Moynihan File (CBO)

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

July 28, 1994

Honorable Daniel Patrick Moynihan
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office and the Joint Committee on Taxation have prepared the enclosed preliminary analysis of the Health Security Act, as ordered reported by the Committee on Finance on July 2. If you have any questions about this analysis or would like further information, please call me, or have your staff contact Paul Van de Water (226-2800) or Linda Bilheimer (226-2673).

Sincerely,

Robert D. Reischauer

Enclosure

cc: Honorable Bob Packwood
Ranking Minority Member

A PRELIMINARY ANALYSIS OF THE HEALTH SECURITY ACT AS REPORTED BY THE SENATE COMMITTEE ON FINANCE

July 28, 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 the Health Security Act, as ordered reported by the Senate Committee on Finance on July 2, 1994. The analysis is based on the description of the Chairman's mark of June 28, the errata sheet of June 29, the amendments adopted during the Committee's markup, and information provided by the Committee's staff. Although CBO and JCT have worked closely with the staff of the Committee, the estimate does not reflect detailed specifications for all provisions or final legislative language and must therefore 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. The analysis also includes a description of the major assumptions that CBO has made affecting 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

The Health Security Act, as ordered reported by the Senate Committee on Finance, aims to increase health insurance coverage by reforming the market for health insurance and by subsidizing its purchase. In the Congressional Budget Office's estimation, the proposal would add about 20 million people to the insurance rolls, and the number of uninsured would drop to 8 percent of the population. Initially, the proposal would add to national health expenditures, but by 2004 national health expenditures would be slightly below the baseline. Over the period from 1995 to 2004, the proposal would slightly reduce the federal budget deficit, and it would ultimately reduce state and local government spending as well.

The estimated effects of the proposal are displayed in the four tables at the end of this document. Table 1 shows the effect on federal outlays, revenues, and the deficit. Table 2 shows the effects on the budgets of state and local governments. Tables 3 and 4 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 bill reported by the Committee on 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 the Finance Committee's proposal, CBO and JCT have made the following major assumptions about its provisions.[1]

Health Insurance Benefits and Premiums

The Finance Committee'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 general, workers in firms with fewer than 100 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 100 or more workers would be experience-rated. The estimated average premiums in 1994 for the standard benefit package for the four types of policies are as follows:

	Community-Rated Pool	Experience-Rated Pool
Single Adult	$2,330	$2,065
Married Couple	$4,660	$4,130
One-Parent Family	$4,544	$4,027
Two-Parent Family	$6,175	$5,472

In addition, separate policies would be available for children eligible for subsidies, as explained below. Supplementary insurance would be available to cover cost-sharing amounts and services not included in the standard benefit package.

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).

Subsidies

The proposal would establish a system of premium subsidies for low-income people to encourage the purchase of health insurance. 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. The partial subsidies would be phased in between 1997 and 2000 by gradually increasing the income eligibility level. In addition, children and pregnant women with income up to 240 percent of the poverty level would be eligible for special subsidies.

In determining eligibility for premium subsidies, a family's income would be compared with the federal poverty threshold for that family's size, except that the threshold would be the same for families with four or more members. The estimate assumes that this limitation would apply for computing both regular subsidies and the special subsidies for children and pregnant women.

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. The estimate also assumes that, except in 1997, the same formula would be used in each year to compute the amount of the subsidy, but that during the phase-in period no subsidies would be available to people above the applicable eligibility level.

Families would not be eligible, the estimate assumes, for both regular premium subsidies and special subsidies for children and pregnant women, but they could choose to receive the larger one. Families could use the special subsidies to help purchase coverage for the entire family, or they could purchase coverage only for the eligible children and pregnant women.

Families, children, and pregnant women with income below the poverty threshold would also be eligible for reduced cost sharing, as determined by the National Health Benefits Board. The estimate assumes that the board would require nominal cost-sharing payments. Health insurance plans would be required to absorb the cost of this reduced cost sharing. In addition, states would have the option of providing subsidies for cost sharing for people with income between 100 percent and 200 percent of the poverty level. The federal government would pay up to $2 billion a year to assist the states in providing these optional cost-sharing subsidies, and states would have to pay the rest of the cost.

The system of subsidies would be administered by the states. States would have the option of providing subsidies to eligible people beginning in 1996 and would be required to provide subsidies starting in 1997. Because of the difficulties involved in setting up the necessary administrative apparatus, the estimate assumes that states would not begin paying subsidies until 1997.

Medicaid and Medicare

Medicaid beneficiaries not receiving Supplemental Security Income 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. Medicaid would continue to provide these beneficiaries with a wraparound benefit covering certain health care services not included in the standard benefit package. States would be relieved of their portion of Medicaid costs for these beneficiaries but would be required to make maintenance-of-effort payments to the federal government. The estimate assumes that these maintenance-of-effort payments would equal the appropriate portion of the states' Medicaid spending in 1994, increased in subsequent years by the rate of growth of national health expenditures plus an adjustment factor. The adjustment factor would equal 1 percentage point through 1997 and would be gradually reduced to zero by 2002.

The proposal would gradually phase out federal Medicaid payments to disproportionate share hospitals (DSHs). The estimate assumes that DSH payments would be limited to 10 percent of medical assistance payments in 1997, 8 percent in 1998, 6 percent in 1999, and 4 percent in 2000. In 2001, DSH payments would be repealed and would be replaced by a program to make payments to vulnerable hospitals. That program would have an annual appropriation of $2.5 billion.

Among the proposed changes in Medicare is a revision in the method of reimbursing Medicare risk contractors. The estimate assumes that this provision is intended to even out reimbursement rates without adding to total costs.

Revenues

The Committee's amendment that added the special subsidies for children and pregnant women also provided that the cost of these subsides would be covered by proportional increases in all of the revenue-raising measures in the proposal, as needed to keep the proposal from adding to the deficit. The estimate includes additional revenues of $13.6 billion over the 1996-2001 period as a result of this provision.

Fail-Safe Mechanism

In the present estimates, the fail-safe mechanism would not be called into play. If necessary, however, the proposal would scale back eligibility for premium and cost-sharing assistance, reduce the new tax deductions, and increase the out-of-pocket limits in the standard benefit package to prevent the proposal from adding to the deficit over a period of years. The deficit would be allowed to increase in any one year, however, but by no more than the amount of any cumulative savings from previous years.

Unforeseen circumstances--such as a major recession, an acceleration in the growth of health care costs, or a more rapid increase in the number of Medicare or Medicaid beneficiaries--could create a shortfall in funding and trigger the fail-safe mechanism. Although the proposal would give the Administration some flexibility in offsetting any unfinanced health spending, 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 reduce the extent of health insurance coverage.

OTHER CONSIDERATIONS

Like other fundamental reform proposals, the plan reported by the Senate Committee on Finance 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 adjustment 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.

In CBO's judgment, however, there exists 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 possible difficulty as well as some other possible consequences of the proposal.

Risk Adjustment

The proposal, like most others, assumes that an effective system could be designed and implemented to adjust health plans' premiums for the actuarial risk of their enrollees. In fact, the feasibility of developing and successfully implementing such a mechanism in the foreseeable future is highly uncertain. Inadequate risk-

adjustment techniques would have adverse consequences for both the community-rated and the experience-rated health insurance markets.

