Mitchell Plan

MEMORANDUM

To: White House Staff
Fr: Harold Ickes
Dt: August 18, 1994
Re: Attached material on Health Care

The Majority Leader has begun focusing on the theme that the American people should have health care as good as Congress and federal employees have. Senators will echo this drumbeat on the floor today. We must make this a central part of our message as well. The attached material outlines the argument that the Mitchell bill simply ensures that the American people have health coverage as good as Congress' -- and by contrast the Dole plan leaves Americans at the mercy of insurance company loopholes and fine print.

I hope you will find this material useful in any public appearances or conversations with the press. Please feel free to call if you have any questions.

SENATORS HAVE THE MITCHELL PLAN BUT
AMERICANS HAVE THE DOLE PLAN

FEHBP	Mitchell	Dole
Solid Insurance With No Loopholes	✓	
Guaranteed Choice of Plans	✓	
Comprehensive Benefits	✓	
Employers and Employees Share Responsibility	✓	
Guaranteed Bargaining Power For More Affordable Rates	✓	

Senators must choose: live under the plan you support or support the plan you live under.

Doesn't every working family deserve what Congress has?

Today, members of Congress have true health security -- they get to pick their own doctor and health plan, pay a fair price for insurance, and their employer -- the taxpayers --picks up most of the cost. They can change plans if they want, and are never denied coverage for pre-existing conditions. ***Doesn't everybody deserve that kind of insurance?***

Private Coverage from their Employer

Members of Congress have their health coverage provided on the job, and most of the premium (72% on average) is paid for by their employer -- the taxpayers.

Hundreds of Plans to Choose from:

Members of Congress -- not their employer -- get to choose from hundreds of insurance plans. They are able to pick from 14 different fee-for-service plans and more than 200 health maintenance organizations -- a total of 300 plans nationwide, and more than a dozen in every district.

The Opportunity to Pick a New Plan Every Year:

Members of Congress and their families can choose a new plan once a year during "open season". A guide to the plan says: *"You may switch plans to lower costs or gain the best coverage for your condition, and use that coverage at the beginning of the year."*

Comprehensive Benefits

Members of Congress typically enroll in plans like the Blue Cross Standard Plan, which has a guaranteed benefits package including hospital and physician services, emergency care, mental health and substance abuse benefits, maternity care, and prescription drugs.

Community Rating

Right now every member of Congress -- young, old, healthy, sick, -- pays the same price for the same health plan. And even if they get sick during the course of the year, their rates don't go up; they still pay the same premiums as everybody else.

The youngest member of Congress and the oldest pay the same price for the same benefits.

No Denials for Pre-existing Conditions

The brochure describing the health benefits for members of Congress says that "*Plans cannot exclude coverage for any pre-existing conditions or illnesses your family may have when you enroll.*"

#1821, 8/17/94

The Mitchell bill provides American families the same guarantees Congress has

Today, members of Congress have true health security -- they pick their own doctor and health plan, pay a fair price for insurance, and their employer -- the taxpayers --picks up most of the cost. They can change plans if they want, and are never denied coverage for pre-existing conditions. The Mitchell plan provides American families with the same guarantees -- solid insurance, guaranteed choice, comprehensive benefits, and bargaining power.

Solid Insurance You Can Count On

Right now every member of Congress, the President, and all federal employees have the security of real insurance -- private insurance without loopholes or fine print. Young, old, healthy, sick, every federal employee pays the same price for the same health plan. Even if they get sick during the course of the year, their rates don't go up. Pre-existing conditions are covered.

The Mitchell bill would provide all families with the security Congress has -- solid insurance; no loopholes. No charging more when people get sick, no dropping coverage, no lifetime caps on benefits. Coverage would be immediate upon enrollment, and pre-existing condition limitations would be limited and then phased out.

Guaranteed Choice of Plans:

Members of Congress -- not their employer -- get to choose the private insurance plan best for their families. And they get the opportunity to change plans once a year.

The Mitchell bill would guarantee families a choice of at least three plans, and would allow people to change plans once a year if they wish. Employees in firms with fewer than 500 employees would have the option of enrolling directly in the Federal Employees Health Benefits Plan.

Comprehensive Benefits

Members of Congress typically enroll in plans like the Blue Cross Standard Plan, which has a guaranteed benefits package including hospital and physician services, emergency care, mental health and substance abuse benefits, maternity care, and prescription drugs.

Under the Mitchell bill, everyone would be guaranteed a solid set of benefits, modeled closely after the benefits plan now provided to members of Congress.

Efficiency

FEHBP enrolls 9 million people in 50 states, contracts with hundreds of plans, yet the entire program is adminstered by only 144 people. It also has very low administrative costs.

The Mitchell bill would bring this efficiency and market competition to the whole health care system.

Increased Bargaining Power

The Federal Employees Health Benefits Plan covers 9 million people -- the President and his family, Members of Congress and their families, and all other federal empoyees and their families. Since they're such a big group, they get the best rates, and costs go up more slowly.

Senator Mitchell's plan guarantees small and medium-sized companies access to purchasing groups that bring bring buying muscle even to the littlest companies.

#4227, 8/17/94

The Dole Plan: If You're Not a Member of Congress... You're Out of Luck

Solid Insurance vs. Loophole-Ridden Insurance

Right now, Bob Dole and all his co-sponsor Senators have the security of real insurance -- private insurance without loopholes or fine print. Young, old, healthy, sick, every federal employee pays the same price for the same health plan. And even if they get sick during the course of the year, their rates don't go up; they still pay the same premiums as everybody else. And pre-existing conditions are covered -- the brochure describing the federal plan says that "*Plans cannot exclude coverage for any pre-existing conditions or illnesses your family may have when you enroll.*"

The Dole plan allows insurance companies to continue to raise rates unchecked, and to charge older people three to four times more than younger people. Some small businesses will continue to pay more than others, and some families more than other families. You could still work hard, pay your premiums, and have medical bills sent back "not covered". Millions would still have phony, fly-by-night insurance, and an estimated 30 million Americans would have no coverage at all.[Lewin-VHI, July 1994]

Guaranteed Choice of Plans vs. No Guarantee of Choice:

Members of Congress -- not their employer -- get to choose the private insurance plan best for their families. And if they don't like the plan they're in, they get the opportunity to change once a year.

The Dole plan does not guarantee that all families would have a choice. If you're employer covers only one plan, and that plan doesn't include your doctor, you're out of luck.

Comprehensive Benefits vs. Insurance Companies Deciding What to Cover

Members of Congress typically enroll in plans like the Blue Cross Standard Plan, which has a guaranteed benefits package including hospital and physician services, emergency care, mental health and substance abuse benefits, maternity care, and prescription drugs.

While the Dole plan describes a standard benefits package (called the FedMed package) and says that every health plan has to offer that option, insurance companies could still sell dozens of other packages that exclude the benefits people need. [Dole Bill Sec. 21115 (a) p.85] This allows insurance companies to effectively deny coverage of certain illnesses by structuring benefits packages to not cover certain treatments. Millions of Americans will continue to face the nightmare of insurance claims coming back: "Sorry, not covered."

Choice in the Federal Employees Health Benefits Program

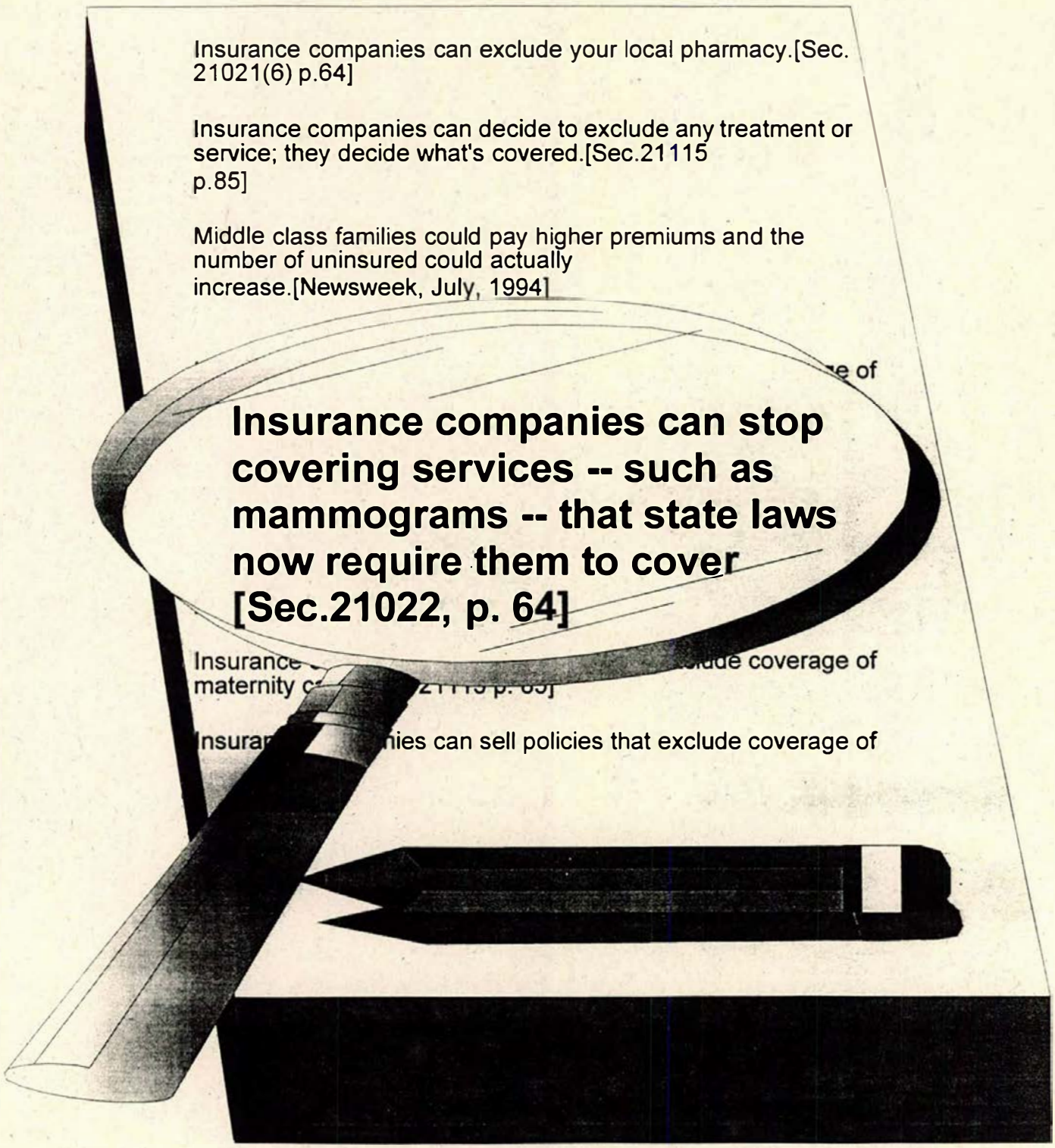
How it works:

