Farewell Tribute to Senator George J. Mitchell

Washington, DC
Wednesday, October 5, 1994

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MITCHELL FILE

MEMORANDUM

To: Health Care Legislative/Policy Working Group

From: Chris Jennings and Jack Lew

Date: September 26, 1994

Re: Status of Health Care Reform

Attached is the prepared text that President Clinton used today for his statement on the status of health reform for the remainder of this Congress. It follows a series of conversations between the Democratic Leadership of both Houses.

We greatly appreciate the cooperation and enormous effort that you have invested in bringing health reform this far down the road. As information becomes available, we will continue to keep you apprised of developments related to decisions about the specific way the Administration will proceed with this issue. It has been a great privilege working with you and we look forward to continuing to do so in the future.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 26, 1994

Statement by the President on Health Care Reform

Today Senator George Mitchell reported that he sees no way to pass health care reform in this session of Congress. He and the bipartisan group of Senators have been doing their best. But he cannot find the 60 votes needed to overcome the Republican filibuster.

I am very sorry to say that this means Congress isn't going to reform health care this year. But we are not giving up on our mission to cover every American and to control health care costs.

When I addressed Congress a year ago, I said our journey to health care reform would have some rough spots in the road. Well, we've had a few. But this journey is far, far from over.

Some Republican leaders keep saying: "Let's put this off until next year." I am going to hold them to their word. We have reached out to Republicans, and we will continue to do that. But we are going to keep up the fight against the interests who spent $300 million to stop health care reform. We will fight for campaign finance and lobby reform so these special interests do not continue to obstruct vital legislation and we will return to the fight for health care reform. There is too much at stake for all the American people and we have come too far to just walk away now.

Although we have not achieved our goal this year, Hillary and I are proud - and our allies should be proud as well - that we were able to bring this debate further than it has ever progressed before. For solid, smart and important reasons, the ordinary working families of America expect their elected leaders to pass health care reform:

*If we don't act, the deficit we have worked so hard to contain will balloon again over time

*And, most important, millions of Americans still won't be able to count on coverage when their families need it. Every month that we don't act, 100,000 more Americans will lose their coverage. They will join the five million Americans who lost theirs in the last five years.

For their sake, and for the sake of those who touched us during this great journey, we are going to keep up this fight and we will prevail.

#

GEORGE J. MITCHELL
MAINE

United States Senate
Office of the Majority Leader
Washington, DC 20510-7010

FOR IMMEDIATE RELEASE
Monday, September 26, 1994

CONTACT: Diane Dewhirst
202/224-2939

STATEMENT OF SENATE MAJORITY LEADER GEORGE J. MITCHELL REGARDING HEALTH CARE LEGISLATION IN THE 103rd CONGRESS

At the beginning of this Congress I said passage of comprehensive health care reform legislation would be a priority.

I repeated that goal at the beginning of this year, and said I would give it my close attention and all my energy.

Two years ago, Americans made the judgment at the polls that the nation's problems had been subordinated for too long to problems abroad. The pressures on working middle income families from corporate downsizing, defense industry conversion, violent crime, college costs, and inflated health insurance costs all made Americans ask Washington to focus on American needs.

President Clinton and the Democratic Congress responded with a budget that cuts the deficit and has contributed to the creation of four million new jobs in the last two years, and with legislation to reduce crime, improve college loans, broaden trade, speed up the introduction of new technologies and economic prosperity they promise. We also made a strong effort to reform the existing health insurance system so that every American could afford private health coverage as good as that which covers Senators and Members of Congress.

The President made this effort a high priority. First Lady Hillary Rodham Clinton devoted thousands of hours to it. Many members of Congress, mostly Democrats, but including some courageous Republicans, worked to develop reforms in our health care system. We welcomed a President who supported our work on health reform.

Most Americans like our health care system, but they know the health insurance system needs fixing. Too many families have lost insurance because a child got cancer or a father lost his job. Too many families can't afford to pay $300 or $400 a month if the place they work doesn't provide insurance. I believe all Americans have a right to affordable, high-quality health care.

