1	0.1
38 Indian Health Service	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Public Health Initiatives	0	1.4	3.2	3.9	4.0	3.9	3.5	3.0	2.8	2.9
39 Social Security Benefits	0	0	0.2	0.5	0.9	0.9	0.9	0.9	0.8	0.8
MANDATORY OUTLAY CHANGES	**-2.4**	**-4.9**	**11.1**	**24.7**	**33.4**	**41.3**	**39.2**	**39.0**	**37.9**	**35.9**
DISCRETIONARY OUTLAYS										
Health Programs										
40 Veterans' Programs	1.2	0.6	-2.9	-4.8	-4.9	-5.1	-5.2	-5.4	-5.6	-5.8
41 Indian Health Supplementary Services	0.7	1.2	1.5	1.6	1.6	1.6	1.6	1.6	1.7	1.7
42 Misc. Public Health Service Grants	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total Health Programs	1.9	1.8	-1.4	-3.1	-3.3	-3.4	-3.6	-3.7	-3.9	-4.1
Administrative Expenses										
43 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
44 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	0	0	0
45 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	1.1	1.1	1.2
Studies, Research, & Demonstrations										
46 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
DISCRETIONARY OUTLAY CHANGES	**2.5**	**3.2**	**0.3**	**-1.7**	**-2.3**	**-0.4**	**-0.5**	**-2.6**	**-2.8**	**-2.9**
TOTAL OUTLAY CHANGES	**0.1**	**-1.6**	**11.4**	**22.9**	**31.1**	**40.9**	**38.7**	**36.3**	**35.1**	**33.0**