- The plan's success in cost containment stems from the fact that it is big enough to carry considerable weight in annual premium negotiations with insurers.
- The government licenses plans to compete for federal employees premium dollar. It pays a substantial amount -- up to 75% for most employees -- towards the premium cost of the chosen plan.
- Nationally, over 300 plan options are offered and between one and two dozen are available in each locality.
- The plan offers 14 traditional fee-for-service plans and more than 200 health maintenance organizations nationwide at monthly costs ranging from $63.58 to $501.96 for family coverage. [Hill Health Care Gets a Closer Look, *The Washington Post*, Kevin Merida, 3-21-94]
- The *consumer* decides which plan to buy and those who are unsatisfied may switch in Open Season. One may also switch plans or options in some specific circumstances. such as marriage, birth of a child or transfer abroad. If a beneficiary is previously a member of an HMO, they may enroll in a new plan if they move from the HMO's service area.
- The Office of Personnel Management sets minimum financial, administrative and benefit terms and conditions for every plan participating in the program. [Health Insurance Plans for Federal Employees: Washington Consumers' Checkbook 15th edition.]

Important aspects:

- The FEHBP enrolls 9 million persons (including about half the population of the Washington D.C. area) yet is run by only 144 Office of Personnel Management staffers.
- The FEHB plans increased in cost at approximately the rate of inflation or less. [*Works Worse and Costs More*, Roll Call, Rep. Frank Wolf, 02-21-94]
- Plans cannot exclude coverage for any preexisting conditions or illnesses. It is also possible to switch plans to lower costs or gain the best coverage for a specific condition, and use that coverage at the beginning of the year. [Health Insurance Plans for Federal Employees: Washington Consumers' Checkbook 15th edition.]
- No physical examinations are required. [Federal Workers Now Choose from at least 10 Health Plans, *Chicago Tribune*, 02-04-94.]

The Dole Bill Is Just Like Most Of Today's Insurance Policies: Fineprint and Loopholes



ON WOMEN'S BENEFITS: TAKE MAMMOGRAMS FOR EXAMPLE. THE MITCHELL PLAN PROTECTS THE BENEFITS WOMEN ALREADY HAVE. *[SEE STATE-BY-STATE DATA ATTACHED]* THE DOLE PLAN WOULD ALLOW INSURANCE COMPANIES TO TAKE THESE BENEFITS AWAY FROM WOMEN IN STATES WHERE THEY ARE ALREADY GUARANTEED. SENATORS HUTCHINSON, KASSEBAUM, FEINSTEIN, MIKULSKI, MOSLEY-BRAUN, BOXER AND MURRAY, WOULD STILL HAVE THEM -- BUT MILLIONS OF OTHER AMERICAN WOMEN WOULD LOSE THEM.

ON MENTAL HEALTH BENEFITS: THE MITCHELL PLAN WOULD ENSURE MILLIONS OF AMERICANS WOULD HAVE MENTAL HEALTH CARE IF THEY NEED IT. *[SEE ATTACHED STATE-BY-STATE DATA]* BUT THE DOLE PLAN WOULD ALLOW INSURANCE COMPANIES TO TAKE MENTAL HEALTH BENEFITS AWAY FROM MILLIONS IN STATES WHERE THESE BENEFITS ARE ALREADY GUARANTEED . SENATOR DOMENICI AND OTHER SENATORS WHO HAVE SPOKEN ABOUT THE NEED FOR MENTAL HEALTH COVERAGE WOULD STILL HAVE THESE BENEFITS FOR THEMSELVES AND THEIR FAMILIES -- BUT MILLIONS OF ORDINARY AMERICAN FAMILIES WOULD NOT.

ON WELL-CHILD BENEFITS: THE MITCHELL PLAN WOULD PROTECT WELL-CHILD BENEFITS FOR MILLIONS OF AMERICAN CHILDREN, BUT THE DOLE PLAN WOULD ALLOW INSURANCE COMPANIES TO DENY WELL-CHILD BENEFITS TO MILLIONS OF CHILDREN IN STATES WHERE THEY ARE ALREADY GUARANTEED. *[SEE ATTACHED STATE-BY-STATE DATA]* SENATOR RIEGLE'S YOUNG DAUGHTER [OTHER SENATORS WITH SMALL CHILDREN?] WILL STILL HAVE WELL-CHILD CARE, BUT MILLIONS OF OTHER CHILDREN WOULD NOT.

ON BENEFITS FOR RURAL AMERICANS: UNDER THE MITCHELL PLAN RURAL AMERICANS WILL HAVE MORE DOCTORS IN THEIR COMMUNITIES, BUT UNDER THE DOLE PLAN RURAL AREAS WILL CONTINUE TO LOSE LOCAL PHYSICIANS. SENATORS WILL STILL HAVE A DOCTOR JUST DOWNSTAIRS IN THE CAPITOL -- BUT MILLIONS OF RURAL AMERICANS WILL HAVE TO TRAVEL HOURS FOR EVEN THEIR MOST BASIC HEALTH CARE NEEDS.

Under the Dole bill:

157,151 women in Alaska will lose their current protection for mammography benefits.

1,261,554 women in Arizona will lose their current protection for mammography and maternity benefits.

9,641,644 women in California will lose their current protection for mammography, maternity and pap smear benefits.

1,288,112 women in Colorado will lose their current protection for mammography and maternity benefits.

1,325,824 women in Connecticut will lose their current protection for mammography and maternity benefits.

264,364 women in Delaware will lose their current protection for mammography and pap smear benefits.

4,504,211 women in Florida will lose their current protection for mammography benefits.

2,180,843 women in Georgia will lose their current protection for mammography, maternity and pap smear benefits.

411,012 women in Hawaii will lose their current protection for mammography and maternity benefits.

1,181,030 women in Iowa will lose their current protection for mammography and maternity benefits.

398,174 women in Idaho will lose their current protection for mammography and maternity benefits.

4,359545 women in Illinois will lose their current protection for mammography and maternity benefits.

2,264,210 women in Indiana will lose their current protection for mammography benefits.

1,018,065 women in Kansas will lose their current protection for mammography, maternity and pap smear benefits.

1,277,490 women in Kentucky will lose their current protection for mammography benefits.

1,242,803 women in Louisiana will lose their current protection for mammography and pap smear benefits.

2,280,477 women in Massachusetts will lose their current protection for mammography, maternity and pap smear benefits.

1,787,265 women in Maryland will lose their current protection for mammography and maternity benefits.

454,968 women in Maine will lose their current protection for mammography and maternity benefits.

3,553,509 women in Michigan will lose their current protection for mammography benefits.

1,748,201 women in Minnesota will lose their current protection for mammography, maternity and pap smear benefits.

1,910,784 women in Missouri will lose their current protection for mammography, maternity and pap smear benefits.

296,620 women in Montana will lose their current protection for mammography benefits.

2,397,520 women in North Carolina will lose their current protection for mammography, maternity and pap smear benefits.

248,491 women in North Dakota will lose their current protection for mammography and maternity benefits.

435,844 women in New Hampshire will lose their current protection for mammography and maternity benefits.

2,948,515 women in New Jersey will lose their current protection for mammography and maternity benefits.

475,415 women in New Mexico will lose their current protection for mammography and pap smear benefits.

421,930 women in Nevada will lose their current protection for mammography, maternity and pap smear benefits.

6,266,314 women in New York will lose their current protection for mammography and maternity benefits.

4,224,370 women in Ohio will lose their current protection for mammography, maternity and pap smear benefits.

1,051,358 women in Oklahoma will lose their current protection for mammography and maternity benefits.

1,174,701 women in Oregon will lose their current protection for mammography, maternity and pap smear benefits.

4,846,981 women in Pennsylvania will lose their current protection for mammography and maternity benefits.

383,450 women in Rhode Island will lose their current protection for mammography, maternity and pap smear benefits.

240,353 women in South Dakota will lose their current protection for mammography benefits.

1,826,659 women in Tennessee will lose their current protection for mammography and maternity benefits.

5,416,583 women in Texas will lose their current protection for mammography and maternity benefits.

676,658 women in Utah will lose their current protection for maternity benefits.

2,196,485 women in Virginia will lose their current protection for mammography and maternity benefits.

237,147 women in Vermont will lose their current protection for mammography and maternity benefits.

1,888,815 women in Washington will lose their current protection for mammography, maternity and pap smear benefits.

2,060,609 women in Wisconsin will lose their current protection for mammography and maternity benefits.

579,956 women in West Virginia will lose their current protection for mammography and pap smear benefits.

Under the Dole bill:

1,518,250 Arkansas residents will be denied their current protection for mental health benefits.

19,317,437 California residents will be denied their current protection for mental health benefits.

2,460,066 Colorado residents will be denied their current protection for mental health benefits.