Unfortunately, the overwhelming majority of our Republican colleagues do not agree. Under the rules of the Senate, a minority can obstruct the majority. This is what happened to comprehensive health insurance reform.

Over the past few weeks, I've had a number of productive meetings with Senators in the so-called Mainstream Group to explore the possibility of a modified reform plan. We reached agreement on almost all issues. I believe we could have and would have come to final agreement on the substance of a bill. But that is not the only factor for a successful outcome: Any bill must command the votes necessary to pass. So we all agreed it would serve no purpose to go forward unless we had the necessary votes. I hoped that agreement with the Mainstream group would produce the 60 votes needed to defeat a filibuster.

Regrettably, very few Senate Republicans took this view. The overwhelming majority opposed any health care legislation, even a modest bill to extend health insurance to children and reform some industry practices.

Then, last week, the Republican leaders of the House and Senate said aloud what their colleagues had been saying privately: They will oppose any health care bill this year, modest or not, bipartisan or not.

Even though Republicans are a minority in Congress, in the Senate, they're a minority with a veto. They have the ability to block legislation and they have chosen to do so on health care reform.

Therefore, it is clear that health insurance reform can not be enacted this year.

-30-

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MITCHELL FILE

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-30-

Lead or Leave Education

interest on Debt per second in school > 1994 - CNN

- Packwood - statements re employer mandate

Mitchell Plan

PRELIMINARY ILLUSTRATION OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR'S MITCHELL'S PROPOSAL
Effects of the Discontinued Coverage of Acute Care, Net of State Maintenance of Effort

(By fiscal year, dollars in millions)