The primary purpose of the risk-adjustment system in the community-rated market would be to redistribute premium payments among health plans, compensating them for differences in risk. Without effective risk adjustment, the profitability of health plans in those markets would be partly determined by the plans' skill in attracting relatively healthy people. Since high-cost plans would be subject to a premium tax under this proposal, an effective risk adjustment would also be important to ensure that health plans were not taxed because their enrollees presented a higher risk.

While there would be no risk-adjustment payments in the experience-rated market, each plan that was not self-insured would have to have a risk-adjustment factor in order to determine whether it was liable for the tax on high-cost plans. Developing such factors would be extraordinarily difficult because the agency responsible for doing that would have to collect and analyze significant amounts of information from the many health plans, some of which would be very small, that made up the experience-rated market.

States' Responsibilities

Virtually all proposals to restructure the health care system incorporate major additional administrative, monitoring, and oversight functions that some new or existing agencies or organizations would have to undertake. A key question with any proposal is whether the designated organizations would have the appropriate capabilities and resources to perform their roles. In the Senate Finance Committee's proposal, states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether--and, if so, how soon--some states would be ready to assume them.

The states' primary responsibilities under the proposal would fall into four broad 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.

Determining Eligibility for Subsidies and Medicaid. The task of establishing and monitoring eligibility for subsidies would be an enormous one for states, even without the complications resulting from the dual structure that would subsidize premiums using two sets of rules (discussed in more detail below). According to CBO's estimates, in the year 2000, about 30 million families and single individuals would be receiving subsidies for health insurance premiums at any time. The actual number of applications would be much greater than that because of changes in employment, family status, or geographic location during the year. In addition, because Medicaid would be required to provide wraparound benefits, states would have to continue to operate their Medicaid eligibility systems using income criteria for families with more than four members that were different from the criteria used by the premium subsidy program.

States would also 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, although federal income tax information could be used, many of the families receiving subsidies would not be tax filers. Moreover, the process would require extensive interstate cooperation in order to track people who moved from one state to another during the year.

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 subsidy payments to health plans and engage in outreach efforts to encourage enrollment of the low-income population. Health plans would be required to have an open-enrollment period of 90 days during the first year and only 30 days in all subsequent years. Establishing effective outreach programs would therefore be essential to ensure that low-income people enrolled in health plans during the open-enrollment window.

The optional programs in which states could participate would also have major administrative components. States electing to subsidize cost sharing for people with income between 100 percent and 200 percent of the poverty level would be responsible for administering those subsidies. Similarly, states would have to administer the complex system of subsidies incorporated in the proposal if they chose to expand home- and community-based services for the disabled. States could also choose to enroll beneficiaries of the Supplemental Security Income program in health plans, in which case they would have to negotiate separate premiums.

Establishing the Infrastructure for the Effective Functioning of Health Care Markets. States would be required to designate the geographic boundaries for the community-rating areas as well as the service areas for implementing the provisions regarding essential community providers. The liability for the tax on

high-cost community-rated and experience-rated plans would be calculated separately for each community-rating area. In addition, states would have to sponsor or establish purchasing cooperatives to serve those community-rating areas in which none were established voluntarily.

States would also have ongoing responsibilities for ensuring that health care markets functioned effectively. Those responsibilities would include establishing the system for adjusting premiums for risk, operating reinsurance pools until the risk-adjustment system was operating effectively, and redistributing losses resulting from the requirement that plans absorb the cost-sharing expenses for people with income below the poverty threshold.

Providing consumers with the necessary information to make informed choices among health plans would be another function of the states. States would be required to produce annual, standardized information comparing the performance of health plans in each community-rating area; they would also distribute that information, educate and provide outreach to consumers, and respond to complaints from consumers. To do all that effectively would require that states establish extensive systems for reporting and analyzing data and qualitative information. They would also be responsible for ensuring that health plans met federal standards for data reporting.

Regulating and Monitoring the Health Insurance Industry. The responsibilities for certifying insured health plans, self-insured plans that operated in one state only, and insurance plans for long-term care would all fall on the states. So too would the task of enforcing the new health insurance standards. Consequently, the duties of state insurance departments would grow considerably. Not only would they be responsible for many more health plans than they oversee today, but the activities they would have to monitor would be much more extensive. States would be encouraged to use private accreditation organizations to assist them with these tasks.

States would, moreover, be required to act in the event that health plans did not meet federal standards. For example, they might have to operate failed or noncompliant health plans for a transitional period to ensure continued access for the plans' enrollees, develop corrective programs, or design other options.

States would have to develop and implement programs to recover payment from automobile insurers for medical services resulting from automobile accidents. These programs would be required to have electronic data bases and include mechanisms for resolving liability issues or disputes rapidly.

At present, state insurance departments vary widely in their capabilities. It seems doubtful, therefore, that all of them would be ready for such an expanded role by 1997.

The Dual System of Subsidies

The proposal includes two subsidy schedules--one for low-income families and the other for low-income children and pregnant women. The two subsidy schemes would have to be integrated because children and pregnant women are a part of families; but integrating them in a sensible and administrable fashion would be extremely difficult. As now structured, the dual system of subsidies would create a confusing array of options from which low-income families would have to choose, would greatly complicate state administration of the already burdensome processes for determining eligibility and reconciling subsidies at year-end, and could result in real or perceived inequities in the treatment of low-income families.

In making its estimates, CBO assumed that no family could participate in both subsidy schemes at the same time but that families could choose whichever scheme gave them the larger subsidy. Permitting families to participate in both programs concurrently--for example, by obtaining special subsidies for the children individually as well as regular subsidies for single or dual policies for the parents --could cause the estimated cost of the subsidies to be somewhat higher than that shown in Table 1.

Insurance Costs for Moderate-Sized Firms

As is the case under other proposals that limit participation in the community-rated market to small firms and nonworkers, some moderate-sized firms--those with 100 to 300 or 400 employees--might face relatively high costs for coverage under the Senate Finance Committee's proposal. Just as they do under the current system, such firms would have to either self-insure or offer coverage through the experience-rated market. Moreover, they would be required to provide their employees with a choice of three plans, including a fee-for-service plan. Thus, the enrollment in some of those plans could be extremely small, especially since some employees in families with two workers could obtain their coverage elsewhere.

Small enrollments would, in turn, result in high administrative costs. Furthermore, because the firm's premiums would be experience-rated, a single employee with a costly medical problem could raise the firm's premiums significantly. Some plans could end up with ever-increasing premiums and

shrinking enrollment as people who could obtain cheaper coverage through their spouse's employer left the plan, raising its premiums further. At a minimum, employees would no longer have a realistic choice of three plans, and in extreme cases, all three plans might be quite expensive. In principle, individuals with income below the poverty level enrolled in such plans would be fully subsidized, but in fact they might have to contribute to the costs of their coverage if the premiums for all three plans were above the average for the community-rated market, which determines the maximum possible subsidy.

Tax on High-Cost Health Plans

The proposed tax on high-cost health plans would be difficult to implement. It would, moreover, result in different effective tax rates on excess premiums of the health plans offered by different insurers or sponsors. These differences might be viewed as arbitrary because they would vary significantly within and among community-rating areas.

