MITCHELL HEALTH CARE LEGISLATION
EXECUTIVE SUMMARY
AUGUST 2, 1994

1. EXPANDING COVERAGE

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

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

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

For low income individuals:

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

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

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

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

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

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

For employers:

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

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

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

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

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

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

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

2. CONTROLLING HEALTH CARE COSTS

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

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

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

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

Among other things, the Commission will report on:

- o Demographics and employment status of the uninsured and reasons why they are uninsured;
- o Structure of health delivery systems;
- o Status of insurance market reforms;
- o Development and operations of health insurance purchasing cooperatives;
- o Success of market mechanisms in expanding coverage and controlling costs among employers and households;
- o Success of high cost health insurance premium tax in controlling costs;
- o Success and adequacy of subsidy program in expanding coverage through employers and households;

The Commission will also issue findings on the per capita cost of health care, including the rate of growth by type of provider, by type of payor, within States and within health care coverage areas. Such findings will also include the expected rate of growth in per capita health care costs, the causes of health care cost growth, and strategies for controlling such costs.

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

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

3. INSURANCE MARKET REFORMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. NATIONAL HEALTH PLAN STANDARDS

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

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

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

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

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

5. BENEFITS PACKAGE

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

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

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

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

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

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

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

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

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

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

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

6. EXPANDED BENEFITS FOR THE ELDERLY AND DISABLED

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

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

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

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

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

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

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

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

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

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

7. MEDICAID PROGRAM

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

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

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

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

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

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

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

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

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

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

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

H. Miscellaneous Medicaid. In addition, the plan:

- allows states to expand eligibility for home-based Medicaid long term care services for single persons by increasing the asset limit from $2,000 to $4,000 for services including personal care attendant services, the Sec. 1915 waiver programs, and the frail elderly home care option.

- eliminates the institutionalization requirement as a condition of eligibility for habilitation services under a home and community based waiver.

- eliminates the "cold bed" rule for home and community based waiver programs.

- requires State Medicaid programs to reimburse directly for services by certified registered nurses and anesthetists or clinical nurse specialists that are authorized to practice under State law, whether or not they operate under the supervision of a physician or other health care provider.

8. HEALTH WORKFORCE AND EDUCATION/RESEARCH

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

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

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

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

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

B. Biomedical and Health Services Research Fund

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

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

9. HEALTH INFRASTRUCTURE

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

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

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

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

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

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

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

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

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

10. UNDERSERVED/ESSENTIAL COMMUNITY PROVIDER

A. Access to Care for the Underserved Population

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

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

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

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

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

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

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

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

11. STATE OPTIONS

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

12. QUALITY AND CONSUMER PROTECTION

A. Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. RELATED ISSUES

A. Veterans Affairs

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

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

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

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

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

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

14. FINANCING

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

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

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

C. Revenues.

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

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

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

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

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

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

  - Increase excise tax on certain handgun ammunition.

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

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

  - Modify exclusion for employer-provided health care.

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

  - Self-employed deduction.

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

- Limitation on prepayment of medical insurance premiums.

- Tax treatment of voluntary employer health care contributions.

- Tax treatment of organizations providing health care services and related organizations.

- Tax treatment of long-term care insurance and services.

  In addition, reserves for long-term care insurance contracts that constitute noncancellable accident and health insurance generally will be determined in accordance with the reserve method prescribed by the National Association of Insurance Commissioners (NAIC).

- Tax treatment of accelerated death benefits under life insurance contracts.

- Definition of Employee.

- Increase in penalties for failure to file correct information returns with respect to non-employees.

- Nonrefundable credit for certain primary health services providers.

- Expensing of medical equipment used in health professional shortage areas.

- Tax treatment of funding of retiree health benefits.

- Tax credit for the cost of personal assistance services required by individuals.