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
47 Increase in Tobacco Tax	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
48 1.75% Excise Tax on Private Health Ins Premiums	0	3.5	6.1	7.1	7.7	8.4	9.1	9.9	10.8	11.7
49 Addl Medicare Part B Premiums for High-Income Individuals ($80,000/$100,000)	0	0	2.0	2.0	2.8	3.5	4.4	5.5	6.9	8.7
50 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
51 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
52 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
53 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules	0	a	a	a	a	a	a	a	a	a
54 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements	0	0.5	2.5	3.9	4.8	5.6	6.3	7.0	7.7	8.5
55 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	-0.5	-0.6	-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-2.0	-2.1
56 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
57 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	---------- Negligible Revenue Effect ----------									
58 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
59 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
60 Remove $150 Million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
61 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4
62 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
63 Increase in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
64 Post-Retirement Medical/Life Insurance Reserves				---------- Negligible Revenue Effect ----------						
65 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	a	a	a
66 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
67 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
68 Disclosure of Return Information to State Agencies				---------- No Revenue Effect ----------						
69 Impose Premium Tax with Respect to Certain High Cost Plans	0	a	0.9	2.2	3.3	6.1	9.5	12.5	16.0	19.9
70 Limit Exclusion for Employer-Paid Health Benefits	0	0	0	0	0	0	0	0	0	0.9
71 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending	0	-0.5	-0.3	-0.7	-1.3	-2.0	-2.4	-3.0	-3.3	-3.7
TOTAL RECEIPT CHANGES	**0.1**	**7.1**	**15.7**	**20.2**	**24.5**	**28.3**	**33.4**	**37.8**	**43.5**	**51.2**
DEFICIT										
MANDATORY CHANGES	**-2.5**	**-12.0**	**-4.6**	**4.5**	**8.9**	**13.0**	**5.8**	**1.2**	**-5.6**	**-15.3**
CUMULATIVE MANDATORY TOTAL	**-2.5**	**-14.5**	**-19.2**	**-14.7**	**-5.8**	**7.2**	**13.0**	**14.1**	**8.6**	**-6.7**
TOTAL CHANGES	**-0**	**-8.7**	**-4.3**	**2.7**	**6.6**	**12.6**	**5.3**	**-1.5**	**-8.4**	**-18.2**
CUMULATIVE DEFICIT EFFECT	**-0**	**-8.8**	**-13.1**	**-10.3**	**-3.7**	**8.9**	**14.2**	**12.7**	**4.4**	**-13.8**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-23.8	-35.6	-39.7	-44.4	-49.6	-55.2	-61.2	-67.6
2 State Maintenance-of-Effort Payments	0	0	-18.5	-26.5	-28.7	-31.1	-33.6	-36.3	-39.3	-42.4
3 Disproportionate Share Hospital Payments	0	0	-8.8	-13.4	-14.8	-15.6	-18.8	-20.7	-22.9	-25.2
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
5 Offset to Medicare Prescription Drug Program	0	0	0.0	0.0	-0.7	-1.5	-1.6	-1.9	-2.1	-2.3
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	a	a	-51.4	-76.0	-84.4	-93.2	-104.3	-114.8	-126.2	-138.3
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Part A Interactions	a	a	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Elimination of Balance Billing	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.5	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.2	14.4	15.7	17.5	19.7	21.5
Total - Medicare	-2.4	-6.6	-10.2	-14.1	-14.7	-14.3	-21.1	-28.9	-38.1	-48.4
Subsidies										
12 Persons between 0-200% of Poverty before Mandate	0	0	66.7	95.4	105.3	116.8	129.3	33.1	0	0
13 Persons between 0-200% of Poverty after Mandate	0	0	0	0	0	0	0	96.1	137.2	149.6
14 Pregnant Women and Kids 0-300% of Poverty				----------	Included in Line 12	----------				
15 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	12.5	14.7	15.9
16 Enrollment Outreach	0	0	1.3	3.3	5.2	6.9	8.4	2.5	0	0
Total - Subsidies	0	0	68.0	103.7	117.6	131.3	146.1	144.2	151.9	165.5
Other Health Programs										
17 Vulnerable Hospital Payments	0	0	0	2.5	2.5	2.5	2.5	2.5	2.5	2.5
18 Veterans' Programs	0	0	-1.4	-1.4	-1.7	-1.8	-1.9	-2.0	-2.0	-2.1
19 Home and Community Based Care	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
20 Life Care	0	0	-0.6	-1.1	-1.1	-0.3	-0.3	-0.3	-0.3	-0.3
21 Academic Health Centers	0	0	4.7	7.0	8.0	9.1	10.3	11.0	11.5	12.1
22 Graduate Medical and Nursing Education	0	0	2.6	3.9	5.8	6.4	6.6	6.8	7.2	7.5
23 Medicare Transfer - Direct Medical Education	0	0	-1.6	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
24 Medicare Transfer - Indirect Medical Education	0	0	-3.4	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
25 Public Health Schools; Dental Schools	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
26 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	a	0	0	0
27 Administration of Enrollment Outreach	0	0	0.4	0.7	0.9	1.0	1.1	1.3	1.4	1.4
Total - Other Health Programs	0	0.3	1.3	6.7	10.0	12.6	14.1	17.2	20.8	24.6
Public Health Initiative										
28 Biomedical and Behavioral Research Trust Fund	0	0	0.9	1.3	1.5	1.6	1.7	2.0	2.2	2.4
29 Health Professions	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
30 Core Public Health	0	0.1	0.3	0.3	0.4	0.4	0.3	0.2	0.1	0.1
31 Prevention	0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
32 Capacity Building and Capital	0	0.3	0.5	0.5	0.4	0.2	0.1	0.1	0.0	0.0
33 OSHA and Workforce	0	0.3	0.4	0.3	0.3	0.2	0.2	0.1	0.1	0.1
34 Supplemental Services	a	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.0
35 Enabling Services	0	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.1	0.1
36 National Health Service Corps (NHSC)	0	0.1	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.0
37 Mental Health & Substance Abuse (CMMH&SA)	a	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
38 School Clinics	a	0.1	0.2	0.3	0.4	0.4	0.3	0.2	0.1	0.1
39 Indian Health Service	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Public Health Initiatives	a	1.4	3.2	3.9	4.0	3.9	3.5	3.1	3.0	3.0
40 Social Security Benefits	0	0	0.2	0.5	0.9	0.9	0.9	0.9	0.8	0.8
MANDATORY OUTLAY CHANGES	-2.4	-4.9	11.0	24.7	33.4	41.3	39.2	21.7	12.1	7.2
DISCRETIONARY OUTLAYS										
Health Programs										
41 Veterans' Programs	1.2	0.6	-2.9	-4.8	-4.9	-5.1	-5.2	-5.4	-5.6	-5.8
42 Indian Health Supplementary Services	0.7	1.2	1.5	1.6	1.6	1.6	1.6	1.6	1.7	1.7
43 Misc. Public Health Service Grants	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total Health Programs	1.9	1.8	-1.4	-3.1	-3.3	-3.4	-3.6	-3.7	-3.9	-4.1
Administrative Expenses										
44 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
45 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	2.0	2.0	2.0
46 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	3.1	3.1	3.2
Studies, Research, Demonstrations, Other										
47 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, Demonstrations, Other	a	0.1	0.1	0.1	a	a	a	a	a	a
DISCRETIONARY OUTLAY CHANGES	2.5	3.2	0.3	-1.7	-2.3	-0.4	-0.5	-0.6	-0.8	-0.9
TOTAL OUTLAY CHANGES	0.1	-1.6	11.4	22.9	31.1	40.9	38.7	21.1	11.3	6.3