The tax would be imposed at a 25 percent rate on the amount by which high-cost premiums exceeded a target premium set for each community-rating area. Various adjustments would be made to premiums to determine which plans would be classified as having high costs. Those adjustments would be difficult to make. Moreover, some of the necessary adjustments--such as those for differences in risk and the cost of living among geographic areas--would require data and methodologies that do not now exist.

The effective tax rate on excess premiums would generally be much higher than the statutory rate of 25 percent for two reasons. First, unlike most other excise taxes, this one would not be a deductible expense for health plans and self-insured employers; in effect, the tax would be paid from after-tax, rather than before-tax, profits. Second, if insurers that expected to be subject to the tax increased their premiums to reflect the additional tax liability, both their excise tax and income tax liabilities would also rise. As a result, the effective tax rate on excess health insurance premiums would not be 25 percent but 62.5 percent for most plans offered by taxable insurers and 33 percent for nontaxable (nonprofit) insurers. Self-insured employers who reduced other compensation to offset their higher expenses for health benefits would face an effective tax rate of 38.5 percent if they were taxable corporations and 25 percent if they were nontaxable sponsors of a health plan.

Although the tax would provide incentives for insurers to offer lower-cost plans, how insurers would actually respond is unclear. Because the calculation of the tax would be based on the combined cost of standard and supplemental policies, insurers might, for example, try to discourage enrollees from purchasing

supplements by raising those premiums considerably. Alternatively, they might not offer supplemental policies at all. A more fundamental problem for insurers is that they would not know the target premium--and, hence, their potential tax liability--at the time they established their premiums because those targets would be announced 90 days after the end of each open-enrollment period. That uncertainty would tend to increase the margins between insurance premiums and expected payouts as insurers attempted to protect themselves from the possibility that their plan would be considered a high-cost plan and thus subject to the tax.

The tax might be considered inequitable for a variety of reasons. In some community-rating areas, a small number of health plans--perhaps two or three--might dominate the market. Using the criterion that high-cost plans covered 40 percent of the primary insured population in an area could necessitate highly arbitrary decisions in the face of such indivisibilities. (For example, the highest-priced plan might cover 20 percent of the primary insured population while the top two plans covered 60 percent.) In the experience-rated market--if accurate risk-adjustment factors cannot be developed--small plans with little ability to control their premiums might well be the ones subject to the tax. Finally, plans in some areas of the country with low payments to providers and parsimonious practice patterns might be subject to the tax even though they were far less costly (even after the required adjustments) than nontaxed plans in other areas. This result could occur in spite of the fact that plans with adjusted premiums in the lowest quartile nationwide would not be subject to the tax.

Reallocation of Workers Among Firms

The proposal would encourage a reallocation of workers among firms and, in doing so, would increase its budgetary cost. This sorting would occur because the subsidies could be reduced by up to the amount that employers contributed for insurance; therefore, a worker employed by a firm that paid for health insurance would receive a smaller subsidy than a worker at a firm that did not pay. Some low-income workers could gain thousands of dollars in higher wages by moving to firms that did not contribute to employee health insurance, and a significant number of them would probably do so. That process would occur gradually as employment expanded in some firms and contracted in others. In the CBO estimate, this reallocation of low-wage workers among firms accounts for $12.6 billion of the cost of the subsidies in 2004.

In addition, some companies might stop paying for insurance, but the effect of that action on the government's costs would probably not be large, for several reasons. For one thing, the number of firms that would be likely to stop paying is limited because, if firms did so, high-wage workers in those firms would lose the tax benefits of excluding health insurance from the payroll tax. Moreover, the

net additional subsidy cost to the government from low-income workers in firms that dropped coverage would be largely offset by higher tax revenues from the workers because, without employer-paid coverage, wages would be higher.

Last, reducing subsidies by up to the amount that employers pay for insurance would mean that people with similar incomes and family circumstances would not be treated alike. In particular, workers at firms that paid for insurance would face larger costs for their insurance than similarly placed counterparts at firms that did not pay.

Work Disincentives

Like other reform plans with substantial subsidies, the Senate Finance Committee'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. For example, the subsidies for low-income families would be phased out as family income rose between 100 percent and 200 percent of the poverty threshold, and those for low-income children and pregnant women would be phased out between 185 percent and 240 percent of poverty. In both cases, many workers who earned more money within the phaseout range would have to pay more for their own or their children's health insurance, thereby cutting into the increase in their take-home wage. In essence, phasing out the subsidies would implicitly tax their income from work.

Estimating the precise magnitude of the implicit tax rates requires information that is not readily available, but rough calculations suggest that the rates could be substantial. In 2000, for example, the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies and 20 to 40 percentage points for workers in families choosing the subsidies for pregnant women and low-income children. Moreover, those levies would be piled on top of the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, the phaseout of the earned income tax credit, and the loss of eligibility for food stamps. In the end, some low-wage workers would keep as little as 10 cents of every additional dollar they earned.

If the employer did not pay for insurance, the implicit marginal rates from the phaseout of low-income subsidies would apply to workers whose income was within the broad range of 100 percent to 200 percent of the poverty level. But if the employer paid some of the costs for insurance, these marginal levies would apply to workers in a much smaller income range. Although this treatment of employer payments would reduce the size of the working population affected by higher marginal levies, it would create the previously described incentive for workers to move to firms that did not pay for insurance.

TABLE 1. PRELIMINARY ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(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	-24.6	-36.7	-41.0	-45.8	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-16.8	-24.0	-26.2	-28.4	-30.8	-33.4	-36.2	-39.2
3 Disproportionate Share Hospital Payments	0	0	-4.1	-7.0	-9.5	-11.6	-18.8	-20.7	-22.9	-25.2
4 Long Term Care Program/Change Fed Match	2.5	2.8	3.1	3.5	3.9	4.4	4.9	5.5	6.1	6.9
5 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total, Medicaid	2.5	2.8	-42.7	-64.7	-73.3	-82.0	-96.5	-106.3	-116.9	-128.1
Medicare										
6 Part A Reductions										
PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reduction	0	-0.7	-0.8	-0.8	-0.9	-1.0	-1.2	-1.3	-1.4	-1.6
Disproportionate Share Hospital Reductions	0	0	0	-0.9	-1.2	-1.3	-1.4	-1.5	-1.7	-1.9
PPS-Excluded Payment Changes	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Sole Community Hospitals	s	s	s	s	s	s	s	s	s	s
Medicare Dependent Hospitals	s	0.1	0.1	0.1	s	s	0.0	0.0	0.0	0.0
Long Term Care Hospitals	s	s	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
7 Essential Access Community Hospitals										
MAF 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
8 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
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Elim Formula Driven Overpayments	-0.5	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Eye & Eye/Ear Specialty Hospitals	s	s	s	0	0	0	0	0	0	0
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Competitive Bid for Part B	s	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	s	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Nurse Pract/Phys Assistant Direct Payment	0	0	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.6
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.8	-0.8	-2.8	-5.2	-8.2	-10.6
9 Parts A and B Reductions										
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	s	s	0	0
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Risk Contracts	s	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total, Medicare	1.3	2.9	-1.5	-3.6	-11.5	-21.0	-26.3	-32.6	-40.0	-47.4