	1997	1998	1999	2000	2001	2002	2003	2004	TOTAL
ALL STATES (1)	600	(200)	(2,900)	(2,200)	(3,600)	(5,100)	(6,600)	(8,300)	**(28,300)**
AK	2	(1)	(9)	(7)	(12)	(16)	(21)	(27)	**(91)**
AL	4	(1)	(18)	(14)	(22)	(32)	(41)	(52)	**(177)**
AR	2	(1)	(11)	(8)	(13)	(19)	(24)	(31)	**(105)**
AZ	11	(4)	(51)	(39)	(64)	(90)	(117)	(147)	**(501)**
CA	98	(33)	(472)	(358)	(586)	(831)	(1,075)	(1,352)	**(4,608)**
CO	6	(2)	(27)	(21)	(34)	(48)	(62)	(78)	**(264)**
CT	12	(4)	(57)	(43)	(71)	(100)	(130)	(163)	**(556)**
DC	4	(1)	(17)	(13)	(21)	(30)	(39)	(48)	**(165)**
DE	1	(0)	(6)	(4)	(7)	(10)	(13)	(16)	**(54)**
FL	27	(9)	(131)	(99)	(163)	(230)	(298)	(375)	**(1,278)**
GA	13	(4)	(64)	(48)	(79)	(112)	(145)	(182)	**(621)**
HI	3	(1)	(14)	(11)	(17)	(25)	(32)	(40)	**(138)**
IA	3	(1)	(16)	(12)	(20)	(28)	(36)	(46)	**(156)**
ID	1	(0)	(5)	(4)	(6)	(9)	(12)	(15)	**(51)**
IL	27	(9)	(133)	(101)	(165)	(233)	(302)	(380)	**(1,295)**
IN	16	(5)	(76)	(58)	(94)	(134)	(173)	(218)	**(743)**
KS	4	(1)	(18)	(14)	(23)	(32)	(41)	(52)	**(178)**
KY	6	(2)	(28)	(21)	(35)	(49)	(64)	(80)	**(273)**
LA	10	(3)	(48)	(36)	(60)	(84)	(109)	(137)	**(469)**
MA	18	(6)	(87)	(66)	(108)	(153)	(198)	(249)	**(850)**
MD	14	(5)	(66)	(50)	(82)	(115)	(149)	(188)	**(641)**
ME	3	(1)	(13)	(10)	(16)	(22)	(29)	(36)	**(123)**
MI	23	(8)	(111)	(84)	(138)	(196)	(253)	(318)	**(1,086)**
MN	9	(3)	(42)	(32)	(52)	(74)	(95)	(120)	**(409)**
MO	13	(4)	(63)	(48)	(78)	(111)	(144)	(181)	**(616)**
MS	3	(1)	(13)	(10)	(16)	(23)	(29)	(37)	**(125)**
MT	1	(0)	(3)	(2)	(4)	(6)	(7)	(9)	**(31)**
NC	13	(4)	(61)	(46)	(75)	(107)	(138)	(173)	**(591)**
ND	1	(0)	(3)	(2)	(4)	(5)	(6)	(8)	**(28)**
NE	2	(1)	(10)	(8)	(13)	(18)	(23)	(29)	**(100)**
NH	1	(0)	(7)	(5)	(9)	(13)	(16)	(21)	**(70)**
NJ	21	(7)	(102)	(77)	(127)	(180)	(232)	(292)	**(997)**
NM	2	(1)	(9)	(7)	(11)	(15)	(20)	(25)	**(85)**
NV	3	(1)	(16)	(12)	(20)	(28)	(36)	(46)	**(157)**
NY	88	(29)	(424)	(322)	(527)	(746)	(965)	(1,214)	**(4,139)**
OH	27	(9)	(133)	(101)	(165)	(233)	(302)	(379)	**(1,293)**
OK	4	(1)	(18)	(14)	(23)	(32)	(41)	(52)	**(178)**
OR	3	(1)	(17)	(13)	(20)	(29)	(38)	(47)	**(161)**
PA	21	(7)	(100)	(76)	(124)	(176)	(227)	(286)	**(975)**
RI	2	(1)	(11)	(9)	(14)	(20)	(26)	(32)	**(110)**
SC	5	(2)	(27)	(20)	(33)	(47)	(60)	(76)	**(259)**
SD	1	(0)	(3)	(2)	(3)	(5)	(6)	(8)	**(26)**
TN	12	(4)	(58)	(44)	(72)	(102)	(132)	(167)	**(568)**
TX	30	(10)	(147)	(111)	(182)	(258)	(334)	(420)	**(1,433)**
UT	2	(1)	(8)	(6)	(10)	(15)	(19)	(24)	**(82)**
VA	10	(3)	(48)	(37)	(60)	(85)	(110)	(138)	**(471)**
VT	1	(0)	(4)	(3)	(5)	(7)	(9)	(11)	**(37)**
WA	11	(4)	(52)	(39)	(64)	(91)	(117)	(147)	**(503)**
WI	5	(2)	(26)	(20)	(33)	(46)	(60)	(75)	**(256)**
WV	3	(1)	(16)	(12)	(20)	(28)	(36)	(45)	**(154)**
WY	1	(0)	(3)	(2)	(3)	(5)	(6)	(8)	**(26)**

(1) From CBO Table 4. Preliminary Estimates of the State and Local Budgetary Effects of Senator Mitchell's Proposal With Mandate in Effect. Consists of lines 1 (Discontinued coverage of acute care) and 2 (state MOE payments).

OTHER EFFECTS -- DSH SAVINGS, LTC, DRUG, AND ADMINISTRATIVE SAVINGS -- ARE NOT CONSIDERED IN THESE ESTIMATES.

State estimates were calculated by multiplying the state's FY 93 share of acute care expenditures for the non-cash & AFDC populations plus the non-cash portion of DSH by the CBO total state changes

These estimates do not account for state variation in growth rates.

10-Aug-94 02:22 PM

Mitchell

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

TO: Chris Jennings

FAX: 456-7431

FROM: David Nexon

DATE AND TIME: 8/18/94

NUMBER OF PAGES: COVER + 2

RETURN FAX NUMBER: (202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL (202)224-7675

Chris - also does the Health Benefits Board on the Cost & Coverage Commission have an inherent ability to create advisory boards if it wants - or do they have to be specifically authorized?