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
48 Increase in Tobacco Tax	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
49 1.75% Excise Tax on Private Health Ins Premiums	0	3.5	6.1	7.1	7.7	8.4	9.1	10.4	11.5	12.4
50 Addl Medicare Part B Premiums for High-Income Individuals ($80,000/$100,000)	0	0	2.0	2.0	2.8	3.5	4.4	5.5	6.9	8.7
51 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
52 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
53 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
54 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules	0	a	a	a	a	a	a	a	a	a
55 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements	0	0.5	2.5	3.9	4.8	5.6	6.3	8.2	9.5	10.5
56 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	-0.5	-0.6	-1.2	-1.3	-1.4	-1.5	-1.6	-1.8	-2.0	-2.0
57 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
58 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	---------- Negligible Revenue Effect ----------									
59 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
60 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
61 Remove $150 Million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
62 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.2	-0.3	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4
63 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
64 Increase in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 2. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
65 Post-Retirement Medical/Life Insurance Reserves	---------- Negligible Revenue Effect ----------									
66 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.2	-0.1	a	a	a
67 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
68 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
69 Disclosure of Return Information to State Agencies	---------- No Revenue Effect ----------									
70 Impose Premium Tax with Respect to Certain High Cost Plans	0	a	0.9	2.2	3.3	6.1	9.5	10.2	11.2	14.7
71 Limit Exclusion for Employer-Paid Health Benefits	0	0	0	0	0	0	0	0	0	0.9
72 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending	0	-0.3	-0.3	-0.7	-1.4	-2.1	-2.6	-11.1	-15.9	-19.0
TOTAL RECEIPT CHANGES	**0.2**	**7.3**	**15.7**	**20.2**	**24.4**	**28.3**	**33.2**	**29.1**	**28.6**	**33.5**
DEFICIT										
MANDATORY CHANGES	**-2.6**	**-12.2**	**-4.7**	**4.5**	**9.0**	**13.0**	**6.0**	**-7.4**	**-16.5**	**-26.3**
CUMULATIVE MANDATORY TOTAL	**-2.6**	**-14.8**	**-19.5**	**-15.0**	**-6.0**	**7.0**	**13.0**	**5.6**	**-10.9**	**-37.3**
TOTAL CHANGES	**-0.1**	**-8.9**	**-4.3**	**2.7**	**6.7**	**12.6**	**5.5**	**-8.0**	**-17.3**	**-27.2**
CUMULATIVE DEFICIT EFFECT	**-0.1**	**-9.1**	**-13.4**	**-10.6**	**-3.9**	**8.7**	**14.2**	**6.2**	**-11.1**	**-38.3**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The budgetary treatment of mandatory premium payments is under review.