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Other Health Programs										
10 Vulnerable Hospital Payments	0	0	0	0	0	0	2.5	2.5	2.5	2.5
11 Home and Community Based Care Program	0	0	0.3	0.7	1.0	1.4	1.6	1.7	1.9	2.0
12 Academic Health Centers Trust Fund	0	4.7	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
13 Grad Medical & Nursing Education Trust Fund	0	2.7	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
14 Medicare Transfer - Graduate Medical Education	0	-1.6	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
15 Medicare Transfer - Indirect Medical Education	0	-4.2	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
Total - Other Health Programs	0	-1.6	-4.6	7.2	9.1	10.8	14.3	15.3	16.3	17.2
Designated Urban/ Rural Health Care Access										
16 Investment in Infrastructure Development (Loans	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Total - Urban/Rural Access	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Subsidies										
Premium Subsidies:										
17 Persons between 0-200% of Poverty	0	0	52.4	86.2	97.6	109.3	121.0	133.6	147.3	161.2
18 Pregnant Women and Kids 0-240% of Poverty	---------- Included in Line 17 ----------									
Cost-Sharing Subsidies:										
19 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	53.7	88.2	99.6	111.3	123.0	135.6	149.3	163.2
Administrative Expenses										
20 Mandatory Administrative Expenses c/	0	0	2.4	4.0	4.3	4.7	4.8	4.9	4.9	5.0
MANDATORY OUTLAY CHANGES	1.4	1.8	13.9	26.5	25.5	24.2	19.6	17.2	14.0	10.4
DISCRETIONARY OUTLAYS										
Administrative Expenses										
21 Administrative and Start-Up Costs	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1
Studies, Research, & Demonstrations										
22 Network and Plan Development Grant Program	0.1	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.3
23 Operating Asst - Telemedicine Demonstrations	0.1	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
24 Capital Investment - Grants	0.1	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
25 Biomedical & Behavioral Research Trust Fund	0	0.7	1.2	1.4	1.5	1.6	1.7	1.9	2.1	2.2
26 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research & Demonstrations	0.4	1.6	2.1	2.5	2.5	2.6	2.7	3.0	3.2	3.4
DISCRETIONARY OUTLAY CHANGES	0.9	2.6	3.3	3.5	3.5	3.6	3.7	4.0	4.2	4.5
TOTAL OUTLAY CHANGES	2.3	4.4	17.1	30.0	29.0	27.7	23.3	21.2	18.2	14.8
RECEIPTS										
27 Increase in Tax on Tobacco Products	13.9	16.3	15.4	15.0	14.3	13.9	13.5	11.3	11.1	10.9
28 1.75% Excise Tax on Pvt Health Ins Premiums	0	3.5	6.2	7.2	7.8	8.5	9.2	10.0	10.9	11.8
29 Addl Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
30 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
31 Include Certain Svc-Rein Income in SECA and Excl Certain Invn-Rein 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
32 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
33 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rule	0	a	a	a	a	a	a	a	a	a
34 Repeal Flexible Spending Arrangements	0	0.3	0.5	0.7	1.1	1.3	1.4	1.4	1.4	1.5
35 Extend 25% Ded for Health Ins Costs of Self-Employed Individuals	-0.5	-0.3	0	0	0	0	0	0	0	0
36 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
37 Deduct for Individuals Purchasing Own Health In	0	-1.4	-5.5	-8.1	-8.4	-8.7	-9.1	-9.8	-10.4	-11.0
38 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Sv	---------- Negligible Revenue Effect ----------									
39 Trmt of Certain Ins Co with Regard to Sect 833	---------- Negligible Revenue Effect ----------									
40 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
41 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
42 Clarify Tax Trmt of Long Term care Ins & Svcs	0	a	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4
43 Tax Trmt 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
44 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

Continued

TABLE 1. Continued

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
45 Post-Retirement Med & Life Ins Reserves			---------- Negligible Revenue Effect ----------							
46 Modify COBRA Continuation Care Rules			---------- Negligible Revenue Effect ----------							
47 Tax Credit for Practitioners in Underserved Area	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
48 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
49 Tax Credit for Cost of Personal Asst Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
50 Disclosure of Return Info to State Agencies			---------- No Revenue Effect ----------							
51 Exempt Doctors from Section 457 Limits	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
52 Impose Prem Tax with Respect to Certain High Cost Plans	0	a	0.9	1.4	1.6	1.7	1.9	1.8	1.9	2.0
53 Indirect Tax Effects of Changes in Tax Trmt of Employer & Household Health Ins Spending	0	a	1.2	1.4	1.4	1.4	1.4	1.6	1.5	1.5
TOTAL RECEIPT CHANGES	13.3	19.8	21.3	19.8	20.3	21.1	21.8	20.3	21.3	22.6
DEFICIT										
MANDATORY CHANGES	-11.9	-18.0	-7.4	6.7	5.2	3.1	-2.2	-3.1	-7.3	-12.2
TOTAL CHANGES	-11.0	-15.4	-4.2	10.2	8.7	6.6	1.5	0.9	-3.1	-7.7
CUMULATIVE DEFICIT EFFECT	-11.0	-26.4	-30.6	-20.3	-11.6	-5.0	-3.4	-2.6	-5.6	-13.3

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.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

c. States would have substantial administrative responsibilities under this plan.

TABLE 2. PRELIMINARY ESTIMATES OF THE STATE AND LOCAL BUDGETARY EFFECTS OF THE HEALTH SECURITY ACT AS REPORTED BY THE COMMITTEE ON FINANCE

(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-18.4	-27.5	-30.7	-34.3	-38.4	-42.7	-47.3	-52.3
2 State Maintenance-of-Effort Payments	0	0	16.8	24.0	26.2	28.4	30.8	33.4	36.2	39.2
3 Disproportionate Share and Vulnerable Hospital Payments a/	0	0	0.5	0.9	1.2	1.4	-0.2	0.0	0.3	0.6
4 Administrative Savings	0	0	-0.2	-0.4	-0.4	-0.5	-0.5	-0.6	-0.6	-0.7
Total - Medicaid	0	0	-1.3	-3.0	-3.7	-5.0	-8.3	-9.9	-11.4	-13.2
Cost-Sharing Subsidies:										
5 Persons between 0-200% of Poverty b/	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Total - Subsidies	0	0	1.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Administrative Expenses										
6 Expenses Associated with Subsidies	0	0	0.8	1.2	1.3	1.5	1.5	1.5	1.5	1.6
7 General Admin and Start Up Costs	0	1.4	2.2	2.4	2.4	2.5	2.7	2.8	3.0	3.2
8 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	1.7	3.0	3.7	3.9	4.1	4.3	4.5	4.7	4.9
Total State and Local Budgetary Impact	0	1.7	3.0	2.7	2.1	1.1	-2.0	-3.4	-4.7	-6.2

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.

b. The states would have the option to provide funding for cost-sharing subsidies for persons below 200% of poverty.

Table 3. 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
	Health Security Act as Reported by the Committee on Finance							
Insured	241	244	246	249	251	253	255	257
Uninsured	23	22	22	21	21	21	21	21
Total	264	266	268	270	272	274	276	278
Increase in Insured	16	18	19	20	20	21	22	23
Uninsured as Percentage of Total	9	8	8	8	8	8	8	8

SOURCE: Congressional Budget Office.