456-7431

Clinton-Mitchell Health Security Act

50 New Bureaucracies

1. National Health Benefits Board [Sec. 1211]
2. Health Insurance Purchasing Cooperatives set up by States or Local Governments [Sec. 1321] p. 96-97
3. Health Insurance Purchasing Cooperatives set up by Federal Office of Personnel Management [Sec. 1341] p. 115-124
4. National Guaranty Fund for Multi-state Self-insured Plans [Sec. 1481]
5. Assistant Secretary for Office of Rural Health Policy [Sec. 1491]
6. Federal Accreditation, Certification and Enforcement (ACE) Program [Sec. 1501]
7. State Accreditation, Certification and Enforcement (ACE) Program [Sec. 1501] p. 51-60
8. Health Plan Service Areas [Sec. 1502]
9. State Risk Adjustment Organizations [Sec. 1504] p. 62-63
10. Advisory Committee for Risk Adjustment Program [Sec. 1504]
11. State Guaranty Funds [Sec. 1505]
12. State Public Access Sites for Medically Underserved Areas [Sec. 1508]
13. Prescription Drug Payment Review Commission [Sec. 2004]
14. Federal Agency to Administer State Programs for Home and Community-based Services for Individuals with Disabilities [Sec. 2101]
15. State Agency to Administer State Programs for Home and Community-based Services for Individuals with Disabilities [Sec. 2102]
16. Client Advocacy Offices for Home and Community-based Services for Individuals with Disabilities [Sec. 2106]

17. Federal Advisory Group on Home and Community-based Services for Individuals with Disabilities [Sec. 2107]

18. State Advisory Groups on Home and Community-based Services for Individuals with Disabilities [Sec. 2107]

19. Advisory Committee on Long-Term Care Insurance Improvement and Accountability [Sec. 2201 / Sec. 2215]

20. Long-term Care Screening Agencies [Sec. 2302]

21. National Council on Graduate Medical Education [Sec. 3001]

22. Graduate Nurse Training Account [Sec. 3071]

23. National Council on Graduate Nurse Training [Sec. 3072]

24. National Advisory Board on Health Care Workforce Development [Sec. 3081]

25. Biomedical, Behavioral, and Health Services Research Fund [Sec. 3201]

26. Advisory Committee on Medical Technology Impact Study [Sec. 3221]

27. Uniform Core Public Health Functions Reporting System [Sec. 3318]

28. Healthy Students-Healthy Schools Interagency Task Force [Sec. 3603]

29. National Advisory Board for Occupational Injury and Illness Prevention [Sec. 3903]

30. United States-Mexico Border Health Commission [Sec. 3908]

31. National Quality Council [Sec. 5001]

32. Quality Improvement Foundations [Sec. 5008]

33. State Consumer Information and Advocacy Centers [Sec. 5009]

34. National Center for Consumer Information and Advocacy [Sec. 5009]

35. Health Information Advisory Committee [Sec. 5172]

36. Joint Program on Fraud and Abuse [Sec. 5301]

37. Federal Outlay Program Fraud and Abuse Account [Sec. 5302]

38. HHS Office of Inspector General Asset Forfeiture Proceeds Fund [Sec. 5303]

39. Mandatory State-based Alternative Dispute Resolution [Sec. 5402]

40. Complaint Review Offices (one per community rating area) [Sec. 5502]

41. State Early Resolution Program (one in each Complaint Review Office) [Sec. 5511]

42. State Provider-based Enrollment Mechanisms [Sec. 6006]

43. Academic Health Centers Account [Sec. 7601]

44. Graduate Medical Education Account [Sec. 7601] p. 295 (menu program)

45. Department of Veterans Administration Plan Fund [Sec. 8102]

46. Veterans Health Care Investment Fund [Sec. 8102]

47. Federal Advisory Group on Indian Health Services [Sec. 8109]

48. Advisory Committee on Indian Transitional Studies [Sec. 8110]

49. Commission on Worker's Compensation Medical Services [Sec. 9003]

50. National Health Care Cost and Coverage Commission [Sec. 10001]

Prepared by Office of Senator Dan Coats

? ⇒ Does Sec have author to create advisor board for the functions outline in attached doc