2,587,326 Connecticut residents will be denied their current protection for mental health benefits.

8,508,751 Florida residents will be denied their current protection for mental health benefits.

4,099,737 Georgia residents will be denied their current protection for mental health benefits.

822,926 Hawaii residents will be denied their current protection for mental health benefits.

8,562,001 Illinois residents will be denied their current protection for mental health benefits.

1,990,346 Kansas residents will be denied their current protection for mental health benefits.

2,442,293 Kentucky residents will be denied their current protection for mental health benefits.

2,427,031 Louisiana residents will be denied their current protection for mental health benefits.

4,459,582 Massachusetts residents will be denied their current protection for mental health benefits.

3,548,633 Maryland residents will be denied their current protection for mental health benefits.

918,033 Maine residents will be denied their current protection for mental health benefits.

3,324,482 Minnesota residents will be denied their current protection for mental health benefits.

3,634,748 Missouri residents will be denied their current protection for mental health benefits.

1,603,388 Mississippi residents will be denied their current protection for mental health benefits.

594,442 Montana residents will be denied their current protection for mental health benefits.

477,723 North Dakota residents will be denied their current protection for mental health benefits.

861,326 New Hampshire residents will be denied their current protectionfor mental health benefits.

11,957,062 New York residents will be denied their current protection for mental health benefits.

8,332,798 Ohio residents will be denied their current protection for mental health benefits.

2,271,282 Oregon residents will be denied their current protection fomental health benefits.

736,637 Rhode Island residents will be denied their current protection for mental health benefits.

3,411,575 Tennessee residents will be denied their current protection for mental health benefits.

10,517,689 Texas residents will be denied their current protection for mental health benefits.

4,321,852 Virginia residents will be denied their current protection for mental health benefits.

457,251 Vermont residents will be denied their current protection for mental health benefits.

3,809,480 Washington residents will be denied their current protection for mental health benefits.

4,031,084 Wisconsin residents will be denied their current protection for mental health benefits.

1,133,348 West Virginia residents will be denied their current protection for mental health benefits.

#4192

Under the Dole bill:

321,893 children in Arkansas will lose their protection for well-child benefits.

4,010,096 children in California will lose their protection for well-child benefits.

470,159 children in Connecticut will lose their protection for well-child benefits.

1,248,375 children in Florida will lose their protection for well-child benefits.

155,227 children in Hawaii will lose their protection for well-child benefits.

498,210 children in Iowa will lose their protection for well-child benefits.

515,715 children in Louisiana will lose their protection for well-child benefits.

731,488 children in Massachusetts will lose their protection for well-child benefits.

599,174 children in Maryland will lose their protection for well-child benefits.

623,270 children in Minnesota will lose their protection for well-child benefits.

625,306 children in Missouri will lose their protection for well-child benefits.

129,070 children in Montana will lose their protection for well-child benefits.

2,082,519 children in New York will lose their protection for well-child benefits.

1,673,585 children in Ohio will lose their protection for well-child benefits.

1,839,099 children in Pennsylvania will lose their protection for well-child benefits.

119,638 children in Rhode Island will lose their protection for well-child benefits.

815,174 children in Virginia will lose their protection for well-child benefits.

#4190

"LET'S START FROM THE BEGINNING — WHY NOT THE SAME KIND OF HEALTH CARE YOU FELLOWS HAVE?"

DRAFT

8/21/94

Possible Options

1. Mitchell accommodates enough of the mainstream to gain broader support of Mitchell, as revised, with the balance of mainstream proposals being debated and voted on.

   - How critical is the triggered mandate in Mitchell? If it is supplanted by the 95% goal of the mainstream, and if the rest of Mitchell revised works, can it be argued that it puts the country on the path to universal coverage and, if so, should the President support it?

     The definition of "what works" is critical. If the President cannot support Mitchell revised, should he declare an impasse; that the Republicans are unwilling to support health care reform this year; but that he will fight for health care reform next year.

     If, after recess, the Congress enacts health care legislation, the President can then decide whether to sign it or not.

   - It is likely, however, that many of the leadership groups supporting health reform will walk away from Mitchell revised.

   - Even if the President wants to declare an "impasse" and to ask the Senate to adjourn, Senator Mitchell may resist this course.

   - If Mitchell revised cannot be supported by the President, should he demand a vote on the Mitchell triggered mandate as well as on the key provisions to show the country who is blocking health reform?

   - Even if Mitchell revised, without the Mitchell mandate, should be pushed, what effect will it have on the House? This will depend upon the configuration of Mitchell revised.

2. If Mitchell cannot accommodate Chafee:

   A. Carry on with the debate on Mitchell and force an early vote on the Mitchell mandate.

- If the vote retains the Mitchell mandate, it is unclear where the process then goes.

- If the vote defeats the Mitchell mandate, the President can declare an "impasse"; state that the Republicans blocked health reform; ask the Senate to recess; and state he will fight for health reform next year.

B. Mitchell tells the President that he needs a recess to work out a modified bill (thus effectively telling the President there isn't sufficient support in the Senate to enact the pending bill); the Senate goes on recess; the press declares health reform dead this session; during the recess, the President and at least the Democratic leadership devise a bill that can be characterized as putting the country on the path to universal coverage, along the lines of the congressional resolution (or some other workable minimal approach) described in paragraph numbered 2 below.

- The President could say that while the universal coverage as he has worked for so hard can't be achieved this year, this alternative proposal, which he devised with the Congress, is a giant step toward that goal.

- Although the public would likely support such a proposal, the leadership groups favoring health reform may disown it.

C. Mitchell tells the President that he cannot get his bill through the Senate. The President declares an "impasse"; states that he has done everything possible to achieve universal coverage, but the Republicans block it; call a Democratic leadership summit (perhaps including some Republicans) to work out an alternative that can command the necessary votes in both chambers, but which will not include universal coverage.

- Even under this option, the President may need a vote on the Mitchell mandate before declaring an impasse and calling the leadership summit to show he went the distance in trying to achieve universal coverage.

- This is a very risky strategy because it is highly probable that the process will drag out, no agreement will be reached that can

command sufficient support, and the President will merely become bogged down in the process.

Other issues:

1. The clock: If Mitchell cannot reach an accommodation with the mainstream, at least in principle, this week, he may well not be able to hold the Senate in session after the final vote on the crime bill. If so, the Senate is not scheduled to return until 12 (Monday) September at the earliest and perhaps not until 19 September.

   The House is scheduled to return on 8 September (Thursday), but if the Senate has not acted on health reform, it is unlikely that the House begin considering health reform before the Senate has acted.

   Even if the House begins debate before the Senate acts, will enough time remain to enact health care this year?

2. If Mitchell is unable to accommodate Chafee, is there any proposal that is less than Mitchell that would be acceptable both politically and policy wise?

   For example a congressional resolution (a) declaring a national goal to achieve universal coverage by a date certain; (b) appointing a bipartisan commission to make recommendations to the next session of Congress to achieve that goal; (c) enacting critical insurance reforms dealing with portability, pre-existing conditions, life time limits, rate bands, medical underwriting (increasing rates), etc; (d) providing coverage for children, pregnant women, and selected others to the extent funds are available; (e) providing prescription drugs and the beginning of long term care for seniors; and (f) some deficit reduction (whether all of (d),(e) and (f) can be financed may be questionable).

Seven Scenarios Under Mitchell's Proposal

These hypothetical scenarios assume that the initial elements of the plan proposed by Senate Majority Leader George J. Mitchell (D-Maine) have gone into effect, but not the possible requirement that employers pay 50 percent of the cost of insurance for their workers. Bottom-line conclusions are based on the average price for family health insurance in the Washington area and on assumptions about how families might act if health insurance were easier to buy and more affordable. These case studies were prepared by health economist Marilyn Moon of the Urban Institute.

FEDERALLY EMPLOYED FAMILY

- **Salary and employment:** $75,000; wife makes $50,000 from government, husband $25,000 from sales.
- **Family members:** Husband, wife, two children.
- **Current health expenses:** $1,390 for comprehensive coverage from the federal insurance program. Husband covered by wife's plan.

Under Mitchell's plan: Family chooses same plan.

Bottom line: No change. Husband continues to be covered under federal policy.

SINGLE MOTHER

- **Salary and employment:** Mother receives Aid to Families with Dependent Children
- **Family members:** Mother, two children.
- **Current health expenses:** Covered by Medicaid.
- **Under Mitchell's proposal:** Family would receive a subsidy to buy insurance in the private sector at or below the average-cost plan in the area. It would have to make small payments to see a physician.
- **Bottom line:** Family could buy same insurance as non-Medicaid residents. Plans would be under pressure to open clinic in poor neighborhoods and would likely financially penalize patients who continue to use emergency rooms.

TWENTYSOMETHING, DOESN'T BUY INSURANCE

- **Salary and employment:** $25,000, first job, does not buy insurance because she does not want to pay the $45 monthly premiums above employer's contribution.
- **Family members:** Single woman.
- **Current health expenses:** None.
- **Under Mitchell's proposal:** She continues to decline insurance to save money.
- **Bottom line:** She is untouched by health reform, does not buy insurance because she does not expect to need it and if she had a serious accident that required hospitalization, her costs might well have to be borne by taxpayers or other insured patients.

WORKING POOR FAMILY

- **Salary and employment:** $19,000 from wages and tips.
- **Family members:** Husband, pregnant wife, three children
- **Current health expenses:** $130 for emergency room visit for child with 106-degree fever; school examinations obtained at free clinics.
- **Under Mitchell's proposal:** Family receives subsidies to cover wife's prenatal care and children's well-baby costs.
- **Bottom line:** Insurance, despite subsidies, still out of reach for family struggling to pay for food and housing. Wife gets care during pregnancy and children are covered. Husband goes without.