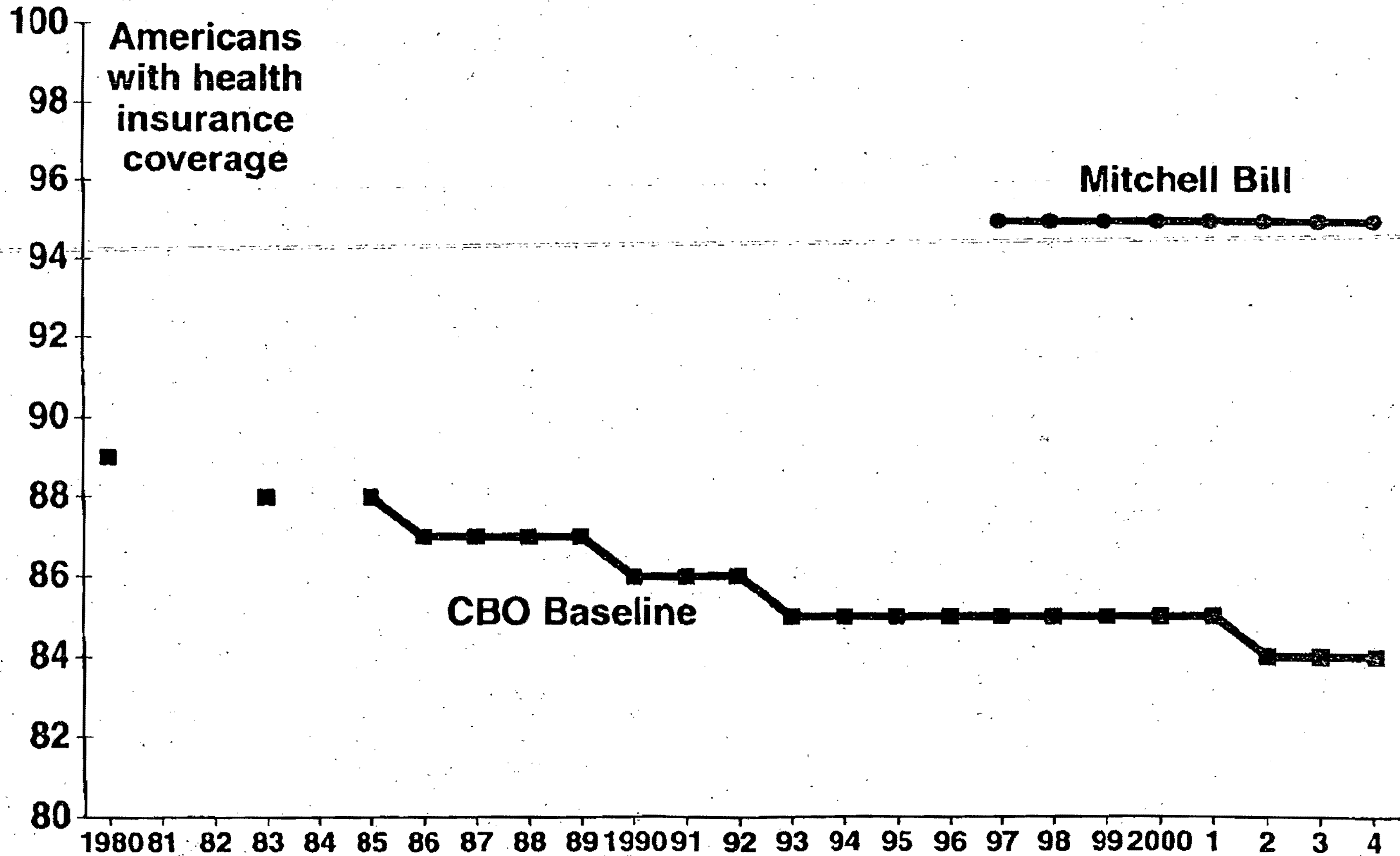
- Disclosure of taxpayer return information for administration of health subsidy programs.

15. CONTROLLING FEDERAL COSTS -- FAIL SAFE

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

REVERSING THE TREND

Mitchell Plan Reverses Declining Coverage Trend



Source; Congressional Budget Office

Mitchell /reverse trend

How Mitchell Plan Helps the American People

- Provides security to Americans who have insurance now
- Expands choice of doctors and choice of health plan
- Makes insurance more affordable for those without coverage
- Creates cooperatives to reduce health insurance costs for small businesses and individuals
- Provides prescription drug benefit for elderly and long term care for elderly and disabled
- Reduces upward spiral of premium costs

How Mitchell Health Care Plan Works

Provides health care for all Americans

- firms must offer choice of at least 3 health plans
- insurers cannot cut benefits or drop coverage
- subsidies for businesses and low-income families
- expanded coverage for children and pregnant women

Controls health care costs

- cooperatives keep down administrative costs for small firms and individuals
- assessment on faster-rising premiums

Greater Emphasis on Primary and Preventive Care

- benefits package includes preventive and primary care
- no copayments for preventive and prenatal care
- vision and dental services for children under age 22

Greater Consumer Choice

- choice of at least three health plans
- choice of doctor
- buy-in to Federal Employee Health Benefits Plan

Maintains High Quality Care

- comprehensive benefits package
- federal quality standards for health plans
- funds for medical research and education

The Road to Universal Coverage

- Voluntary system
- Insurance market reform
- Subsidies for uninsured
- Voluntary purchasing cooperatives

The Road to Universal Coverage

If voluntary system achieves 95% coverage by the year 2000, then:

Commission recommends to Congress ways to provide coverage to those still uninsured.

Congress votes on recommendation on fast track (amendable but not subject to filibuster).

No further action required.

The Road to Universal Coverage

If voluntary system does not achieve 95% coverage by the year 2000, then:

By May 15, 2000, Commission recommends to Congress ways to provide coverage to those still uninsured.

Congress votes on recommendation on fast track (amendable but not subject to filibuster).

If Commission's recommendations are enacted into law by December 31, 2000, no further action required.

If Commission's recommendations are not enacted into law by December 31, 2000, then on January 1, 2002, requirement takes effect:

Employers with 25 or more employees must provide coverage to their employees -- 50% paid by employer, 50% paid by employee.

Employers with fewer than 25 employees exempt.

Individuals not otherwise covered are required to purchase insurance.

Mitchell file (CBO)

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:

- determining eligibility for the new subsidies and the continuing Medicaid program;
- administering the subsidy and Medicaid programs;
- establishing the infrastructure for the effective functioning of health care markets; and
- 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
<u>Subsidies</u>										
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
<u>Other Health Programs</u>										
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
<u>Public Health Initiative</u>										
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.

...ATES OF THE STATE & LOCAL BUDGETARY EFFECTS OF SENATOR MITCHELL'S PROPOSAL

...IN EFFECT...

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
...AYS										
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.