? = nat'l Benefits / Cost Comm commissioners have author

just as sec

DATE: 8/19/94
TIME: 8:50 am

Executive Office of the President
Office of Management and Budget
Health Policy

725 17th Street, NW, Room 7021
Washington, DC 20503

FAX: (202) 395-3910 Voice: (202) 395-3844

To: NEM, Chris/Jack, Gary/Larry, Ken

FAX #: 5-7289, 6-7431, 401-7321

Voice #: 5-5178, 6-5560, 690-6870

From: Linda Blumberg

Notes:
A slightly revised Dole table follows -- it now includes an estimate of federal subsidy administration costs. For those who care, the administration costs were calculated by taking the finance admin. costs, multiplying them by (.5/.75) because finance is a 75% match and Dole is a 50% match, and then multiplying by (.89/.92) to adjust down for the lower coverage in Dole.

Number of Pages (including cover sheet): 2

Fiscal Analysis of Dole Plan

08/19/94

08:58 AM

CR pool 50, NO MANDATE, no premium caps

	1995-1999	1995-2004
Subsidies	201	806
Medicare Savings	(26)	(159)
Medicaid Savings	(121)	(469)
State Medicaid MOE	(68)	(235)
Supplemental Program	39	129
PHS	1	1
Subsidy Administration	5	20
Net Revenues Effect	19	84
Net Deficit Effect	50	177

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

HEALTH CARE REFORM: POSSIBLE COMPROMISE

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

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

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

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

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

  Minimum employer payment to receive subsidy (I assume 50%)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1/ No subsidies available in 1995 and 1996.

NOTE: Employer subsidies phase out for workers with wages between $18,000-$28,000.

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

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

HEALTH CARE COMPROMISE -- ISSUES

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

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

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

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

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

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

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

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

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

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

- *How are "non-insuring firms" defined? (1) Many firms insure some, but not all of their workers. Are such firms considered insuring or non-insuring? (2a) What about firms which currently pay less than 80 percent of their employees's insurance costs? Are they considered to be not insuring their employees? (2b) What if a firm currently providing no insurance starts picking up less than 80 percent of insurance costs? For what subsidies are they eligible?*
  - (1) To most effectively target the transitional employer subsidies, employers will only get them for currently uninsured workers, including part-time and temporary workers. Hence, a firm with 20 insured employees and 200 uninsured employees would only get the supplemental transitional subsidies for the 200 uninsured employees. The ongoing costs of the 20 insured employees would also be subsidized, but at a lower level during the transition period.
    - A potential problem with this approach is that any worker that joins a firms during the transition could be considered currently uninsured and eligible for the more generous transitional subsidies. This problem could be alleviated by prohibiting subsidies to (1) new workers at firms which currently insure all their workers, and (2) new workers whose wage or job description is similar to that of other co-workers who were covered before the transition.
  - (2a) Firms paying less than 80 percent coverage could be treated any number of ways: We could, for example, offer extra subsidies to encourage them to increase their contribution up to 80 percent, but it is not clear how much additional coverage would be bought with these federal dollars -- just those workers who would be willing to purchase already available insurance if their employer would increase their contribution. Nor -- if you believe in passback -- would supplemental subsidies to these employers ultimately reduce the burden on employees.
  - (2a) A second alternative would be to give firms paying less than 80 percent of their employees' insurance costs the same subsidies we give to other insuring firms. Alternatively, we could pro-rate their subsidies based on the portion of the premium they cover.
  - (2b) The same issues -- and possible responses -- exist for currently non-insuring firms which start providing insurance, but at less than the 80 percent rate.

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

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

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

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

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

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

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

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

Mitchell File

CBO VALIDATES THE MITCHELL BILL

The Mitchell bill provides universal coverage through a system of insurance market reforms, voluntary purchasing cooperatives, and incentives and subsidies to those who need them. The Mitchell health care bill will provide affordable health care for all Americans, control the rising cost of health insurance, emphasize primary and preventive care, and expand choice of doctors and health plans. The bill will also provide long term care and prescription drug benefits for elderly and disabled Americans, reduce paperwork, and facilitate consumers' ability to compare health plans.