YOUNG FAMILY, CAN'T AFFORD INSURANCE

- **Salary and employment:** $28,000 from small business, no insurance.
- **Family members:** Husband employed, wife home with baby.
- **Current expenses:** Husband has diabetes. Family spent $3,000 for baby's delivery and medication for the father.
- **Under Mitchell's proposal:** Employer still offers no insurance, but family can get insurance at same rates as others. Husband cannot be turned down. Income is too high for family subsidies, which end at $24,650. Infant son would qualify for subsidies.
- **Bottom line:** Family buys modified HMO plan. The cost, minus an infant subsidy, is $3,500, one-eighth of family income.

TYPICAL METRO AREA FAMILY

- **Salary and employment:** $53,000 from father's full-time and mother's part-time job.
- **Family members:** Father, mother and one child.
- **Current health expenses:** $1,388 per year for HMO premiums (above employer's 70 percent contribution).
- **Under Mitchell's plan:** Family chooses to drop HMO; selects fee-for-service plan; pays more in both premiums and for doctor visits.
- **Bottom line:** Family now has a choice of three plans, previously was limited to an HMO selected by the father's employer.

SELF-EMPLOYED BUSINESSMAN

- **Salary and employment:** $30,000 from start-up business and other sources.
- **Family members:** Single 50-year-old man.
- **Current health expenses:** $3,000 for individual policy with a large deductible.
- **Under Mitchell's proposal:** He chooses the standard plan, which costs $2,400 (because of his age) through new version of federal employees health program.
- **Bottom line:** He has better insurance at a lower cost because he buys through a group instead of as an individual.

HEALTH CARE HIGHLIGHTS

- **THE HOUSE** got a new entry in the health legislative sweepstakes, a "moderate" bill with that rarest of attributes—bipartisan cosponsorship. The bill would expand coverage to another 5 percent of the population by squeezing savings out of Medicare and Medicaid.
- **THE SENATE** droned on for the third day with opening statements. Senators engaged in a war of anecdotes, each recalling health horror stories that would either be cured, or exacerbated, by the Democratic bill under consideration.
- **THE AMERICAN ASSOCIATION OF RETIRED PERSONS** was criticized by members who opposed its endorsement of the Senate plan.

Race-Conscious District Reinstated in Louisiana

By Joan Biskupic
Washington Post Staff Writer

The Supreme Court yesterday reinstated Louisiana's second majority-black congressional district, temporarily shelving a lower court decision that the state's voting map constituted illegal "racial gerrymandering."

The court's order, which immediately affected candidate registration for the fall election underway in Louisiana, spares black Democrat Rep. Cleo Fields from seeking reelection in a new, overwhelmingly white district drawn by a federal court. The order restores the state legislature's reapportionment map of Louisiana's seven congressional districts, which was backed by the Justice Department and challenged by four state voters as unconstitutionally segregating people based on race.

Only Justice Antonin Scalia dissented from yesterday's order, which followed an emergency request by the Justice Department and Louisiana officials. Without comment, he favored the lower court plan that called for only one majority-black district. Newest Justice Stephen G. Breyer joined the majority, but, like the others, wrote no separate statement.

The order in *Louisiana v. Hays* was not a decision on the merits of the case. Rather, it likely reflected the court's traditional deference to legislature's reapportionment plans. The court will not announce whether it will hear the dispute until the new term begins in October.

The black-majority district at issue looks like a sash across Louisiana. The legislature had earlier drawn a Z-shaped district but it had been struck down last year as improperly "race-conscious."

In its July decision, the federal district court in Shreveport said "the bizarre and irregular shape" of the new 4th Congressional District suggests that the legislature "classified its citizens along racial lines."

Responding to yesterday's order, Fields said, "The issue is not about whether I will serve in Congress, but it is about whether someone like me will have to opportunity to serve in Congress." The lower court plan would have put Fields in the same district with Rep. Richard H. Baker (R-La.).

BY RICHARD FURNO—THE WASHINGTON POST

Yesterday's order is part of a new round of national voting rights lawsuits arising from the Supreme Court's 1993 decision, *Shaw v. Reno*, enhancing the ability of white voters to challenge minority districts. The Supreme Court had said some district shapes may be so "bizarre" that they offend "principles of racial equality."

Such districts have grown out of states' efforts to comply with federal law, requiring them to strengthen the chances of minority candidates, while at the same time trying to preserve the power bases of white incumbents. The result has been several unusually shaped districts.

But the districts do not automatically violate the Constitution's guarantee of equal protection. A federal court in North Carolina, for example, recently upheld that state's creation of a meandering, worm-shaped district dominated by blacks to remedy past black-voter discrimination.

The Justice Department and state officials contend that Louisiana's second black majority district counteracted the effects of white bloc voting. (The first black district covers New Orleans.)

Jay Lefkowitz, a Washington attorney for the four Louisiana voters, said he expected them to prevail on the merits of the case. After yesterday's order, state officials began contacting candidates who already had registered to tell them a new map was in place.

Dueling Anecdotes Overshadow Details

By Dana Priest and Helen Dewar
Washington Post Staff Writers

There are a million stories about health care out in the country, and senators seem determined to tell every last one of them.

There is Maryland Democrat Barbara A. Mikulski's "guy named Willy"—her father, who died of Alzheimer's disease. There is Iowa Democrat Tom Harkin's Jim and Carol Kaplan, a middle-aged farm couple with $15,000-a-year medical bills. There is Ohio Democrat Howard M. Metzenbaum's Patrick Joyce, a 3-year-old with cystic fibrosis who, without money for medical care, "cannot lead a normal life."

The confusion over inches-high health care bills and insurance and tax code changes has given way in the first three days of Senate debate to old-fashioned storytelling. The duel over whether to make major or minor changes in the country's medical system is being fought with dueling anecdotes.

Senate Majority Leader George J. Mitchell (D-Maine) opened debate Tuesday night with three sad tales, one of a woman from Cleveland whose emphysema medication cost her $2,300 a week. "She lost her job and with it her insurance. She had to file personal bankruptcy to be eligible for Medicaid," he said.

"Why is our society willing to allow people to experience the degradation and the humiliation of begging for care after a lifetime of work and personal responsibility?" asked Mitchell, whose bill would provide billions of dollars in subsidies for low-income people to buy insurance.

Senate Minority Leader Robert J. Dole (R-Kan.) responded with the story of John Schermerhorn of New Hampshire, whose 10-year-old son nearly drowned. The boy's father believes he was saved only because he was transferred to the nearest hospital, stabilized and quickly sent to Children's Hospital in Boston for the highest-quality care.

"What makes those miracles possible is the American commitment to the freedom of individuals, the freedom of markets, and not the government," said Dole, the proponent of a much scaled-back alternative.

Lawmakers say the technicalities of health care reform are mind-numbing, if not boring, for many constituents. The human stories, help make the unintelligible understandable.

"The president and First Lady have really been great at it; it's contagious," said Sen. Pete V. Domenici (R-N.M.).

Even such events as birth or old age can propel an individual into the Congressional Record these days, as Sen. John H. Chafee (R-R.I.) did when he mentioned Diana Rebello of Pawtucket, R.I., "born Sunday night at 10:06 p.m., and Theresa Nigrelli of Westerly, "who is 100 and still stringing pearls everyday at Nigrelli Jewelers—without need of glasses."

"This legislation will affect how we are born, the quality of our lives and how we die. It is that far-reaching," said Chafee, who opposes making employers pay for insurance for their employees and wants a moderate bill.

But not Nigrelli. She thinks employer payments are a good idea. "Yeah, you've got to do it," she said. Her grandson Joe, who co-owns the family jewelry business and provides insurance for three of his four employees, said it's "only fair."

"I don't understand why the politicians don't want to do it, maybe it's because the doctors are making too much money," he said.

Most of the stories have been intensely personal, and a few have brought observers to tears.

Sen. Patty Murray (D-Wash.) talked about her own life, of growing up in Bothell, Wash., with a father with multiple sclerosis.

"He had to quit his job, and my mother was forced to take a job as a bookkeeper. She did not get health benefits with her job and my parents had to buy their own plan.

"The premiums were astronomical, the benefits were meager and the list of disqualifying preexisting conditions a mile long. . . . My mother spent all day behind a desk . . . she spent many long sleepless nights caring for my father.

"My six brothers and sister and I put ourselves through school," the senator said, because their parents had to spend their money on doctor's bills.

"While their friends sail to Hawaii enjoying their golden years, my parents count the number of times a week they eat macaroni and cheese for dinner," she said.

"My parents are ordinary people. With simple wishes. They do not want to be a burden to any of us. . . . And we only want them to be free of these worries."

Battle Lines On Health Care Drawn in House

GOP, Southern Democrats Offer Conservative Plan That Covers Only 90%

By David Rogers
Staff Reporter of The Wall Street Journal

WASHINGTON — The health-care debate is rapidly dissolving into a classic confrontation, with business and medical interests lined up against the Clinton administration and its allies in labor and lobbies for the elderly.

After more than four decades of failed attempts, this was supposed to be the year that a broad-based coalition of interests would finally push health-care reform into law. But yesterday in the House, the lines of battle were drawn when Republicans and Southern Democrats announced a conservative reform plan that will be a rallying point for opponents of the Democratic leadership's bill.

The Mitchell Health Bill
Could the health bill proposed by Sen. George Mitchell work in real life? It wouldn't be easy. Article on page A12.

With the setback hours later to the administration's crime bill, Republicans are further energized to block the president's agenda. Top White House aides came to the Capitol last night to confer on legislative strategy for health care. Democrats must overcome not only internal divisions but the mood of uncertainty that dogs their party going into November's elections. "This is the Weimar Republic," laughed Sen. Christopher Dodd (D., Conn.) last night.

Senate Democrats have no intention of altering their plans to continue on health care next week. But Speaker Thomas Foley indicated that House action on the issue will be postponed at least a week as the chamber struggles with the crime bill and awaits budget estimates on the various health proposals.

"I think the members want to do both," said House Majority Leader Richard Gephardt last night. "I think we will do both."