Table 6. Projections of National Health Expenditures
(By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Senator Mitchell's Proposal–Without Mandate in Effect								
Proposal	1,301	1,401	1,519	1,647	1,779	1,923	2,079	2,246
Change from Baseline	38	29	31	33	31	29	27	25
Senator Mitchell's Proposal–With Mandate in Effect								
Proposal	1,301	1,401	1,519	1,647	1,779	1,943	2,093	2,254
Change from Baseline	38	29	31	33	31	48	41	34

SOURCE: Congressional Budget Office.

Table 6. Projections of National Health Expenditures
(By calendar year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004
Baseline	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
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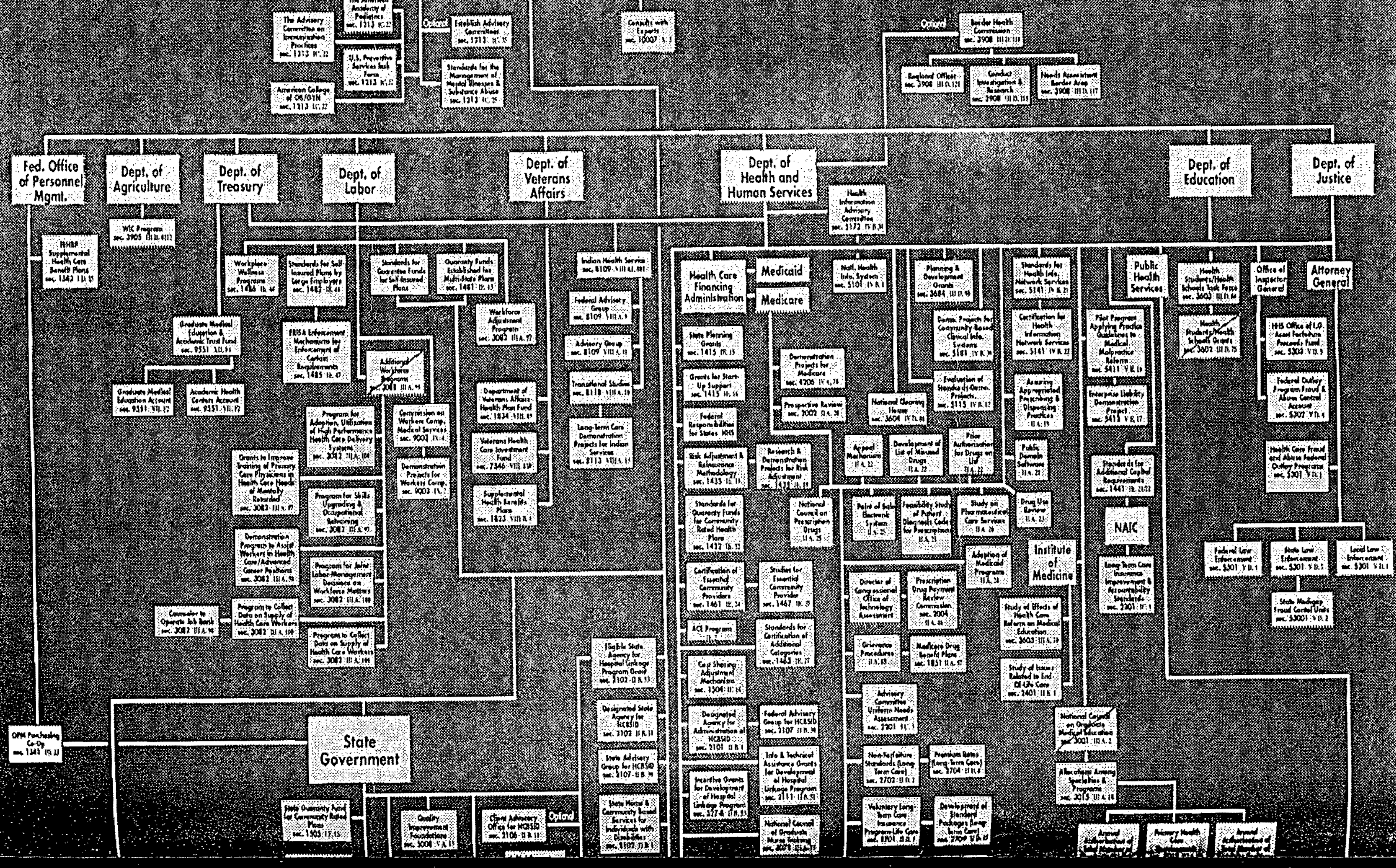
Change from Baseline	38	29	31	33	31	48	41	34

SOURCE: Congressional Budget Office.

Mitchell File

Clinton/Mitchell: Another Prescription for Big Government?



Senator Mitchell's Health Security Act

- New entities, programs, & functions
- Existing entities /programs with new or expanded functions and responsibilities or other change in function
- Both new and existing entities & programs (regional variance)

Plans sec. 1503
Improvement Foundations sec. 5008
Office for HCBSID sec. 2106
Individuals with Disabilities sec. 2102
National Council of Graduate Nurse Training sec. 3072
Insurance Program-Life Care sec. 2701
Packages (Long-Term Care) sec. 2709
Annual Authorization of Total Number of Graduate Medical Education Positions "Quotas" sec. 3012
Primary Health Care Requirements sec. 3013
Annual Authorization of Total Number of Specialty Positions sec. 3012

State Guaranty Fund for Self-Insured Plans sec. 1506
State Office of Consumer Advocacy sec. 5009
Information on Health Care Providers sec. 5013
Initial Screening Process for HCBSID sec. 2103
Workforce Development sec. 3081
National Workforce Advisory Board for Health Care sec. 3081
Long-Term Care Screening Agency sec. 2707
Mechanism for Appeals of Screening Agency (Long-Term Care) sec. 2707