Table 4. 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
Health Security Act as Reported by the Committee on Finance	1,297	1,403	1,515	1,635	1,761	1,903	2,055	2,218
Change from Baseline	34	32	27	21	13	9	3	-2

SOURCE: Congressional Budget Office.

Moynihan File

DANIEL PATRICK MOYNIHAN
CHAIRMAN

LAWRENCE O'DONNELL, JR.
STAFF DIRECTOR

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, D. C.

May 13, 1994

Dear Harold:

As the chairman raced to the airport this afternoon, he asked me to send you the clips on the President's trip to New York. As today's Newsday editorial makes clear, the net effect of the trip was to make it impossible for the Chairman to support comprehensive health care reform legislation that does not change the medicaid formula.

We didn't know what the trip was designed to accomplish, but now we know what it did accomplish.

Sincerely,

Lawrence O'Donnell, Jr.

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The White House
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Thanks, But. . .

Clinton admits Medicaid funding is unfair to New York; he mustn't wait to correct it.

In addition to the traffic jams that always accompany his visits to the Big Apple, President Bill Clinton brought something more positive when he visited New York City on Monday: an admission that the federal Medicaid formula discriminates against New York State and ought to be changed.

To call it a *frank* admission might be stretching it a bit. What Clinton said was that "states like New York with high per-capita incomes but huge numbers of poor people are not treated quite fairly under a formula that only deals with per-capita income." And while he conceded there was "no question that the formula should be changed," the president clearly doesn't want this change to be part of his already bulky health-care package.

He'd rather appoint a commission to study the whole issue until 1995. He mustn't be allowed to get away with this. New York is in an excellent position right now to improve the Medicaid formula, and its position will almost certainly be weaker next year.

The state's two top Democrats have a powerful interest in making sure the formula is dealt with in the health-care reform process. Gov. Mario Cuomo is running for a fourth term, and a bigger helping of Medicaid funding from Washington would play very well in the state's voting booths. And Sen. Daniel Patrick Moynihan, as chairman of the Finance Committee, has great leverage because health-care reform must pass through his bailiwick on its way to the statute books.

In New York and other relatively prosperous states, Washington currently covers only 50 percent of Medicaid costs; in others the federal share runs as high as 83 percent. This is partly because New York is more generous with Medicaid benefits than Mississippi — but then living costs in Babylon or the Bronx are considerably higher than they are in Biloxi.

Officials here have come up with a Medicaid formula that would bring the state as much as $1.1 billion more a year from Washington, but getting more favored states to give up some of their funding won't be easy. All the more reason for Clinton to reconsider his opposition to *any* increase in broad-

M Baucus Boren

Wednesday Farmers Together to Finance Members → Ask Pat

Stakeholders window afternoon

ND · Conrad
LA · Breaux
OK · Boren
MT - Baucus

Grassley
Danforth
Durenberger

Iowa NB
Kerrey
MN

- ~~Tuesday~~ Thursday - Rural/Farm calls

- Discuss Day or ~~Thursday~~ → Rural Crowd Tuesday — East Front

— Wednesday Leadership Meeting.

· Tuesday morning Leadership
· [illegible]

— Thursday - Rural/Farm Finance

June 13th — July 7th.

16th 17th - Chicago - World Cup Soccer

24th → Fundraiser Capital Marriott

23rd 24th - ~~Event~~ Jersey City Fundraising

June health quarter.

Today / Myself
Phil crowd
What states

Draft Outline for Senate Finance Committee Chairman's Mark

Moynihan Fly

Health Security Act of 1994

I. Insurance Reforms

A. Guaranteed Issue: Require insurers to accept all applicants.

B. Guaranteed Renewal: Prohibit insurers from terminating or failing to renew coverage.

C. Pre-Existing Conditions: Prohibit insurers and employer plans from imposing any exclusions for pre-existing conditions.

D. Modified Community Rating

1. Permit variation for family size, geography, and age (with limits so that the highest age-adjusted premium for a given family size and geographic area would be no more than twice the lowest age-adjusted premium).
2. Require all firms with fewer than 500 employees to purchase community rated insurance and prohibit self-insuring below this level.
3. Treat existing Taft-Hartley and rural cooperative plans with 500 or more employees, and bona fide multiple employer plans (MEWAs) with 1000 or more employees, as large employers; however, prohibit MEWAs from self-insuring and limit each such plan to its present size.

E. Risk adjustment and reinsurance mechanisms: The Secretary of HHS would develop mechanisms for implementation by the States.

F. Antitrust Reform: Repeal health insurance immunity from antitrust suits under the McCarran-Ferguson Act.

II. Coverage: Employer and individual mandate with special rules for small business

A. All employers with more than 20 employees would be required to pay 80 percent of the average premium for a qualified standard health plan; employees would be required to pay 20 percent, or less if the employer elects to pay more. (Non-workers and workers in exempt firms would be responsible for the full cost of the standard plan.)

B. Small employers (20 employees or fewer) would have the option to be excluded from the 80 percent mandate; firms exercising the option would pay a payroll assessment of 1 percent if they have 1-10 employees and 2 percent if they have 11-20 employees.

C. Trigger: The employer mandate would be imposed on small employers

1. at the end of 1998 if 97% of all employees (and their dependents) are not receiving employer-provided health insurance or
2. at the end of the year 2000 if 98.5% of all employees (and their dependents) are not receiving employer-provided health insurance.

III. Subsidies: Payable to both individuals and employers (including firms with 20 or fewer workers that voluntarily provide coverage)

A. Individuals: Family payments for the 20 percent share would be capped at 5 percent of income up to $30,000. Families with incomes below 150 percent of poverty would pay less, based on a sliding scale. Workers in exempt firms who are responsible for paying the full premium would be eligible for income-based subsidies that cap total payments at 5 to 7 percent of income up to $30,000.

B. Employers: In general, employer contributions would be limited to no more than 12 percent of each worker's wage. For firms with 11-75 employees with average wages below $24,000, the cap on contributions would be as low as 5.5 percent. For low wage firms with 10 or fewer employees that elect to pay premiums, premiums would be capped at one-half the otherwise applicable rate, ranging from 2.8 to 6.0 percent of each worker's wage. Eligibility for a subsidy would be based on the individual worker's wage; however, the amount of the subsidy would be based on firm size and the average wage of the firm.

C. Independent contractor and S-corporation shareholder anti-abuse provisions would be included.

IV. Benefits

A. Mental illness services would have parity with services for other medical conditions. The Secretary of HHS would develop standards for the appropriate management of these benefits.

B. The benefit package would have an actuarial value equivalent to the Blue Cross/Blue Shield Standard Option under the FEHB program.

C. Cost-sharing options described in statute would include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services.

D. Plans would be required to offer a standardized set of covered services.

E. Categories of covered services specified in statute would include: hospital services; health professional services; emergency and ambulatory medical and surgical services; clinical preventive services; mental illness and substance abuse services; family planning and services for pregnant women; hospice care; home health care; extended care; ambulance services; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation; durable medical equipment, prosthetic and orthotic devices; vision and dental care for children; and investigational treatments.