The new conservative reform plan in the House promises to achieve only 90% coverage over the next 10 years, leaving more than 27 million people uninsured. But by avoiding the taxes, employer mandates and cost controls espoused by the administration, it offers a safe haven for medical and business interests who have grown fearful of more ambitious reforms.

Already endorsed by the American Medical Association, the measure will be quickly embraced by lobbies for retailers, other business, for-profit hospitals and research drug firms. The success of health-care reform has depended on many of the same groups' feeling secure enough to make concessions in the name of improving the current health system. Their embrace of the conservative bill underscores how far those hopes have faded. And instead of coming together in the name of change, competing interests now seem determined most to protect what they already have.

"People want reform, but they want it done cautiously," said Rep. Fred Grandy, an Iowa Republican and part of a younger intellectual cadre who once favored a more ambitious approach to reform. "Some of the expectations about health-care reform are unrealistic," said a Grandy ally, Rep. Jim Cooper (D., Tenn.). "We've got to be able to deliver on what we promise."

What the conservative bill promises is a mix of insurance market reforms and subsidies targeted to families earning as much as 200% of the poverty level. Much of the current Medicaid program for the poor would be folded into this subsidy system. While the resulting savings are significant, the plan is severely restricted because of the decision to avoid even a modest tax increase on cigarettes.

By the year 1998, the proponents hope to be able to subsidize coverage for families below the poverty level, but it could take another six years before the same assistance is fully available for those up to 200% of the poverty line. This is a far slower pace than that proposed by moderate Republicans in the Senate. And while pregnant women and children would qualify for assistance up to 240% of the poverty level, the bill offers far less for working-class families than what has been proposed by the Democratic leadership.

As outlined, the bill would expend about $140 billion over the first five years. Apart from the subsidies, the measure includes expanded tax deductions for the self-employed and workers who buy

Please Turn to Page A4, Column 3

Callers Protest as AARP Endorses Health Proposals

By a Wall Street Journal *Staff Reporter*

WASHINGTON—The American Association of Retired Persons was flooded with calls protesting its endorsement Wednesday of the health bills offered by the Democratic leaders in Congress.

So many calls poured into the group's Washington headquarters yesterday that its phone lines were tied up for much of the morning and afternoon. John Rother, the AARP's chief lobbyist, estimated that about 1,000 calls came in Wednesday and yesterday, the bulk of them blasting the group for its stance.

But he added that it wasn't a surprising reaction, given that the AARP has about 33 million members. "Our members span the ideological spectrum," Mr. Rother said. "Whenever we do something like this, we hear from the extremes first."

The United Seniors Association, a conservative group opposing the Clinton and Democratic leadership health plans, said it had heard yesterday from more than 300 "angry seniors who say they've had it with the AARP," according to spokesman Mike Korbey. "We've been swamped."

Bipartisan Group in House Offers Conservative Health Reform Plan

Continued From Page A3

their health insurance without any employer contribution. Medicare and Medicaid savings would finance the bulk of the package, but the measure also includes a potentially controversial provision to eliminate existing aid for legal aliens whose financial sponsorship agreements have lapsed or defaulted.

The expanded deductions have been a major cause for the National Federation of Independent Business, and the U.S. Chamber of Commerce rushed to praise the bill. The AMA won malpractice reforms including a $250,000 cap on noneconomic damages. The Health Insurance Association of America, which has fought bitterly against the administration this year, also is expected to be sympathetic to the measure, though Mr. Cooper and his allies were able to win tougher fair-rating practices than first proposed by the House GOP, making it harder for companies to deny insurance or charge higher rates to women, for example, or the disabled.

At its heart, the bill remains a stalking horse for the Republican leadership, which hopes to take advantage of divisions among Democrats and replicate its victory on the crime bill. Minority Whip Newt Gingrich has quietly lent support to the alternative. In a dig at the Georgia firebrand's tactics, Rep. Gephardt refers to the new conservative entry as "Gingrich-bipartisan."

The House schedule on health reform is driven in large part by the need to finish Congressional Budget Office estimates for the competing plans. And the process has been further extended as all sides make revisions in an effort to build support.

Until the CBO completes its analysis, the full cost of these modifications won't be known, but Mr. Gephardt has plunged ahead in an effort to fortify alliances with large state delegations. California-based Amgen Inc., a large supplier of a drug for chronic renal failure, stands to benefit from concessions to the biotech industry. And adjustments in a new $50 million-a-year program could open the door for additional non-profit hospitals in New York, North Carolina, Indiana, and California to apply for interest subsidies on large development projects under way.

In an effort to appease liberal critics, the revised Democratic bill would set a substantially lower out-of-pocket cap on personal medical expenses than had previously been approved by the House Ways and Means Committee. The new ceiling, $3,000 per individual and $6,000 per family, is still much higher than that proposed by President Clinton and contained in many private health plans. And within the Medicare program, the leadership would require higher-income recipients to pay more for their Part B non-hospital care benefits to provide more money for long-term health care.

Mitchell's Health-Care Proposal Doesn't Cut Headaches of Administering Complex System

By Hilary Stout
Staff Reporter of The Wall Street Journal

WASHINGTON — President Clinton likes to say the bottom-line test for any health-care reform plan should be whether it works.

The health bill proposed by Majority Leader George Mitchell that the Senate began debating this week is supposed to extend medical coverage to 95% of the population by the turn of the century. The formal arbiter of such claims, the Congressional Budget Office, says the system of subsidies and insurance market rules established by the legislation could indeed accomplish this.

But could it work in real life?

It wouldn't be easy. The existing health system is already enormously complex, with 1,500 different insurance companies, each with its own bureaucratic structure. And the ability to carry out any major health-care legislation would be even more daunting than getting the legislation passed in the first place. But Sen. Mitchell's bill, in trying to target subsidies to the people who need them most and step around politically explosive cost-control and employer-mandate measures, would add new challenges that make the system he envisions particularly tricky to administer.

Subsidies

The Mitchell bill targets federal financial assistance to a wide array of specific populations — such as children, pregnant women and temporarily unemployed workers — not just low-income people. Specifically, it offers subsidies to families with incomes below 200% of the federal poverty line — $32,000. But children younger than 19 and pregnant women would get subsidies if their incomes were as high as 300% of poverty, or about $44,000 for someone in a family of four.

Economists say that targeting the subsidies to particular needy populations is a more efficient approach than targeting an entire income class. "That's a way of directing your money in a more cost-effective manner," says CBO Director Robert Reischauer. "You get more coverage per dollar that you spend if you aim for lower-income children or the unemployed." However, the administration of such a program becomes extremely complicated.

Take a family at 250% of poverty. The father might not qualify for any aid, but the children or wife — if pregnant — could. How are the eligible people identified? And to whom does the government give the aid if the family is buying a family policy? How does the woman prove she's pregnant? Does her coverage end as soon as she is out of the delivery room?

"Any policy that makes government subsidies a function of pregnancy is fraught with problems," says Uwe Reinhardt, a health economist at Princeton University. "It sounds so good because we're all protective of pregnant women. . . . But I'd rather have it be any mother of children under 18." But that would be far more expensive for the federal Treasury and, of course, the U.S. taxpayer.

Similarly challenging under the Mitchell bill is identifying people who would be eligible for a new subsidy for temporarily unemployed people — that is, those who were full-time employees and who had health coverage for at least six months before they lost their job. This program would assist people until they find a job, for up to six months.

The bill also would have a program that aims to encourage businesses to expand their employee health-insurance coverage voluntarily. If a business covers only full-time workers and decides to expand coverage to part-time employees, for example, it could get some government help. The employer would pay 50% of the premium or 8% of each newly insured employee's wage, whichever is less. The worker would pay 50% of the premium. The subsidy would phase out for each company after five years.

The general idea of the Mitchell bill is to have states carry out this new system. But Republicans and some state officials contend that such a scheme would heap enormous new and costly administrative burdens on states, which they claim are already choking under federal mandates. Sen. Mitchell says states are in an ideal position to administer the subsidy program because they already have a bureaucracy in place for the Medicaid low-income health program that has similar functions. "They have extensive experience," he said recently. "They have to determine who is eligible for getting the subsidies. That's what they've been doing in Medicaid." Moreover, he adds, "They will be getting financial assistance."

If Congress shuns the politically difficult employer mandate, the health-care reform debate will inevitably become a bidding war over subsidies: how much money can help how many more people obtain health insurance and where the money would come from. The Mitchell plan is simply the most ambitious of the proposed subsidy schemes to date, and therefore the most vulnerable to attack.

Mandates

Recognizing that the White House's proposal to immediately begin phasing in a requirement that all employers pay for 80% of their workers' health insurance plans didn't have the votes in the Senate, Mr. Mitchell is proposing a far weaker, last-resort-only mandate. If a state hasn't achieved 95% coverage by the year 2000—and if Congress hasn't approved a plan to cover the rest — a backstop mandate would take effect for the state in 2002. It would require companies with 25 or more workers to pay for 50% of their employees' health insurance premiums. A so-called individual mandate would fall on workers in companies with fewer than 25 employees, requiring them to obtain insurance, with the promise of some federal financial assistance.

A CBO analysis of the Mitchell plan, released this week, raised numerous problems with the practical administration of this partial mandate. One of the biggest complications is the state-by-state implementation. Having the mandate apply only to particular states may be easier for lawmakers to digest, but the CBO says: "The practical problems of implementing mandates in some states and not in others could be overwhelming. 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?" Moreover, economists, including those at the CBO, worry about a migration of companies from states with a mandate to states without one.

Insurance Tax

Since President Clinton's government-imposed health insurance premium caps proved to be unpopular on Capitol Hill, Sen. Mitchell has proposed another way to attack the cost problem. To discourage insurers from instituting large price increases, his bill would levy a 25% tax on the amount by which premiums for a federally defined standard benefits package exceed a "reference premium." This has caused so much consternation among senators that it may be one of the first things scrapped. But if it stays, the CBO says it will be enormously difficult to administer.