Early Resolution Programs sec. 5511
Complaint Review Offices sec. 5502
Local Office of Consumer Advocacy sec. 5009
Needs Assessment for HCBSID sec. 2102
Federal Forward Payments
Study by The Federal Reserve Board sec. 3303
Public Access Sites sec. 1508
Quality Assurance & Safeguards for HCBSID sec. 2106
Rural Health Career Training sec. 3081
Inappropriate Practice Barriers Full Utilization of Skills sec. 3081
Primary Care Physician & Physician Assistant Training sec. 3081

State Certifying Authority sec. 1001
Retention of Rural Health Care Providers sec. 3081
Training of Underrepresented Racial & Ethnic Minorities & Disadvantaged Persons sec. 3081
Federal Payments to Schools of Public Health sec. 3074
Federal Payments to Medical Schools sec. 3061
Federal Formular Payments for the Operation Costs of Approved Physician Training Programs sec. 3031
Federal Formular Payments to Academic Health Centers sec. 3061
Federal Payments to Dental Schools sec. 3073
Federal Payments to Graduate Nurse Training Programs sec. 3071
Payments for Dental & Pediatric Positions sec. 3034
Multi-State Plans sec. 1504
State Risk Adjustment Organization sec. 1504
Discretionary Grants Regarding Access to Academic Centers sec. 3131
Nurse Training sec. 3081
Eligible Graduate Nurse Training Programs sec. 3071
Standard Health Plan Sponsor sec. 1111
Mandatory Reinsurance sec. 1504
State Established Reinsurance Programs
Health Services for Medically Underserved sec. 3411
National Health Service Corps sec. 3471
Nursing Scholarship & Loan Program sec. 3472
Loan Program for Psychiatrists, Psychologists, & Clinical Social Workers sec. 3473
Office of Rural Health Policy sec. 1491
Advisory Opinions sec. 1404
Compliance Monitoring to HHS sec. 1411
State Single-Payer System sec. 1521
Requirements for Participating States sec. 1411
ACT Program
Public Health Prevention Programs sec. 3312
Traineeship Program sec. 3303
Agency for Health Care Policy Research
Biomedical, Behavioral, & Health Services Research sec. 3301
Advisory Committee for Technology Study sec. 3321
Medical Technology Impact Study sec. 3321
Director of Natl. Inst. of Occupational Safety & Health sec. 3903
Education Programs for Occupational Safety for Health Professionals sec. 3903
Grants for National Prevention Initiatives sec. 3331
State Local Core Grants sec. 3313
Uniform Code Public Health Functions Reporting System sec. 3318
Center for Disease Control
Natl. Advisory Board for Occupational Injury & Illness Prevention sec. 3903
Grants for Development & Implementation Regarding Domestic Violence sec. 3901
Large Employer Purchasing Groups sec. 1306
Board of Directors sec. 1321
Purchasing Cooperatives sec. 1321
Risk Adjustment & Reinsurance sec. 1117
Grants & Contracts for Enabling & Supplemental Services sec. 3461
Community Health Advisory Programs sec. 3332
Office of Rural Health Policy sec. 3341
Rural Information & Referral System sec. 3131
Quality Assurance Standards sec. 1112
Health Plans
Health Plans
Internal Quality Assurance Standards sec. 1123
Transportation sec. 3461
Grants for Development of Rural Telemedicine sec. 3341
Grants & Contracts for Development of Plans Networks sec. 3342
Program for Prevention of Occupational Injury & Illnesses sec. 3903
Surveillance Programs for Occupational Illnesses sec. 3903
Education Programs for Employees & Employers Regarding Workplace Hazards sec. 3903
Community & Patient Outreach sec. 3461
Payments to Hospitals Serving Vulnerable Populations sec. 3481
Rural Primary Care Hospital sec. 4111
Consumer Grievance Process sec. 1123
Education sec. 3461
Rural Health Care Network sec. 4111
Information & Marketing Standards sec. 1125
Translation Services sec. 3461
Grants to States for Development of Mental Health & Substance Abuse Programs sec. 3531
Limited Service Hospital Program sec. 4111
Case Management sec. 3461
Criteria for Eligible Centers of Specialized Care sec. 1128
Home Visiting sec. 3461
National Quality Council sec. 5001
Alternate Dispute Resolution Mechanisms sec. 5402

Optional
Advisory Committees sec. 5001
National Center for Consumer Advocacy sec. 5009
Health Plan Reports of States sec. 5005

HMO | Fee-for-Service | PPO | POS | Other Managed-Care Networks
Workers Compensation Plans
Optional
National Goals & Performance Measures sec. 5002
Administrator of Agency for Health Care Policy Research sec. 5006
Consumer Report Cards sec. 5005
Prescription Drugs | Providers | Hospitals | Ambulatory | Others
Provider-Based Enrollment Mechanisms sec. 1506
Optional
Survey Administration & Data Analysis sec. 5004
Development & Dissemination of Practice Guidelines sec. 5006
Research On Quality Care Priorities sec. 5007
Large Employer Group Sponsors | Taft-Hartley Plans | Self-Insured Corporations (ERISA) +500 | Association Health Plans sec. 1352
HMO | Fee-for-Service | PPO | POS | Other Managed-Care Networks
Prescription Drugs | Providers | Hospitals | Ambulatory | Others
Individuals & Families | Medicaid | Medicare | Unemployed | Early Retirees
Government Subsidies