F. National Health Benefits Board

1. A National Health Benefits Board would be established in the Department of HHS to clarify covered services and cost-sharing; define medical necessity and appropriateness; consult with expert groups for appropriate schedules for covered services; refine policies regarding coverage of investigational treatments; and propose modifications to the benefits package that would go into effect unless voted down by Congress under fast-track procedures.
2. The Board would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.

V. Health Insurance Purchasing Cooperatives

A. Voluntary Participation: No employer or individual would be required to purchase through a cooperative. Individuals and employers eligible to purchase insurance through a cooperative could elect to purchase insurance at modified community rates through a broker or insurance company.

B. Eligibility: Firms with fewer than 500 employees (and their employees), self-employed individuals, and individuals not connected to the workforce, as well as dependents of those persons, would be eligible to purchase insurance through a cooperative.

C. Competing Cooperatives
   1. Cooperatives would be permitted to contract selectively with certified health plans. If a cooperative negotiates a price lower than the community rate, that price becomes the plan's new community rate.
   2. Nothing would prevent a cooperative from serving more than one area.
   3. If a cooperative were not established in every area by 1996, the State would be required to sponsor or establish a cooperative. In such cases, the State would only be required to establish or sponsor one cooperative that could serve all unserved areas within the State.

D. Federal Employees Health Benefits (FEHB) program: Employers with 2-10 employees who contributed at least 50% of the cost of health insurance would be permitted to enroll their employees in a FEHB program at the same premium price (both employer and employee share) paid by federal employees, plus an administrative fee.

E. Rules for Cooperatives
   1. Cooperatives would be required to accept all eligible individuals and employers within the area.
   2. Individuals not connected to the workforce would enroll based on residence.
   3. Cooperatives could require payroll deductions for employed individuals.
   4. If employees ask their employers to make payroll deductions for a cooperative, employers would be required to comply.

F. Choice of Health Plans/Cooperatives
   1. Enrollees, not employers, would choose a health plan within the cooperative. Employees of the same employer could choose different health plans.
   2. Employers above the community rating threshold would be required to provide employees with a choice of at least three health plans, including a fee-for-service plan.
   3. Employees of firms with 20 or fewer employees whose employer contributes at least 50% of the cost of health insurance could enroll in a cooperative chosen by the employer. Employees could purchase insurance at modified community rates elsewhere, but the employer would not be required to make the same contribution to insurance costs.
   4. Employees of firms with 20 or fewer employees whose employers do not contribute at least 50% to the cost of health insurance could enroll based on either residence or worksite.

G. Governing Structure
   1. Cooperatives would be non-profit organizations governed by a board of directors elected by members of the cooperative.
   2. Insurers would be prohibited from forming a cooperative, but would be permitted to administer a cooperative.

H. Duties of Cooperatives
   1. Cooperatives would be required to enter into agreements with health plans, employers and individuals; collect and forward premiums to health plans; coordinate with other cooperatives; and provide a complaint process.
   2. Cooperatives would be expressly prohibited from approving or enforcing provider payment rates; performing any activity relating to premium payment rates; and bearing insurance risk.

VI. Cost Containment

A. Managed competition would help contain costs by encouraging consumers to make informed health care purchasing decisions based on the price and quality of a standardized benefit package, by banding consumers into large purchasing pools with lower administrative costs, and by encouraging providers to form more efficiently organized delivery systems.

B. Premium Targets
   1. Targets for changes in per-capita premiums would be set by law at CPI plus or minus an adjustment factor that would take into account increases in real per-capita income, changing demographics and health status indicators, and changes in medical technology and the use of services.
   2. An independent National Health Cost Commission would be established to monitor per-capita premiums. The Commission would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.
   3. If the Commission determines that the targets have been exceeded, it would recommend appropriate actions for consideration by the Congress under fast-track procedures.

C. Federal Deficit Control
   1. OMB would determine annually, through 2004, whether enactment of health care reform had caused an unprojected increase in the deficit.
   2. Any deficit increase would trigger automatic reductions in subsidies unless Congress enacts alternative budget reductions (considered by fast-track) or OMB determines that GDP growth has fallen below 0% for 2 consecutive quarters.

D. Malpractice Reforms
   1. Alternative dispute resolution (ADR) procedures would be established by health plans and malpractice claims could not be brought in court until they had gone through the plan's procedures.
   2. Contingency fees paid to attorneys would be limited to a sliding-scale schedule.
   3. Awards would be reduced by the amount of any payment for the same injury from another source.

4. Payments of over $100,000 could be made on a periodic schedule determined by the court.
5. Demonstration projects would be authorized for limiting liability to health plans rather than physicians.
6. Demonstration projects would be authorized for adopting medical practice guidelines as the standard of care in medical liability actions.
7. Federal law would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney fees or a person's liability, or permitted additional defenses to malpractice actions.
8. Federal law would govern actions in State courts and would not establish a basis for bringing malpractice actions in federal courts.

E. Administrative Simplification and Paperwork Reduction
1. Establish a process for setting health information standards for paper and electronic transactions.
2. Create a public/private health information network to facilitate cost effective administration and practice of health care including automated coordination of benefits and claims routing.
3. Issue health identification cards using the Social Security number.
4. Require all health providers and plans to use standard electronic transactions to conduct business after a grace period for implementation.
5. Fund demonstration projects in telemedicine and electronic medical record systems in primary care.
6. Certify organizations to produce aggregated data for quality assessment, public health, research, and planning.

F. Fraud
1. Federal sanctions would be applied to all health care fraud that affects federal subsidies or other federal outlays.
2. A health care anti-fraud trust fund would be established to fund federal enforcement activities; a portion of the fines and civil penalties collected from such activities would go to the trust fund and the remainder to the Treasury.

VII. Financing (unofficial estimates)

A. Revenue Raisers (over 5 years)
1. Increase tobacco excise tax to $2.00 per pack = $86 billion.
2. Increase handgun ammunition excise tax to 50% (except .22 caliber) = $140 million.
3. Impose a 1% employer payroll assessment on firms of 500 or more employees = $50 billion.
4. Extend HI tax to all State and local employees = $6 billion.
5. Recapture Medicare part B subsidies for individuals with incomes over $90,000 and couples with incomes over $115,000 = $4 billion.
6. Health benefits provided through a flexible spending arrangement would not be excludable = $2 billion.

7. Levy an assessment on health insurance premiums, phased up to 2.5% of premiums by 1999, for academic health centers and medical education and research = $40 billion.
8. Payroll assessments on small firms that do not provide coverage = $10 billion.

B. Revenue Losers (over 5 years)
   1. Provide 80% self-employed health insurance deduction = ($5) billion.

C. Medicare Savings (over 5 years) = $33 billion.

VIII. Medicaid

A. Mainstreaming of AFDC and Non-Cash recipients: Both groups would be treated like other low-income individuals and families for purposes of community rating, enrollment in health plans and subsidies. States would pay a maintenance of effort based on current spending on these groups for services covered in the benefit package.
B. SSI recipients: Those not enrolled in Medicare could enroll in health plans. States could make premium payments based on negotiations with certified health plans.
C. Services not covered in the standard benefit package: Retain current Medicaid mandatory and optional eligibility groups for provision of services not otherwise provided by health plans. States could negotiate with health plans to provide supplemental services.
D. Federal matching payments: Enhance matching payments for Medicaid home and community based long term care services, and change overall federal Medicaid matching formula.