For one thing, the Treasury secretary would have to calculate the "reference premium" every year for every regional community-rated insurance pool — at least one per state. "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," the CBO says, adding: "Little reliable information of this sort is available."

—David Rogers contributed to this article.

Health-Care Challenge

Administering the Mitchell plan:

SUBSIDIES

- For individuals and families with incomes under 200% of poverty
- For children under 19 up to 300% of poverty
- For pregnant women up to 300% of poverty
- For temporarily unemployed and uninsured workers who were full-time employees with health coverage before they lost their jobs
- For employers who expand coverage to an additional class of worker (such as all part-time employees)
- For employees in firms with fewer than 25 workers, with incomes under 200% of poverty

MANDATES

- Could go into effect on state-by-state basis in 2002 if coverage in the state is below 95%, or if Congress hasn't acted on other recommendations to expand coverage
- Requires all firms with 25 or more workers to pay for half their employees' health insurance
- Requires all workers in firms with fewer than 25 workers to obtain health insurance (employer has no obligation.)

INSURANCE TAX

- 25% tax on the amount by which insurance premiums exceed a "reference premium"
- Reference premium calculated for each community-rated pool by Treasury secretary based on formula involving: age, sex, socioeconomic status, health status, current health spending levels, uninsured, underinsured, presence of teaching hospitals

Health Care Reform

August 2, 1994

- **Both the House and Senate bills, as proposed by Congressman Gephardt and Senator Mitchell achieve what the American people want -- Universal Coverage -- guaranteed health insurance that can never be taken away.** The bills ensure real health security for hard working middle class Americans who deserve nothing less. We applaud both Majority Leaders and the many members of the House and Senate who have been working diligently to bring bills to the floor which work for ordinary Americans.

- These bills utilize distinct approaches to achieve the common goal of health care coverage for every American. And while differences in the approaches exist -- the similarities are essential. Both bills provide universal coverage, enable Americans to keep their current insurance and their family doctor, maintain quality health care, and provide greater opportunity to keep health coverage affordable for American families. And both have chosen to build upon the current system of shared responsibility -- a system we know works -- to achieve universal coverage.

- **We have made extraordinary progress toward realizing guaranteed health security for every American**. The Senate and House are now poised to cast an historic vote in favor of the hard working middle class. We have come this far and we must not turn back now. If Congress fails to achieve universal coverage, we will not do our best to control health care costs and we will not do our best by middle class Americans. That's simply unacceptable.

- **The House and Senate will soon begin a debate that will engage every American family concerned about their health security.** And while the differences in these approaches will be worked out as the legislative process moves forward, the bottom line of universal coverage must remain the same. During the course of the historic floor debate, there will be those who will say that achieving universal coverage is not necessary. To those, we say, let the debate begin. Fighting for universal coverage is a fight for the middle class. This is a debate we must -- and we will -- win.

United States of America

Senator John Breaux

Democrat-Louisiana

Contact: Belle Phelan, Karen Gravois, 202-224-4623; Bob Mann, 504-382-2050

FOR IMMEDIATE RELEASE **August 2, 1994**

SEN. BREAUX SAYS MITCHELL HEALTH CARE PLAN A GOOD START

WASHINGTON (Aug. 2) -- Sen. John Breaux (D-La.) issued the following statement in response to a new health care reform outlined today by Senate Majority Leader George Mitchell:

"George Mitchell has taken a major step forward on health care legislation based on market reforms rather than relying on bureaucratic mandates and regulations. It's a good start and Congress should now begin its work on the floor."

###

SUMMARY OF THE HOUSE BILL

Coverage

- Universal coverage achieved by January 1999, offered through private plans, including an expanded FEHBP plan, and a new Medicare Part C program for the unemployed, low-come and others not served by private system (see below).

- Standard benefits package includes inpatient/outpatient hospital and physician services, prescription drugs, mental health, substance abuse, preventive care. HHS Secretary defines 10 classes of supplemental packages that insurers can offer.

Insurance Reforms

- Insurance reforms include guaranteed issue, guaranteed renewability, ban on pre-existing condition exclusions, patient access improvements, and anti-discrimination provisions.

- Insurers must sell policies to individuals in firms or groups of 100 or fewer at a "pure" community-rate.

- Employers or associations with 100 or more members can self-insure.

- Any provider willing to accept a plan's fees/schedules is guaranteed ability to contract with any plan.

- Individuals have choice of at least one fee-for-service, and one managed care plan, and a catastrophic plan with a medical savings account.

Financing

- Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Subsidies in the form of tax creditsavailable to firms of 50 or fewer workers, based on average payroll.

- Individuals required to pay 20% of premium costs. Full subsidies for individuals up to the pverty level. Sliding scale of subsidies from 100% to 240% of poverty.

Cost Containment

- Federal spending is constrained by integrating the Medicaid program into Medicare C and by limiting the growth for Medicare part A through C to the rate of GDP growth by 2000.

- A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 if expenditures exceeded targets. Congress must approve the cost containment on its own, otherwise Medicare's payment methods would go into effect on January 1, 2001.

Medicare, Medicare Part C, Medicaid, UFEHBP

- Medicare would be retained and strengthened through drug, preventive and mental health benefits. Caps and other savings mechanisms would be added to slow spending to targeted growth rates.

- Medicare Part C would be established in 1999 for all those not covered by employer provided insurance plans and for individuals in firms with fewer than 100 workers who choose the Part C option.

- Employers could offer coverage to their early retirees through Medicare Part C. Medicaid program for acute care would be replaced by the Medicare Part C program. States would continue to manage Medicaid's long-term care component.

- Universal FEHBP would be established after insurance reforms and would be available to individuals working in firms of 100 or fewer employees.

States

- Those states who have already started reforming their systems will be able to continue with these reforms, and those would like to establish their own systems -- including single payer, managec competition or employers mandate systems -- will be able to.

Tax Provisions/Miscellaneous

- The bill also includes investments in public health initiatives, a consumer protection program, a commission for studying integrating worker's compensation and automobile insurance, a $.45 increase in the cigarette tax, an expansion of rural health care facilities, and a 2% surcharge on private premiums.

HOUSE HEALTH BILL

Democratic Caucus Information Packet
July 29, 1994

House Health Bill
Democratic Caucus
July 29, 1994

HOW OUR PLAN WORKS

- **Ensures that everyone will have health insurance by 1999.**

- **Accomplishes universal coverage through employer-employee shared responsibility -- 80/20.**

- **Provides subsidies for small employers & families.**

- **Medicare Part C -- option for:**
  - **low income families.**
  - **seasonal and part-time workers.**
  - **unemployed.**
  - **small business employers and their employees.**

Constrains federal costs directly and contains private sector costs thru competition.

- **Choice of health care plans:**
  - **At least one managed care;**
  - **At least one choice for your own doctor;**
  - **For some, FEHBP;**
  - **For some, Medicare Part C;**
  - **Medical savings account.**

- **Nationally guaranteed benefit package including prescription drugs, women's health, mental health, preventative care and long-term care.**

- **Brings doctors and high quality health facilities to inner cities** and rural areas.

What Does Our Plan Do For The American People?

- Provides guaranteed health insurance that can never be taken away.
- If you change jobs, you don't lose coverage.
- No pre-existing conditions/exclusions.
- Provides choice of doctor.
- Keeps insurance costs down.
- People with health insurance coverage now -- stays the same or gets better.

How will our plan affect people who already have health insurance?

- Present coverage stays the same or gets better.
- Can't lose coverage because of illness.
- Won't lose coverage if you change jobs.
- Parents get prescription drugs through Medicare.
- More long term care.
- Increases number of providers in rural and urban areas.
- Simplifies forms.

Key Differences from the Clinton Plan

- **NO** mandatory alliances.
- **NO** new, large government bureaucracies to run the system.
- **NO** automatic price controls, as government would serve only as a back-up to private sector efforts.
- **NO** disruption to the large marjority of Americans who already have health insurance.
- Guarantees every American the right to choose their own doctors and health plan.
- Establishes a federal safety-net insurance plan to ensure that an affordable insurance plan is available to every American.

Budget Consequences

(Preliminary Estimates)

In the first 5 years = Reduces deficit by $2 billion

In the second 5 years = Reduces deficit by $15 billion

HOW WILL THE PLAN BE PAID FOR?

Most of the cost of the program will be covered by contributions from employers and individuals.

Additional funds will be required to pay for improvements to the current Medicare program, the new long-term care program, subsidies for low income individuals and small, low-wage companies, and assistance to academic medical centers. Funds to cover these costs will be raised in four sensible and fair ways:

- **Savings from slowing the rate of growth in Medicare and Medicaid costs;**
- **A gradual and moderate increase of 45¢ in the tax on tobacco products;**
- **Eliminating the tax subsidy for health benefits provided through cafeteria plans;**
- **and a 2% surcharge on private health insurance premiums.**

Health Insurance Premium Obligations Under House Bill

Illustrative Examples

Example 1: **Single-Parent Working Family with One Child**			**Example 2:** **Two-Parent Working Family with Two Children**		
Income Level	Annual Family Premium	Actual Monthly Premium Owed	Income Level	Annual Family Premium	Actual Monthly Premium Owed
<$11,500	$834	$0.00	<$16,000	$1,134	$0.00
$19,550	$834	$35.00	$27,200	$1,134	$47.25
$23,575	$834	$52.00	$32,800	$1,134	$70.75
$27,600 and up	$834	$69.50	$38,400 and up	$1,134	$94.50

Protections for Low Wage Workers and Other Low Income Individuals Under House Bill

Protections for Lowest Income Families	Protections for Other Low Income Families
Income Levels: ▸ Individual: up to $7,400 ▸ Single-parent family with one child: up to $11,500 ▸ Two-parent family with two children: up to $16,000	**Income Levels:** ▸ Individual: $7,400 - $17,760 ▸ Single-parent family with one child: $11,500 - $27,600 ▸ Two-parent family with two children: $16,000 - $38,400
Key Features of Bill: ▸ No premium obligation ▸ No cost-sharing for health benefits ▸ Comprehensive supplemental benefits for children	**Key Features of Bill:** ▸ Premium subsidies on sliding-scale basis ▸ No cost-sharing for pregnant women, children and cash recipients up to 200% poverty threshold ▸ Comprehensive supplemental benefits for children to 200% poverty threshold

Acme Shoe Company

(Employs 4 low wage workers)

- **In four years, ACME is required to cover 80% of their employees' health insurance. ACME can do this by:**
  - **Enrolling employees in Medicare Part C.**
  - **Offering choice of at least 2 private plans:**
    - **Choose own doctor**
    - **Managed care**
  - **Medical Savings Account.**
  - **Universal FEHBP.**
- **These payments are fully deductible to the company.**
- **ACME will be subsidized for 50% of their employees health care costs.**

Relief for Small Businesses

- Reduced premium obligations through a tax credit of up to 50% of the employer's share of the premium.
- Community rating keeps premiums affordable when an employee gets sick.
- Relief through changes made to workers compensation.
- Access to safety net public program -- Medicare Part C.
- Medical Savings Account.
- Self-employed individuals can deduct 80% of premiums.