Costs of Administering Subsidies in Senator Mitchell's Proposal

	Fiscal Year							
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Non-Medicaid Households With Subsidies (Millions)	32.9	33.1	33.4	34	34.1	39	39	39
Federal Subsidy Costs (Millions $)	6580	6,819	7,087	7,431	7,676	9,042	9,314	9,593

24-Aug

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To GARY CLAXTON From KT

Dept./Agency Phone #

Fax # Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

Estimates of the Number of Uninsured Children Covered Under the Mitchell Bill
(Persons in millions, 1997)

	Eligibles (1)	Insured through Subsidies (2)		Total
		Covered by Low-Income Voucher (3)	Covered by Children's Program (4)	Covered
Uninsured Children (<19yrs)				
Less Than 100% Poverty	3.5	3.3		3.3
100-185% Poverty	3.2	0.0	3.0	3.0
185 - 300% Poverty	1.9	0.0	0.4	0.4
Greater Than 300% Poverty	1.2			
All Uninsured Kids	**9.7**	**3.3**	**3.4**	**6.7**

(1) Based on March 1993 Current Population Survey. Projected to 1997 using CBO growth assumptions for the uninsured.
Note that "poverty" in these estimates includes transfer payments, which will be excluded in the subsidy eligibility determination.
(2) Both the Low-Income Voucher and the Children's Voucher may cover children. To make these categories
mutually exclusive, it was assumed that the children would be covered by the subsidy program that is most generous.
(3) Assumes 95% participation for persons with full subsidies, and 20% participation for those with partial subsidies.
(4) These counts estimate the incremental or additional number of children covered by the children's voucher program.
Assumes 95% participation for persons with full subsidies, and 20% participation for those with partial subsidies.
Totals may not sum due to rounding
24-Aug-94

08/24/94 15:40 ☎202 401 7321 HHS ASPE/HP →→→ JENNINGS 003/003

DRAFT Preliminary Illustration
Mitchell Bill State Maintenance of Effort (MOE) Payments:
With and Without the Non-Cash Portion of Disproportionate Share (DSH) Payments
(Dollars in millions, fiscal years)

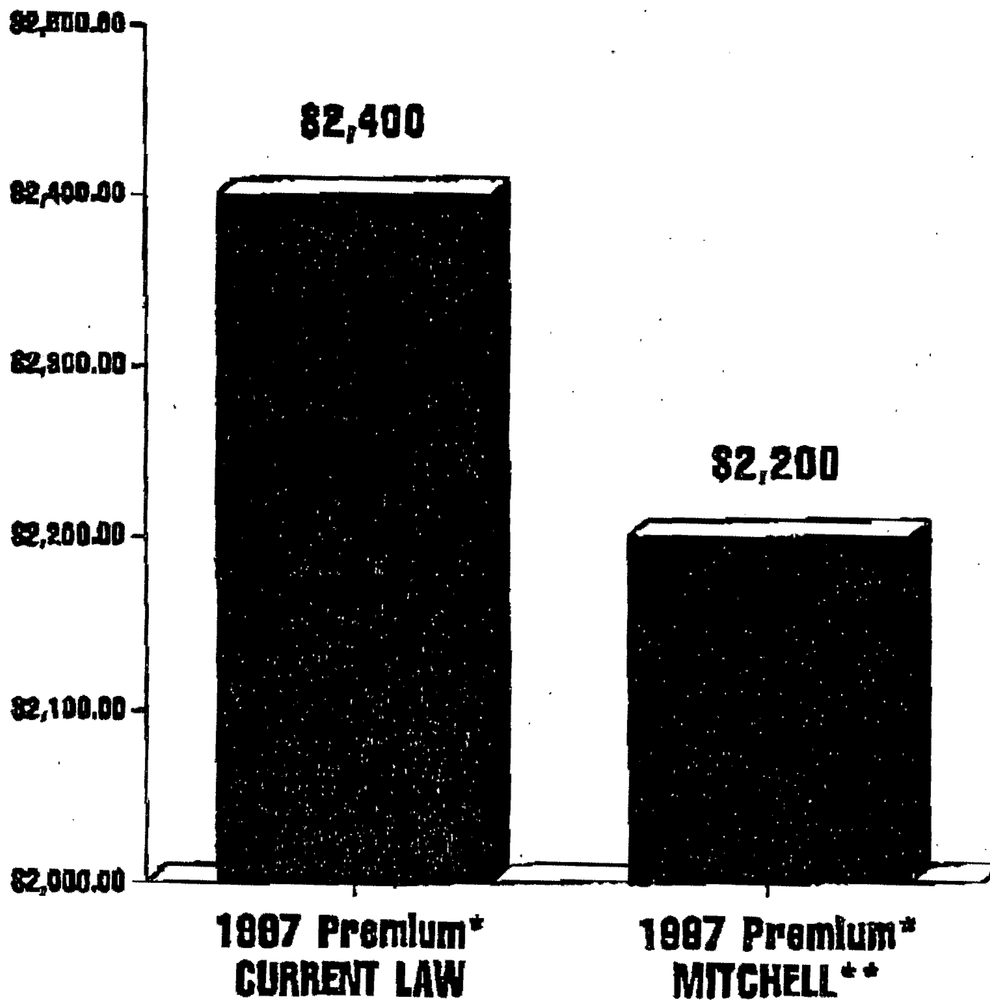
	1997*	1998	1999	2000	2001	2002	2003	2004
MOE (1)	-18.5	-26.5	-28.7	-31.1	-33.6	-36.3	-39.3	-42.4
DSH (2)	-2.2	-3.2	-3.5	-3.7	-4.1	-4.4	-4.8	-5.2
MOE Minus DSH	-16.3	-23.3	-25.2	-27.4	-29.5	-31.9	-34.5	-37.2