The non-partisan Congressional Budget Office analyzed the Mitchell bill and confirmed that the Mitchell bill will:

Meet Its Goal of Universal Coverage

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

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

Pay for Itself, with Money Left over for Deficit Reduction

CBO says that the Mitchell bill -- with subsidies for individuals with incomes up to 200 percent of poverty, children and pregnant women up to 300 percent of poverty, employers expanding coverage and the temporarily unemployed -- will be fully funded, yet still generate *$8.6 billion in deficit reduction by 2004.* The Mitchell bill will yield short term deficit reduction of $6.5 billion by 1999. [CBO Analysis of Senator Mitchell's Health Proposal, Table 1]

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

Allow Job Creation to Continue on its Expected Upward Path

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

Mitchell File

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

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

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

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

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

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

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

The Mitchell bill provides comprehensive preventive care for kids.

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

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

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

The Mitchell bill supports essential nutrition programs .

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

CHILDREN AND HEALTH CARE:
The Problem Today

MILLIONS OF CHILDREN HAVE NO INSURANCE; MILLIONS MORE INSECURE:

- 9 million children and half a million pregnant women have no health insurance. [Census Bureau, CPS, 3/93]
- One out of every ten children under age six are uninsured, perhaps the most critical years of a child's development. [Census Bureau, CPS, 3/93]
- One in five American children had no contact with a doctor in 1992. [Children's Defense Fund]
- 17 million children are uninsured for part or all of the year. [Bureau of the Census, 1990-1992 SIPP for CDF]
- Many thousands of children are locked out of the health insurance system because of pre-existing condition exclusions

MAJORITY OF UNINSURED CHILDREN IN MIDDLE CLASS FAMILIES

- 58% of uninsured children were dependents of full-time, full year workers. [Subcommittee on Children, 11/16/93]
- Approximately 30% of adolescents without insurance live in middle class families with incomes above 200% of poverty. [Subcommittee on Children, 11/16/93]

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

- If current trends continue, only about half of the nation's children will be covered by employer-provided health insurance by the year 2000. *"For two decades, employer cost-cutting and the rising cost of health insurance have forced millions of children out of the private health insurance system."* [Children Defense Fund, 3/3/94]
- The percentage of children who were covered by employers fell from 64.1 percent in 1987 to 59.6 percent in 1992. Had the coverage percentage stayed at 1987 rates, more than 3 million additional children would have had employer-based insurance in 1992. [Children Defense Fund, 3/3/94]

MILLIONS MORE CHILDREN HAVE INADEQUATE COVERAGE TODAY:

- Millions have private insurance that fails to cover preventive services as well as special treatment needed by children with physical and emotional disabilities.
- Only about a third of health insurance policies in medium and large firms -- typically the most comprehensive plans -- covered well-baby care. [BLS, Employee Benefits Survey, 5/93]
- Only 42% of children with health insurance are covered for routine immunizations. [Subcommittee on Children, 11/16/93]

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

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

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

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

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

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

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

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

MEDICARE

- **Preserves and Strengthens Medicare**

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

- **Provides Prescription Drug Coverage**

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

- **Increases Choice for Medicare Beneficiaries**

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

- **Protects Seniors Against Fraud and Overcharges**

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

- **Lowers Medigap Premiums**

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

- **Eliminates Balance Billing**

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

OLDER AMERICANS: THE CURRENT SYSTEM

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

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

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

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

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

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

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

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

THE DOLE BILL IS BAD FOR STATES

Problems with Medicaid

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

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

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

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

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

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

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

Problems with the New Low-Income Subsidy Program

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

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

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

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

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

<u>No Real State Flexibility</u>

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

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

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

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

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

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

Mitchell

CBO VALIDATES THE MITCHELL BILL

CBO SAYS THE MITCHELL BILL WILL....

not CBO Marsh

Meet Its Goal of Universal Coverage

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

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Allow Job Creation to Continue on its Expected Upward Path

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

compromise?

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

Lower the Growth of Health Costs

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

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

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

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

Notes:

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

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

Mitchell file

8/2/94

SUMMARY OF MITCHELL HEALTH CARE LEGISLATION

The Mitchell health care bill would:

- provide affordable health care for all Americans
- control the rising costs of health insurance
- emphasize primary and preventive care
- maintain America's high quality care and expand choice of doctors and health plans

The bill also would provide long term care and prescription drug benefits for elderly and disabled Americans, reduce paperwork, and facilitate consumers' ability to compare health plans.