Employer Contribution

	# of Employees	Average Wage of Employees in the Firm	Annual Average Employer Payment Per Worker
Firm 1	5	$11,000	$1,275/$0.16 per hour
Firm 2	50	$11,000	$1,613/$0.78 per hour
Firm 3	100	$11,000	$2,625/$1.26 per hour
Firm 4	500	$11,000	$2,625/$1.26 per hour
Firm 5	1,000	$11,000	$2,625/$1.26 per hour
Firm 6	6,000	$11,000	$2,625/$1.26 per hour
Firm 7	5	$25,200	$2,548/$1.22 per hour
Firm 8	50	$25,200	$2,567/$1.23 per hour
Firm 9	100	$25,200	$2,625/$1.26 per hour
Firm 10	500	$25,200	$2,625/$1.26 per hour
Firm 11	1,000	$25,200	$2,625/$1.26 per hour
Firm 12	6,000	$25,200	$2,625/$1.26 per hour
Firm 13	5	$39,600	$2,625/$1.26 per hour
Firm 14	50	$39,600	$2,625/$1.26 per hour
Firm 15	100	$39,600	$2,625/$1.26 per hour
Firm 16	500	$39,600	$2,625/$1.26 per hour
Firm 17	1,000	$39,600	$2,625/$1.26 per hour
Firm 18	6,000	$39,600	$2,625/$1.26 per hour

Meeting the Needs of Rural America

Expansion and Integration of Rural Health Care Facilities

- More doctors, nurses and health care professionals will dramatically strengthen rural primary care centers and the National Health Service Corps.
- To rebuild and expand the capacity of health care facilities serving underserved populations, substantial funds would be available for the capital needs of certain rural and urban facilities.
- The development of managed care plans in rural areas would be supported.

Expanded primary care provider incentives

- Medicare bonus payments for physicians in underserved areas would be increased to 20% (from 10%).
- Physicians providing primary care services in rural underserved areas would be eligible for a tax credit of $1,000 per month for up to 60 months; nurse practitioners, certified nurse-midwifes, and physician assistants would be eligible for a tax credit of $500 per month.

EXPANDING THE GUARANTEE OF HEALTH SECURITY FOR SENIORS

Expanding Medicare Benefits

- A new prescription drug benefit would be added to the Medicare program
  - the benefit would provide unlimited prescription drug coverage with a $1,000 cap on beneficiary out-of-pocket costs.
- Medicare coverage of mammography screening for women age 65 and older would be enhanced.
- New preventative health benefits would be added.

New long-term care program

- An important first-step in providing needed services to individuals with severe disabilities would be provided through a new program to cover long-term home and community based care.

Maintaining beneficiary choice under Medicare

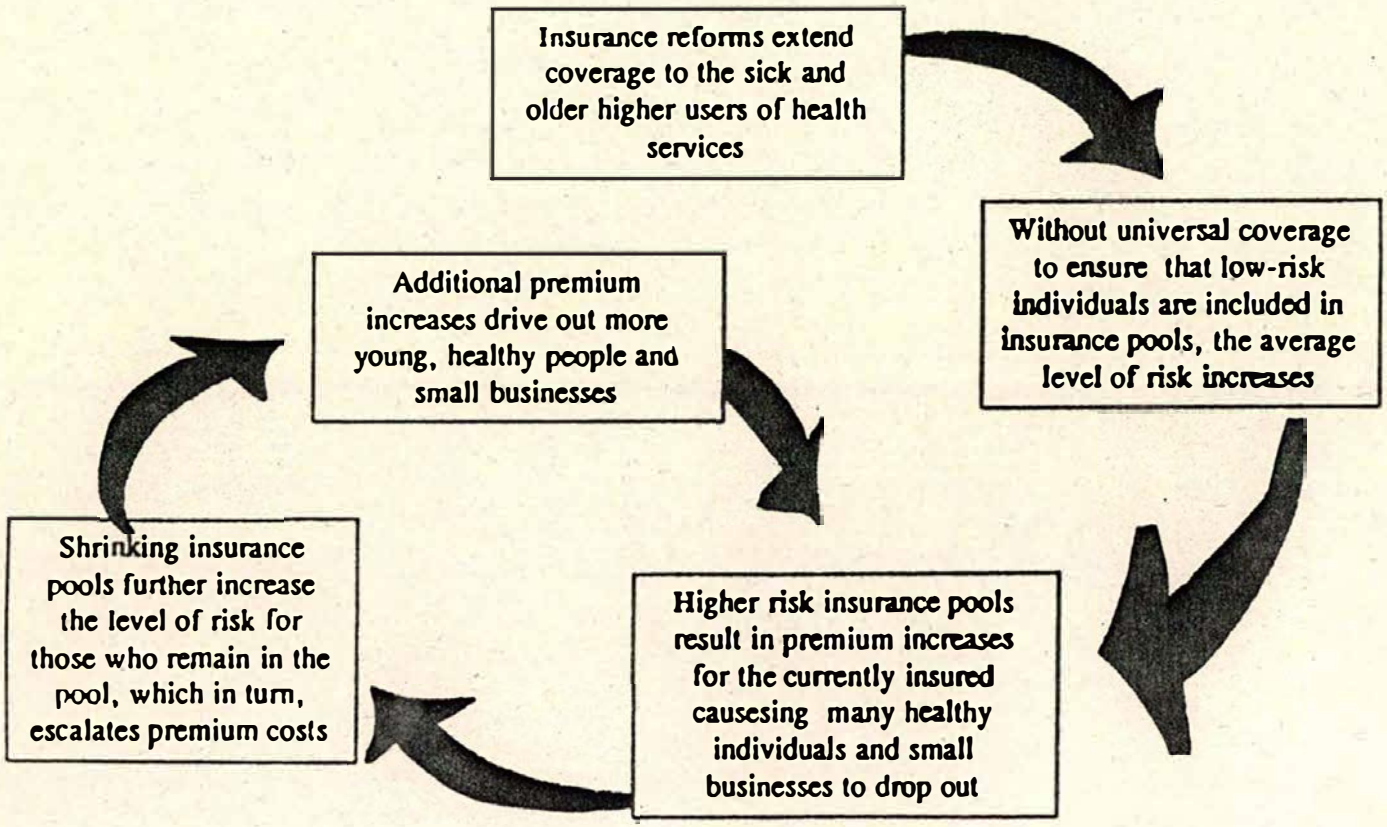
- The ability of Medicare beneficiaries to access their providers of choice would be preserved.

Alternative Plans Don't Work

- **DO NOT GUARANTEE HEALTH INSURANCE FOR EVERY AMERICAN.**
- Insurance reform alone increases premiums for most of the insured.
- Insured forced to pay more to offer subsidies for the uninsured.
- Create business uncertainty.
- Encourage people to buy insurance only when they get sick.
- Encourage insured to drop coverage.
- Encourage welfare dependency.

The Vicious, Upward Spiral

The Impact of Incremental Reform on Insurance Premiums



Working Families' Premium Payments

Family of 4

Family Income	House Bill	Dole Bill	Additional Cost of Dole Plan
$14,781	$0	$1,699	$1,699
$25,000	$560	$6,796	$6,236
$35,000	$1,134	$6,796	$5,662
$45,000	$1,134	$6,796	$5,662

QUESTIONS AND ANSWERS
ABOUT
THE HOUSE DEMOCRATIC LEADERSHIP
HEALTH REFORM PROPOSAL

On July 29, 1994 the House Democratic Leadership announced its health reform proposal. The plan announced by the Leadership is based on the health reform plan passed by the Ways and Means Committee, and includes key improvements made by the Leadership.

This plan offers a simple and logical way of achieving the President's goals of universal coverage and cost containment that:

- **Minimizes disruption to our current health care system and to the 85% of Americans who already have insurance**
- **Guarantees unrestricted choice of doctors and hospitals for all Americans -- regardless of income**
- **Is affordable to all**
- **Ensures and improves the quality of care**
- **Creates no new bureaucracies**
- **Creates no new broad-based taxes**

Under the plan, every American will be covered by a comprehensive set of health care benefits by January 1998 and, by the year 2001, health care inflation will be brought in line with the rest of the economy.

Question: *How will the plan guarantee universal coverage?*

Answer: The Leadership plan includes three steps that, together, provide a concrete path to health security for all.

The plan will build on our existing employer-based system to ensure coverage for everyone who is connected to the work force. Today, the majority of Americans

competition in the health care market. If after five years, these market forces fail to control costs, a system of cost containment would go into effect.