*Represents 3/4th of a year, due to implementation on January 1, 1997.
(1) CBO estimates from the Mitchell Bill Analysis
(2) Assumes noncash portion equals 29% of total DSH.
NOTE: Although the "MOE" line was calculated by the CBO, the "DSH" and "MOE Minus DSH" lines were not calculated by CBO.
Thus, CBO may have a different estimate of the non-cash portion of DSH included in the MOE and produce a different estimate of the MOE minus DSH.

24-Aug-94

Mitchell File

Mitchell Bill Will Lower Health Care Costs



*Based on average costs for an individual in a small business with 10 workers.

**Savings result from reducing costs of uncompensated care, and reducing administrative and overhead costs.

Mitchell File Long

INTRODUCTION

- o Universal coverage must be a goal of any reform effort. Not only is universal coverage a humane objective, it is also necessary if we are to control spiralling health care costs and treat fairly those employers who now provide health care coverage.

- o Some have suggested that we can achieve universal coverage without a mandate on employers or individuals.

- o Today I'd like to discuss the issue of mandates in health care reform, and why I think a mandate makes sense as the way to achieve universal health care coverage.

- o The non-partisan Congressional Budget Office concluded that universal coverage would not occur under a voluntary health care system. State experience confirms that voluntary systems would leave many Americans without health care insurance.

- o A mandatory health care system, on the other hand, would lead to universal coverage in CBO's estimation. State experience corroborates this conclusion.

- o And despite claims to the contrary, studies and state experience show that an employer mandate would not have a large net impact on jobs.

CURRENT VOLUNTARY SYSTEM IS NOT WORKING

- An increasing number of Americans are losing health insurance in today's voluntary market. In 1992, 39 million Americans were without insurance, up from 34 million in 1989. By 2004, CBO estimates that 44 million Americans will lack insurance. Among the nonelderly:

  - Most individuals with private insurance -- 63 percent -- receive coverage through an employer, while only 9 percent purchase private insurance through other means.

  - Most of the uninsured -- 84 percent -- are either workers or dependents of workers.

  - The number of Americans with employer coverage dropped by 3 million from 1989 to 1992.

WHY WE NEED UNIVERSAL COVERAGE

- Universal coverage is essential if all Americans are to receive adequate health care. Studies show that the uninsured do not receive timely or appropriate care. And when they finally do seek care, their problems tend to be worse and more expensive to treat.

    - For example, the uninsured are twice as likely as the privately insured to be hospitalized for diabetes, hypertension, and other conditions which could be treated in a doctor's office.

    - And 71 percent of the uninsured report that they postponed seeking care which they felt they needed because they could not afford it, compared to 21 percent of the privately insured.

- Universal coverage is also critical to controlling health care costs. In its analysis of Congressman Cooper's bill, CBO stated that one of the key features of any market-based mechanism to control health care costs is universal health insurance coverage that eliminates cost shifts from the uninsured to the insured.

    - A 1991 Lewin study estimates that one-third of employers' current premium costs result from various forms of cost shifting, the largest part due to working spouses whose employers contribute nothing today. HSA would eliminate most of this cost shifting and significantly lower per worker costs for those employers who offer insurance today.

- Furthermore, health policy experts warn that health insurance market reforms without a mandate could actually increase the number of uninsured as health insurance costs rise for low risk firms and individuals, causing them to drop out of the system, further raising premiums for those in the system, causing more low risk firms and individuals to drop coverage, and so on.

EVIDENCE ON VOLUNTARY SYSTEMS

- Some have suggested that we can achieve universal health care coverage by introducing insurance market reforms and subsidies into the current voluntary system. But both CBO analyses and state experience demonstrate that such voluntary systems will not result in universal coverage.

CBO Analysis of Managed Competition Model:

- In its recent analysis of the Cooper bill, CBO concludes that a voluntary system of health insurance coverage which includes insurance market reforms and large subsidies for lower income households will not solve the problem of the uninsured. Even ten years after enactment CBO predicts 26 million Americans (or 9 percent of the population) would remain uninsured under Cooper.

- And the Cooper plan's partial solution -- which reduces the number of uninsured by just 40 percent -- is achieved only at a very large federal cost. Assuming a benefit package comparable to HSA's, subsidy costs in the Cooper plan exceed savings by $300 billion from 1996 to 2004.

- While providing health insurance to 91 percent of all Americans moves closer to universal coverage, it still leaves out 26 million Americans, and continues the massive cost shifting that occurs in the current system.

State Experience:

- State experience bears out CBO's conclusion that a voluntary system will not achieve universal coverage.

- Several states have unsuccessfully tried to expand health care coverage by providing financial inducements to voluntarily purchase insurance.

    - For example, the Robert Wood Johnson Foundation ran demonstration projects in ten states designed to make health insurance more affordable and available to uninsured small businesses and individuals. Strategies included increased cost sharing, premium subsidies -- up to 50 percent in some cases -- for small firms and limiting pre-existing condition exclusions.