IX. Long-Term Care

A. Retain Medicaid long-term care program with improvements.
B. Establish federal long-term care insurance standards.
C. Include tax credit for cost of personal assistance services for working disabled.
D. Exclude certain accelerated death benefits from taxable income.
   NO tax deduction

X. Medicare

A. Maintain Medicare as a separate program.
B. Individuals could maintain coverage through private health plans when they become eligible for Medicare.
C. Medicare Select would become a permanent option in all States.
D. Medicare risk contracts would be improved.
E. Improvements in hospital payment methodologies would include:
   1. Medicare Dependent Hospital Extension,
   2. EACH/RPCH program improvements and extension to all States,
   3. making Medical Assistance Facilities permanent and available to all States,
   4. extending the rural health transition grant program, and
   5. rebasing PPS exempt hospitals.

XI. Academic Health Centers and Medical Education and Research

A. Academic Health Centers (AHCs) Trust Fund

1. A trust fund for AHCs would be established with contributions from the Medicare indirect medical education (IME) adjustment at current law levels, plus a portion of revenues from a 1.5% assessment on premiums and on premium equivalents for self-insured plans.
2. Payments would be made to all AHCs and teaching hospitals in a manner modeled after the current IME adjustment.
3. Payments would total $6.28 billion in 1996, $7.25 billion in 1997, $8.22 billion in 1998, $9.4 billion in 1999, and $10.64 billion in 2000, increased annually thereafter by the change in the national premium targets.

B. Biomedical and Behavioral Research

1. A Health Research Trust Fund would be established to fund expanded biomedical and behavioral research through NIH.
2. The trust fund would be financed with an assessment on premiums and premium equivalents equal to 0.25% in 1996, 0.50% in 1997, 0.75% in 1998, and 1.0% in 1999 and subsequent years. Also, the tax code would be amended to authorize persons filing Federal tax returns to elect to make contributions to the trust fund or to donate tax overpayments to the trust fund.

C. Graduate Medical and Nursing Education Trust Fund

1. A trust fund for graduate medical and nursing education and for transitional costs would be established with contributions from Medicare direct medical education costs at current law levels, plus a portion of revenues from the 1.5% assessment on premiums and premium equivalents.
2. Graduate medical education payments would be made to qualified applicants operating approved residency programs or participating in voluntary consortia.
   a) Payments would be based on historical costs of individual programs.
   b) Payments would total $3.2 billion in 1996, $3.55 billion in 1997, and $5.8 billion in 1998, increased annually thereafter by the change in the national premium targets.
3. Graduate Nursing Education
   a) Payments would be made to qualified applicants operating graduate nurse training programs based on national average costs with a geographic adjustment factor.
   b) Payments would total $200 million in 1996, increased annually by the change in the national premium targets.
4. Medical School Account
   a) Payments would be made to medical schools to assist in meeting additional teaching and research costs associated with the transition to managed competition and expanded ambulatory teaching.
   b) Payments would total $200 million in 1996, $300 million in 1997, $400 million in 1998, $500 million in 1999, and $600 million in 2000, increased annually thereafter by the change in the national premium targets.

XII. Access Issues in Urban and Rural Areas

A. A trust fund based on a portion of receipts from the tobacco tax (approximately $1.3 billion per year) would be established for infrastructure development. It would provide funding for the development of health plans and capital investment for hospitals and other facilities.

B. Provide tax incentives for practitioners that locate in designated urban and rural areas.

XIII. State Flexibility

A. States would have the option to establish a single-payer system.

B. States would have the option to implement other systems designed to increase coverage, control costs, or fund uncompensated care, but which do not have a significant adverse impact on the administration of plans maintained by multi-State employers.

XIV. Privacy and Confidentiality

A. Protect all health information which could be related to a specific individual, regardless of form or medium.

B. Specify appropriate and necessary uses and reasons for release of protected information.

C. Reduce the amount of information released to the minimum necessary to perform authorized tasks.

D. Other uses and release of protected information, without specific authorization by the individual concerned, would be subject to penalties.

E. Define individual rights to access, annotate, and limit release of protected information.

XV. Health Plan Standards

A. National standards for health plans would be set by the Secretary of HHS for:

1. Capital and solvency standards, including guaranty fund, capital requirements, and risk adjustment/reinsurance;
2. Quality standards for quality improvement and assurance, continuity of care, physician credentialing, utilization management, and medical recordkeeping;
3. Patient protection standards for advance directives, physician incentive plans, participation by physicians in policymaking, anti-discrimination, grievance procedure, confidentiality, marketing, and ethical business conduct; and
4. Access standards for specialized services and essential community providers.

B. Accreditation and Enforcement

1. States would certify that health plans meet the national standards using a State program or private accreditation organization.
2. Federal grants would be available to States to help fund their enforcement programs.

XVI. Quality and Consumer Information

A. Provide Federal funding to support research on appropriateness and outcomes of medical treatments.

B. The Secretary of HHS would provide grants to quality improvement foundations to disseminate research findings to improve provider practice patterns.

C. States would be required to provide health care consumers with comparative value information on health plans. Federal grants would be available to States to help fund their programs.

D. States would be required to establish a standardized appeals process for benefit denial, reduction or termination.

E. Modify Federal remedies for benefit denials, reductions or terminations.

XVII. Tax Treatment of Health Care Organizations

A. Strengthen current law "community benefit" standard for tax exemption for non-profit hospitals.

B. Repeal cap on tax-exempt bonds for section 501(c)(3) organizations.

C. Repeal special deduction for Blue Cross/Blue Shield organizations.

D. Limit tax exemption for HMOs to "staff" or "dedicated group" model.

E. Impose certain penalty excise taxes ("intermediate sanctions") on tax-exempt health care organizations for transactions involving private inurement.

Ken, Chris Jamie

COMMUNITY RATING; <500 EXCLUSIVITY!

½ SUBSIDIES FIRMS - IN AT $ BENEFITS. PHASE IN -

PRICE SCHEDULE -

PERSONS - BUY AT - FULL HSA.

? ADVERSE SELECTION.

IF 3 X EXPENSIVE ; ↑ 6% P. Capita

<45 = YOUNG - ↑ Community Rate

* Written Before Moynihan's cancellation of 2/25-4:30pm meeting.

MEMORANDUM

TO: Hillary Rodham Clinton February 24, 1993
FR: Chris Jennings X-2645
RE: Thursday Hill Visits with Moynihan, Sasser, and Riegle
cc: Melanne, Ira, Steve R., Howard P.

Tomorrow, starting at 4:30, you are scheduled to hold consecutive meetings with Finance Chairman Moynihan, Budget Chairman Sasser, and Finance Subcommittee on Medicaid Chairman Riegle. The timing of these meetings are particularly opportune because of the relevance of these Members (especially Moynihan and Sasser) opinions and responsibilities with regard to reconciliation and health care reform.

Following this memo, you will find a brief description of the three Members and their health care records.