HEALTH INSURANCE FOR ALL AMERICANS

While the vast majority of Americans now have private health insurance, millions of them are at risk of losing their coverage if they get sick or if they change jobs. The bill would make it illegal for insurance companies to:

- arbitrarily drop coverage
- cut benefits
- increase rates if an individual gets sick
- use lifetime limits to cut off benefits

In addition, insurance plans would be required to allow unmarried children up to age 25 to be covered by a parent's policy.

The bill would expand insurance coverage through federal subsidies that make insurance more affordable, voluntary purchasing cooperatives and insurance market reform -- achieving 95% coverage.

New programs would target subsidies to vulnerable populations and groups that comprise large portions of the uninsured:

- children and pregnant women with income under 300% of poverty
- families with income under 200% of poverty
- temporarily unemployed workers
- firms that agree to insure all workers

Employers that voluntarily contribute toward the cost of health insurance for any employee would be required to make equal contributions for all employees.

Every American would have a choice of at least three private insurance plans and many will be able to enroll in Federal Employees' Health Benefits (FEHB) plans.

These provisions would greatly expand health insurance coverage, reducing the number of uninsured Americans by two-thirds and raising the percentage of Americans covered by health insurance to 95%.

These measures to increase health insurance coverage would be backed up by the National Health Care Cost and Coverage Commission.

On January 1, 2000 the Commission would determine whether 95% of Americans have insurance coverage. If that goal is not met, the Commission would develop a plan to expand coverage to the remaining uninsured. Congress would have until December 31, 2000 to adopt such legislation under special procedures that limit the time of debate. If Congress does not act by that date, beginning January 1, 2002, in those states with less than 95% coverage, businesses with 25 or more employees would be required to share half of insurance premium costs with their employees. For workers in firms of less than 25, employees would be required to purchase coverage. Subsidies would be available to make insurance more affordable.

CONTROLLING HEALTH CARE COSTS

The bill would make health insurance affordable for American businesses and families.

- Community rating of insurance premiums would be required, to ensure that premiums do not increase when people need coverage the most.

- Health insurance purchasing cooperatives (HIPCs) would be established for small and medium-size firms to reduce administrative costs that now put insurance premiums out of reach for millions of businesses.

The bill would more effectively spend federal health care dollars.

- Medicaid recipients would be integrated into private health insurance plans, ensuring that Medicaid expenditures would grow no faster than general health care costs.

- The Medicare program would be improved to provide beneficiaries greater choice of and access to managed care plans.

The bill would create mechanisms to control national health care spending.

-- Standardizes benefits to make it easier for consumers to choose between health plans based on price

-- Establishes quality performance measures for health plans to better equip consumers to choose health plans based on price

-- Reduces administrative costs by standardizing insurance forms and simplifying billing

-- Imposes an assessment on insurance plans that grow faster than the target rate of growth, making consumers more sensitive to cost differentials of insurance plans

-- Funds increased biomedical research and research in health outcomes research to find new cures for disease and to reduce unnecessary health services

Beginning on January 1, 1999, the National Health Care Cost and Coverage Commission would issue annual reports on the cost of health insurance and strategies for controlling such costs. If at any point, the Commission determines that fewer than 35 percent of the population eligible to enroll in community rated health plans cannot enroll in a plan that costs less than the target premium established in the high cost plan assessment, the Commission would develop a plan for meeting the growth targets. Congress would consider such a plan under special procedures that limit the time for debate.

GREATER EMPHASIS ON PRIMARY AND PREVENTIVE CARE

One reason Americans spend so much on health care is we spend almost all on curative care -- making people well after they've become sick. This plan puts equal emphasis on keeping people well -- by encouraging personal responsibility for one's own health through regular check-ups, prenatal and well-baby care, childhood immunization, and healthier lifestyles.