- o But these projects had modest impact: Tampa had the best results, and even there only 17 percent of non-insuring firms under 25 enrolled in the project.

o Critics cite reasons for these dismal results: area businesses were uninformed, the projects were too limited, and they took place in an unreformed insurance market.

- o Yet Florida's universal coverage initiative suggests that even a well-publicized state-wide system which includes voluntary alliances and market reform will not lead to universal coverage.

- o In testimony before the Finance Committee earlier this year, Governor Chiles indicated that Florida's voluntary market-based system will fall far short of its universal coverage goal, insuring only about 50 percent of the currently uninsured, and still leave 10 to 12 percent of all Floridians uninsured after reform.

MANDATORY SYSTEMS ACHIEVE UNIVERSAL COVERAGE

- While a voluntary health insurance system would leave millions of Americans uninsured, a system which requires health insurance coverage would result in universal coverage.

- In its analysis of the President's health care bill, CBO concludes that the HSA's employer/individual health insurance mandate would result in universal coverage.

- Hawaii's experience with a mandatory health insurance system supports CBO's conclusion that a mandatory system would achieve far greater coverage than a voluntary system would.

  - In 1992, only 6 percent of Hawaii's population was uninsured, the lowest rate of any state in the nation, compared to 15 percent nationwide. Coverage is not universal in Hawaii because the state's mandate excludes some groups, such as part-time workers, the unemployed, and dependents of workers.

ECONOMIC IMPLICATIONS OF AN EMPLOYER MANDATE

- Despite claims by some that an employer mandate would destroy jobs, economists agree that an employer mandate with large subsidies for small business as included in the HSA will not have a large net impact on jobs. In fact, employers in general would be financially better off under the HSA's employer mandate, since HSA's lower health care costs and generous employer subsidies reduce businesses' costs. In 2004 alone, CBO estimates that businesses' health costs would drop by $90 billion.

- According to CBO, HSA's net effect on jobs would be minimal, and "would probably have only a small effect on low-wage employment." Researchers at the Employee Benefit Research Institute, Lewin-VHI, the Economic Policy Institute, the Rand Corporation, and the Council of Economic Advisors agree that the HSA's effect on employment would be minimal.

- While some economists suggest there may be fewer jobs in the retail and food service industries under HSA, they also suggest that any losses in those areas should be offset with gains elsewhere, including in manufacturing and health services.

- And although many economists agree that the greatest effect of an employer mandate could be on workers at or near the minimum wage, recent studies even call into question that effect.

  - A Princeton study found that when California raised its minimum wage by 27 percent in 1988, no job loss among low wage workers occurred, and overall employment in the retail trades was unaffected. Similarly, a Harvard-Princeton study found no negative employment effects in the Texas fast-food industry when the federal minimum wage rose by 27 percent between 1990 and 1991.

  - HSA, which would increase costs for the smallest minimum wage firms by no more than 15 cents an hour, should have a similarly small net impact on low wage firms. No firms receiving subsidies under HSA would pay more than 34 cents more an hour for minimum wage workers. In comparison, the last minimum wage increase was $0.90 an hour.

- Actual experience at the state level supports these conclusions. While Hawaii has had an employer mandate in place since 1975, its economy performs better than the national average on several fronts.

  - Since Hawaii instituted an employer mandate, its unemployment rate has dropped relative to the national average, and private non-farm employment has increased almost twice as fast as in the United States as a whole.

  - Hawaii's rate of business failure has been consistently lower than the national average. And Hawaii's small businesses have one of the lowest bankruptcy rates in the nation, and one of the highest rates of business startups.

INDIVIDUAL VS. EMPLOYER MANDATE

- Up until this point, I have limited my discussion of mandates to employer mandates. At this time I'd like to discuss how an employer mandate compares with an individual mandate.

- The HSA, of course, requires both employers and individuals to contribute to the cost of health insurance. Before subsidies, employers pay 80 percent of the average per worker premium, families pay no more than 20 percent of the average premium. Placing the bulk of the responsibility on employers makes sense for several reasons:

  - It builds upon the current system, in which over 90 percent of private insurance is purchased through the workplace with an employer contribution.

  - 84 percent of the uninsured are workers and their families, so it makes sense to cover them through an employer-based system.

- Moreover, poll after poll shows that the American people believe that employers should contribute to their workers' health care costs:

  - An April poll found that 66 percent of Americans favor an employer mandate. In contrast, by a 69 percent to 26 percent margin, voters say the President should veto legislation that covers everyone but requires employees to purchase insurance without help from their employers.

  - A February ABC/Washington Post poll found 73 percent of Americans favor federal law requiring all employers to provide health insurance.

  - A February CBS poll found that Americans favor an employer-based system over an individual requirement 53 percent to 27 percent.

- The alternative to an employer mandate is an individual mandate which absolves businesses of any responsibility to provide health care insurance to their workers. Yet an individual mandate raises several concerns:

- To make health care affordable to low and moderate income individuals, an individual mandate would require substantial federal subsidies. Depending on how generous they are, these subsidies could increase federal costs relative to HSA.

- An individual mandate may reinforce the recent trend of employers dropping coverage. Businesses currently providing coverage may drop it under an individual mandate -- particularly if federal subsidies provide a safety net for their workers. Polling data indicate that this is exactly the outcome the public fears in the absence of an employer mandate.