Before summarizing the Senators' health backgrounds, I think it would be useful to fill you in on two late night conversations I had with the Chief of Staff of Majority Leader Mitchell's office, John Hilley, and the chief health analyst of the Senate Budget Committee, Kathy Deignan. (John debriefed me on today's afternoon meeting with the Chairmen and Kathy updated me on some budget resolution issues that are extremely important). Highlights include:

* John stated that there remains a consensus (although I am not certain where Appropriations Chairman Byrd stands) among the Senate Chairmen (no women chairs) that there will not be a sufficient number of votes for two tax bills and that a one-vote reconciliation strategy remains the best (and probably the only) option to pursue if there is a desire to pass health reform this year in the Senate. (FYI, Sasser shares this position and, although Moynihan has not yet focused on this because he has been sick, Hilley is confident he will stick with Mitchell on this issue).

* John (who used to be the Staff Director of the Senate Budget Committee) said that it would be difficult to impossible, on both procedural and political grounds, to develop -- much less pass -- a second reconciliation bill. Assuming a second bill is even possible (and that is not even clear to him), he cited 3 primary other reasons why it would be problematic:

(1) it is difficult to see how a second reconciliation package would pass a budget rules test known as the reconciliation "preponderance" test because, to do so, the bill must fundamentally be a deficit reduction bill. He believes it would be virtually impossible for a health reform bill to meet this test because it is difficult to see how it would be possible to come up with the taxes and cuts necessary to meet the deficit reduction test AND to underwrite the costs of a health care package.

(2) any attempt to get around the preponderance test (perhaps by splitting up the deficit reduction provisions between the two separate packages) would likely invite even more political problems for the first reconciliation bill. This is because the tax to cuts ratios would likely be even more difficult to defend than they are now.

(3) it is extremely difficult to see this Congress finishing action on even one reconciliation package before September. Even if they break a record in this regard and pass it in the summer, it is virtually unthinkable to see a second reconciliation process completed this year or next. (Congress rarely takes a bite out of the deficit in any significant way more than once every two years).

* In order to accomodate the concerns of both the House and the Senate, one budget reconciliation/health care strategy could be as follows:

(1) Pass the budget resolution with a health reform plus (see discussion below) around March 20th;

(2) Immediately bring up and pass the stimulus package with a commitment that cuts will be in the reconciliation package;

(3) Have the House pass its reconciliation bill first WITHOUT health reform (sometime in late May/early June);

(4) Have the Senate -- as it usually does in its more slow and deliberate way -- pass its reconciliation bill WITH health reform after the House passes its bill;

(5) Have the House pass a protected health reform bill that they can bring to a joint Senate/House conference; and

(6) Go to conference in September and work out a deal that can pass the Congress and be presented to the President.

John endorses the above strategy and it may well be attractive to the House leadership as well. We may find this approach attractive to because we would not be refereeing the dispute and leaving the decision up to the Congress.

* My conversation with Kathy Deignan of the Budget Committee centered around what provisions in the Senate budget resolution would be necessary to assure that the President would need only 51 votes to pass a reconciliation bill WITH a health reform package attached. Two health "plugs" are apparently necessary are:

  (1) A "Reserve Fund" provision that allows spending on health reform (reform can be very broadly defined) to be payed for by new revenues without a 60 vote budget point of order must be included in the budget resolution. (Our last two Senate budget resolutions have had this provision, so there is precedent; nothing is easy in the Senate, though, and most Republicans are likely to oppose.)

  (2) A separate waiver of a budget provision known as the "Byrd" rule will likely be necessary to be incorporated into the resolution to assure that the health care provisions imperative for the passage of the bill are not stripped on the Senate floor because they do not come into line with the rule.

  There are a number of provisions of the Byrd rule, but one of the most far reaching is one that disallows any provision that is "extraneous" (defined as has no impact on the budget) to the bill. (This could include, for example, insurance market and medical malpractice reform because they have no cost impact). I know of no such waiver related to health that has ever been attached to protect unnamed health provisions in a Senate budget resolution.

  The Byrd waiver will be more difficult to get included in the budget resolution than the "Reserve Fund" provision. I do not believe that Senator Byrd has taken any formal position on whether he would support such a waiver.

* Although it will be difficult to get the two "plugs" included in any budget resolution, it will not be impossible. If the above provisions are not incorporated, however, it appears likely that the President and you will have to find 60 votes to pass health care. John Hilley believes they can find the votes for a "plugged" Senate resolution. While Kathy's confidence does not match John's, she does believe it can be done. The bottom line, though, is that it must be done because we cannot count on 60 votes.

* Lastly, in today's meeting with Senator Sasser, it may be advisable would be wise not only to get his opinion about what we should do with regard reconciliation, but to ask him for an update on any discussions he and/or his staff has had with Sentor Byrd. If Senator Byrd is not supportive of a Byrd waiver provision, it will be extremely difficult to get that particular health plug in the reconciliation bill.

Daniel Patrick Moynihan
New York

United States Senate
Washington, D.C.

April 10, 1993

Dear Mr. President,

The weekend press accounts of the briefing given by your aides on the health plan made it known that you plan to "give all Americans a 'health security card.'" This strikes me as a splendid idea, especially if it is a <u>real</u> card -- hologram, that sort of thing -- unlike our 1930-ish paste board Social Security card. I have been trying to get them to issue a genuinely new card for some seventeen years now, but with no success. It occurs to me, however, that we might merge the two cards into one. In any event, we surely should consider having just one number. As you know, children now get their Social Security number at birth.

More generally, I am concerned that the Social Security system has entered a period of protracted crisis. Or so I believe. In part this is generational. You will perhaps recall my going on television in the New York primary with the simple message that Jerry Brown's flat tax would put an end to Social Security as a contributory insurance plan. It would have done. May yet do. Not because Governor Brown is opposed to social insurance. Quite the contrary.

But for some reason this particular (New Deal?) program simply does not make a sufficient claim on their attention. Or, well, loyalty.

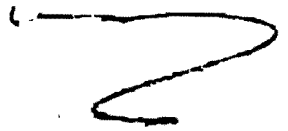
Yet it is the only such program we have, and is, of course, very much a health insurance system (e.g., Disability, Medicare) as well as a system that provides retirement benefits. It has a perfect half century record of on-time payments. Yet a majority of non-retired adults do not think they will "get" their Social Security. All too easily this could become self-fulfilling. Already two of the last three Social Security Administrators are heading nationwide mass mailing campaigns telling the citizenry that we are looting the Trust Funds and planning huge benefit cuts.

If a large portion of the citizenry feel the Federal government is cheating them of their retirement savings, would it not be prudent to ask just how much faith they will have in a promise of universal health coverage?

I made a considerable effort last winter to see if we couldn't get the administration to propose that all working adults receive an annual statement of their Social Security contributions and expected benefits. As they do in Canada. No one ever turned me down; there was simply no interest.

In the meantime, the position of Social Security Commissioner has been vacant for more than half a year. This used to be a position of honorable tenure in the American government. No longer. There were six occupants in the 1980s. You can, of course, change this. For I certainly hope we will address the problem of this long established program before we set about constructing a new one.

Respectfully,



The President
The White House
Washington, D.C. 20500