The plan would eliminate copayments for clinical preventive and prenatal services. The comprehensive benefits package covers vision and dental services for children under the age of 22. The plan would encourage doctors to become primary care physicians in fields such as family medicine, general internal medicine, and general pediatrics.

The plan also would fully fund the supplemental food program for women, infants, and children (WIC).

MAINTAIN HIGH QUALITY CARE

- All Americans would be covered by a comprehensive benefits package.
- Insurance plans would be required to meet federal quality standards such as measures on waiting times, consumer satisfaction, and report cards for consumers.
- An assessment on insurance premiums would fund graduate medical education and important research at the Agency for Health Care Policy and Research (AHCPR) and the National Institutes of Health (NIH). These efforts are important to keep America on the forefront of medical science.

EXPANDS CHOICE OF DOCTOR AND CHOICE OF PLAN

The bill would expand the choices Americans have for their health care. Individuals would continue to be able to choose their own doctor and, for the first time for many, be guaranteed a choice of health insurance plans.

- Every American would have the choice of at least three health insurance plans, one of which must be a traditional fee-for-service plan in which an individual can choose his or her own doctor.

- Small and medium sized employers must offer workers the opportunity to choose a plan through a HIPC. In addition, they may offer a choice of three insurance plans.

- HIPCs must provide enrollees a choice of three plans: a fee-for-service plan, a health maintenance organization (HMO), and a point-of-service plan.

- Large firms must offer their employees a choice of three plans: a fee-for-service plan, a health maintenance organization (HMO), and a point-of-service plan.

ALLOWS STATE OPTIONS

The bill would give states the ability to implement federal health care reforms on a fast track. The bill would allow states to implement a single payer system. Existing state waivers would be grandfathered.

SIMPLICITY

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

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

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

HOW IS THIS BILL PAID FOR?

- The rate of growth of Medicare would be reduced by $55 billion over the next 5 years and $278 billion over the next 10 years. Approximately $100 billion of this would be used to fund prescription drug benefits.

- The tax on a pack of cigarettes would be phased in, from 15 to 45 cents, over the next five years, raising $56 billion.

- Reducing the number of uninsured would lead to savings of about $129 billion in disproportionate share payments to hospitals.

- Over 10 years there would be savings of $387 billion in federal costs and $232 billion in state costs from the existing Medicaid program. These savings would be used to provide targeted subsidies to low income families and individuals, who would be integrated into the private health insurance system.

- Additional sums would be raised through an assessment on the premiums of high growth plans, the elimination of health benefits as part of cafeteria plans, income related premiums for Medicare patients, and extending Medicare coverage to all state and local government employees.

The bill would include a fail safe mechanism to guard against unanticipated cost overruns increasing the federal deficit. To the extent that the legislation's cost exceeds estimated levels, the program would be cut back automatically to offset any shortfall.

Mitchell File

Sources of Mitchell Health Care Reform Bill

1. Finance Committee

The following provisions are taken directly, or with minor modification, from the Finance Committee bill:

1. Medicaid/Medicare
2. Financing Mechanisms
3. Cost Containment
4. Subsidies for Low-income Pregnant Women and Children
5. Benefit Approach

2. Labor Committee

The following provisions are taken directly, or with minor modification, from the Labor Committee bill:

1. Public Health Infrastructure
2. Workforce Priorities
3. Quality Improvement
4. Consumer Protections

3. Finance and Labor Committees

The following provisions are blended provisions based on the Finance and Labor Committees bills:

1. Insurance Market Reforms
2. Health Insurance Purchasing Cooperatives
3. Low-income Subsidies
4. Federal Employees Health Benefits Program
5. Long-Term Care
6. Academic Health Centers/Graduate Medical Education
7. Fraud and Abuse Program

Sources of Mitchell Health Care Reform Bill

4. Other Provisions

The following provisions were not included in either Committee, or if included, have been subject to modification.

1. Medicare Prescription Drug Benefit
2. Expanded Coverage
   - Additional Coverage for Pregnant Women and Children
   - Coverage for Temporarily Unemployed, Uninsured Workers
   - Incentives for Employers to Expand Coverage to Additional Workers
3. Backup Mechanism to Enable Coverage of the Remaining Uninsured