- Some economists believe that even if employers do drop coverage, workers would be no worse off because employers would increase their wages to reflect any cut in health benefits.

    - However, even if employers did passback wages to their employees, there is no guarantee that it would occur instantaneously, nor that it would be evenly distributed among workers.

    - I know I would have trouble convincing my constituents that they needn't worry about losing their health care benefits because some economists assure me that their bosses will make it up to them with salary increases.

CONCLUSION

- o Despite huge and growing expenditures on health care, more and more Americans are without health insurance.

- o If we are ever to control spiralling health care costs, we must assure that all Americans are in the health care system.

- o The only way to assure health care coverage for all Americans is to mandate coverage. Let me remind you again, CBO estimates that the HSA would result in health care coverage for all Americans, compared to the 26 million left uninsured under a highly subsidized voluntary system with managed competition.

- o State experiences confirm that voluntary systems would leave many more Americans without health care insurance than would a mandatory system.

- o State experience and economic analysis also demonstrate that an employer mandate would not significantly decrease net jobs, and instead would enhance job opportunities for some.

- o An HSA-like employer mandate builds on our current health care system and is favored by the American public. An individual mandate is much less popular with the public, and could be more expensive.

GEORGE J. MITCHELL
MAINE

Mitchell File

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

FOR IMMEDIATE RELEASE
Friday, August 19, 1994

CONTACT: Diane Dewhirst
202/224-2939

**STATEMENT OF SENATE MAJORITY LEADER GEORGE J. MITCHELL
REGARDING HEALTH CARE REFORM PROPOSAL**

Upon introduction of my health care bill on August 2, I said that I welcomed constructive suggestions and alternatives to my proposal. Since that time a number of Senators have conveyed to me their recommendations for how my bill could be improved. I have taken all suggestions seriously and have given them careful thought.

Today I received the recommendations of a bipartisan group led by Senators Chafee and Breaux. I am in the process of carefully considering their recommendations. I hope to respond early next week. I believe there are a number of areas on which we will agree and others that may need to be resolved by the full Senate.

As I review these recommendations, I will consult with other colleagues. I hope the result of all of our efforts will enable the Senate to reach agreement on a bill that will give all Americans the health care security they deserve.

- 30 -

To Chris

Date 9/1/93 Time 3:15

WHILE YOU WERE OUT

M Parashar

of

Phone

Area Code Number Extension

TELEPHONED		PLEASE CALL	✓
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	

RETURNED YOUR CALL

Message Sen Mitchell will be on Meet the Press Sun. Whole program is on health reform

McDermott D-WA } other guests
Armey R-TX }

Operator

AMPAD EFFICIENCY® 23-021 - 200 SETS 23-421 - 400 SETS CARBONLESS

Please review fax tonight + call tomorrow AM with comments/additions. Thanks

Senator Mitchell

GEORGE J. MITCHELL
MAINE

United States Senate
WASHINGTON, DC 20510-1902

FAX COVER SHEET

TO: Chris Jennings

FR: Parashar Patel, Senator Mitchell's Office

DATE: 9/1/93

Number of pages, including cover: 3

If there are problems, please contact us at 202/224-5344.

Chris,
This is what we did for Mitchell in early Aug. Please update as appropriate.

I don't think he'll discuss any of the specifics, but he should know the details just in case.

Please feel free to add anything else you think he ought to know.

Thanks

[signature]

Policy

Key policy elements of the President's plan can be summarized as follows:

- the plan provides universal coverage for all American citizens and permanent residents through regional health alliances;
- a uniform comprehensive benefits package will be provided by health plans through alliances;
- employees of firms with 5,000 or fewer employees will obtain coverage through health alliance; employees of firms with more than 5,000 will obtain coverage through the firm's corporate alliance or, at the firm's option, through health alliance;
- corporate alliances must follow many of the same rules as health alliances; they will have flexibility on other issues;
- Medicare, and Department of Defense (CHAMPUS) systems will remain separate for the short-term; they may be integrated into the larger system after a number of years;
- Veterans and Indian health systems will operate like health plans; Veterans and Indians will have a choice of enrolling with their own systems or with health plans open to the public;
- all federal, state, and local government employees will be part of health alliances (irrespective of size of employer);
- employers will pay 80% of the average premium in the alliance where employee lives; the employee will pay the difference between the employer's share and the premium for the plan chosen by the employee;
- services in the comprehensive benefit package will include most services currently provided by major insurers and HMOs and most BC/BS organizations;
- states will be required to establish health alliances which must conform to minimum federal guidelines regarding size, borders, premium rating, etc.; only one health alliance per region
- alliances must make sure premium increases meet federally set budgets, but states will be responsible for overruns in the long-term;
- health alliances will negotiate with health plans to provide benefit package; will the ability to refuse to contract

because of price, quality, discrimination, etc.; and

- there will be additional funds and programs to improve public health infrastructure, gradually change delivery systems, reduce administrative costs, and reform the malpractice system.

While many issues have been resolved, there are a number of unresolved issues:

- the financing mechanism, i.e., the mechanism by which employers and individuals will pay premiums, has not been finalized;
- other key, unsettled financial issues include: (1) the amount and mechanism for subsidies for unemployed individuals, low-income individuals, and low-wage businesses and (2) the tax treatment of health benefits.
- Medicaid recipients will be integrated into the system; there are several options under consideration to determine how such integration will occur.