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

TABLE 3. PRELIMINARY ESTIMATES OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITHOUT MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-17.9	-26.7	-29.8	-33.3	-37.2	-41.4	-45.9	-50.7
2 State Maintenance-of-Effort Payments	0	0	18.5	26.5	28.7	31.1	33.6	36.3	39.3	42.4
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	1.1	-0.8	-0.6	-0.5	-0.1	0.2	0.5	0.8
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	a	a	a
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.5	-1.1	-1.2	-1.4	-1.6	-1.7
6 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	a	a	1.6	-1.4	-2.6	-4.3	-5.4	-6.9	-8.3	-9.9
Administrative Expenses										
7 Expenses Associated with Subsidies	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
8 General Administrative and Start Up Costs	0	0	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6
9 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	0.3	4.7	6.3	6.7	7.3	7.9	8.6	9.3	10.0
Public Health Initiatives										
10 School Health Clinics	0	0.1	0.1	0.2	0.3	0.5	0.5	0.5	0.3	0.2
TOTAL OUTLAY CHANGES	a	0.3	6.4	5.1	4.4	3.5	3.1	2.2	1.3	0.3
RECEIPTS										
11 Revenue Collected for Subsidy Administration	0	0	3.6	5.1	5.5	6.0	6.5	7.1	7.7	8.3
Total State Changes	a	0.3	2.8	-0.0	-1.1	-2.5	-3.4	-4.9	-6.4	-8.0

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

TABLE 4. PRELIMINARY ESTIMATES OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL WITH MANDATE IN EFFECT

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-17.9	-26.7	-29.8	-33.3	-37.2	-41.4	-45.9	-50.7
2 State Maintenance-of-Effort Payments	0	0	18.5	26.5	28.7	31.1	33.6	36.3	39.3	42.4
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	1.1	-0.8	-0.6	-0.5	-0.1	-5.0	-5.2	-5.5
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	a	a	a
5 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.5	-1.1	-1.2	-1.4	-1.6	-1.7
6 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	a	a	1.6	-1.4	-2.6	-4.3	-5.4	-12.1	-14.0	-16.2
Administrative Expenses										
7 Expenses Associated with Subsidies	0	0	3.6	5.1	5.5	6.0	6.5	7.5	8.2	8.9
8 General Administrative and Start Up Costs	0	0	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6
9 Automobile Insurance Coordination	0	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total - Administrative Expenses	0	0.3	4.7	6.3	6.7	7.3	7.9	9.0	9.8	10.6
Public Health Initiatives										
10 School Health Clinics	0	0.1	0.1	0.2	0.3	0.5	0.5	0.5	0.3	0.2
TOTAL OUTLAY CHANGES	a	0.3	6.4	5.1	4.4	3.5	3.1	-2.6	-3.9	-5.4
RECEIPTS										
11 Revenue Collected for Subsidy Administration	0	0	3.6	5.1	5.5	6.0	6.5	7.5	8.2	8.9
Total State Changes	a	0.3	2.8	-0.0	-1.1	-2.5	-3.4	-10.1	-12.1	-14.3

SOURCE: Congressional Budget Office.

a. The estimate assumes that states will continue to provide some assistance to hospitals serving disproportionately large numbers of uninsured or underinsured people.

Table 5. Health Insurance Coverage
(By calendar year, in millions of people)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline								
Insured	224	226	228	229	230	232	233	234
Uninsured	40	40	40	41	42	43	43	44
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	15	15	15	15	15	16	16	16
Senator Mitchell's Proposal--Without Mandate in Effect								
Insured[a]	250	253	255	257	259	261	262	264
Uninsured	13	13	13	14	14	14	14	14
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	5	5	5	5	5	5	5	5
Senator Mitchell's Proposal--With Mandate in Effect								
Insured	250	253	255	257	259	274	276	278
Uninsured	13	13	13	14	14	0	0	0
Total	264	266	268	270	272	274	276	278
Uninsured as Percentage of Total	5	5	5	5	5	0	0	0

SOURCE: Congressional Budget Office.

a. Includes people eligible for coverage under the enrollment outreach provisions of the proposal.