In those states where market reforms and other State strategies don't work, a national "fee schedule" system -- or an alternative system proposed by a new national cost containment commission (which will be adopted, rejected, or changed by the Congress in 2000) -- will be applied. Under the fee schedule system, maximum payment rates for medical services would be set, and each year, these rates would be increased at levels that would keep spending within the target.

Like it is now, this "fee schedule" system would be used to pay doctors and hospitals who provide care under the Medicare programs.

By controlling costs in this way, the Leadership plan will give the private market a fair chance to control costs, will keep fee-for-service medicine affordable, and will maintain the kind of delivery system that most patients and providers prefer.

Question: ***What benefits will be included in the standard package?***

Answer: Every American will be guaranteed a health insurance package that covers a comprehensive set of benefits, including prescription drugs, mental health and substance abuse services, and preventive care. Covered minimum benefits will include:

Service	Cost-Sharing Schedule	
	Fee-for-Service	Managed Care
Inpatient hospital services	no cost sharing	no cost sharing
Outpatient hospital services	20% co-pay	$15.00
Physician and other health professional visits	20% co-pay	$15.00
Medical and other health services including services and supplies provided as part of a physician's care, diagnostic, laboratory and other tests, surgical dressings, splints and casts, durable medical equipment, ambulance services, prosthetic devices, hearing aids for children, physical, occupational and speech therapy services, nurse mid-wife services	20% co-pay except no co-pay for diagnostic tests	$15.00
Outpatient prescription drugs/biologicals	20% co-pay	$10.00

Question: *What happens if I want additional benefits to those covered in the standard benefit package?*

Answer: The Leadership plan does not in any way limit the amount or kind of additional benefits that people can buy.

The Secretary of Health and Human Services will define ten standard supplemental insurance packages that insurers can offer. Any individual who wants to purchase supplemental insurance or additional benefits -- either to cover services not included in the basic benefit package, or to cover co-pays and deductibles -- may purchase these benefits. And, any employer who wants to provide benefits that exceed those covered by the standard package can do so, so long as they provide the extra benefits to all of their employees equally.

By establishing a set of standardized supplemental packages, the plan will help consumers make meaningful comparisons among supplemental packages, and will ensure that consumers are not being offered supplemental insurance for benefits already provided in the nationally guaranteed package.

Question: *In general, how does this plan change the current health care system?*

Answer: One of the main objectives of the Leadership plan is to fix what is wrong with our current system while making as few changes as possible to existing relationships among insurers, employers, providers, and consumers, and to the way people already purchase, pay for, and get their health care. As a result, there will in general be little disruption -- and few changes -- to the current system.

Most people will continue to receive their health insurance through private plans provided through their employers; employers will retain their role as negotiators on behalf of their employees; employees will continue to contribute to their coverage through deductions from their paychecks; and all the options which currently exist for health care delivery -- including fee-for-service and managed care -- will continue. In addition, employers may choose to offer their employees and contribute to a high deductible plan with a medical savings account.

Question: *How will this plan affect me, and what kind of changes will I see?*

Answer: There are several basic and important benefits to everyone. Everyone will see a reduction in the rate at which their health premiums increase. No one will be denied coverage or lose their coverage when they change jobs. Over time, as the cost to employers of providing coverage decreases, workers should also see an increase in their wages.

Question: *How much will health coverage cost individuals?*

Answer: In general, the maximum amount most people will pay for health insurance will be limited to 20 percent of the cost of their insurance. Employers will pay 80 percent of the cost of the package for their full-time employees, and will contribute for their part-time workers based upon the number of hours worked.

Under the Leadership plan, every insurer will be required to offer the guaranteed benefit package for three basic "classes" of enrollment: individual, single-parent family, and two-parent family. Couples without children may choose to purchase two "individual" policies.

The table below illustrates the estimated cost of the guaranteed benefit package, along with the approximate amount that full-time workers will pay each year.

Estimated Cost of Guaranteed National Benefit Package under the Leadership Plan

	Individual	Employer*	Total
Individual	$428 (.21/hr)	$1,712 (.84/hr)	$2,140 (1.05/hr)
Single Parent Family	$834 (.40/hr)	$3,336(1.60/hr)	$4,170(2.00/hr)
Two-Parent Family	$1,134(.54/hr)	$4,536 (2.18/hr)	$5,670 (2.78/hr)

*These numbers reflect the approximate employer obligation for employers with more than 50 employees, and for high-wage employers with less than 50 employees. Low-wage employers with fewer than 50 employees will have lower premium obligations.

In general, although premiums will vary somewhat across insurers, coverage for a comprehensive set of medical benefits will be available to every person -- depending upon family status – for between about $35 and $95 a month. For those whose employers choose to contribute more than the required amount, or for those whose employers offer an alternative "high-deductible medical savings account" plan, these amounts may be even less.

Question: *What about low-income people who cannot afford to pay?*

Answer: The plan would make sure that <u>every</u> person can afford to purchase the health insurance to which they are entitled, and to use the services covered by the guaranteed benefit package.

a plan's enrollees, the appropriateness and outcomes of the services provided, and patients' overall satisfaction with their care. States will be required to provide the results of these assessments to consumers at least once each year, and to take steps to fix any problems that are found.

As added assurance that people do not "get stuck" in health plans that are not meeting their needs, the proposal will ensure: 1) that every individual is able to change health plans, without cause, during a minimum six week period each year, and; 2) that -- in cases where a health plan is not complying with health insurance standards -- individuals could disenroll from that plan at any time, and enroll in a new plan.

Question: *What will be done to ensure access to care for people living in underserved rural and inner city areas?*

Answer: People living in rural and inner-city communities often face special barriers to obtaining health care that others don't face. These barriers include a shortage of doctors and other health care providers, inadequate medical facilities, and an insufficient number of health plans serving these areas.

The Leadership plan includes six initiatives to eliminate these barriers and to make access to health care a reality for people in inner-city and rural areas.

- Grants will be available to all fifty states to help them develop health care networks in underserved areas.

- A new grant program will be made available to local governments and health care facilities to help them expand or establish primary and acute care networks in underserved areas.

- Financial assistance will be provided through a new federal trust fund to inner city and rural medical facilities to help them meet their capital financing needs.

- The resources available to primary care doctors practicing in rural areas will be increased by doubling Medicare bonus payments, and by providing tax incentives to primary care doctors, nurse practitioners, and others who locate in rural and urban underserved areas.

- Substantial new federal funding would be provided to support the operation of community and migrant health centers

- Additional funding for the National Health Service Corps would be provided.

Question: *How will small employers be able to afford to pay?*

Answer: More than half of all employers with fewer than 100 employees already contribute to the cost of health coverage for their workers. Among small employers who do help pay, the average contribution in 1992 was about $2,300 (EBRI, *Sources of Health Insurance and Characteristics of the Uninsured,* 1994). For these firms, and particularly for those that currently offer this level of coverage to all their employees, providing coverage under the Leadership plan will result in minimal if any additional payments.

Those small businesses which are currently least likely to help pay for their employees health coverage are low-wage businesses with fewer than 50 employees. The Leadership plan will help low-wage small businesses who would otherwise have a difficult time making their required contributions in several ways.

Subsidies will be provided to small, low-wage businesses to reduce the amount they must contribute toward their workers' premiums: firms with 25 or fewer employees would be eligible for a maximum subsidy of 50 percent, and firms with 26-50 employees would be eligible for a maximum subsidy of 37.5 percent. For companies with 25 or fewer employees, the subsidy will reduce the employer obligation for an individual premium from about $.85 per hour to about $.42 per hour. For companies with 26-50 employees, the subsidy will reduce the obligation to about $.53 per hour.

The new Medicare Part C plan and the expanded Federal Employee Health Benefits Program will offer small employers two simple and affordable ways of providing high quality coverage for their employees.

Question: *How will states be affected by the plan?*

Answer: Under the Leadership plan, states will have broad flexibility to create the kind of health system that best meets the needs and desires of their citizens -- so long as the system meets the national goals of universal coverage and cost containment. Those states who have already started reforming their systems will be able to continue with these reforms, and those who would like to establish their own system -- including single payer, managed competition, or employer mandate systems -- will be able to.

States may also see a significant reduction in their health care spending under the proposal. As their uninsured residents are brought into the health care system, the increasingly large share of state and county resources being consumed by uncompensated hospital care and indigent health care programs should be reduced.

services, however, do not require any "bureaucracy" beyond the few payers -- public and private insurers -- themselves. Each of these payers has a strong incentive to know and pay only the right price, and each of the sellers -- doctors and hospitals -- has a strong incentive not to jeopardize a relationship that pays the bills for hundreds of patients. In fact, the vast majority of private insurers already use some form of fee schedule to establish the amounts they will pay for each service

The second concern is that price controls make the buying and selling of goods more complicated. Fee schedules, however, actually *simplify* the administrative aspects of "selling" and "purchasing" health care. In a system without maximum payment rates, doctors and hospitals have to figure out what different insurers will pay for their services, insurers have to figure out providers' "charges", and disagreements have to be fought over and resolved. With fee schedules, everyone knows what they can charge and what they will be expected to pay.

The third concern is that price controls only hold costs down temporarily, and that when the controls are removed, inflation comes back at even higher levels than before. Fee schedules for medical services, however -- although updated and revised -- would not be removed. As a result, there is no danger of a bout of post-control inflation.

The fourth concern is that price controls lead to "waiting lists" or "shortages". Fee schedules for doctors and hospitals, however, do not impose any kind of constraint or arbitrary limit on a medical system's capacity to provide needed care. There are no cut-off points after which doctors and hospitals will not be paid, and there are no incentives to not provide needed care. Under the Leadership plan, if spending exceeds the "expenditure target" in a particular year, the fees paid to providers the next year will simply be allowed to rise less.

Question: ***Will fee schedules work to control costs ?***

Answer: Some argue that fee schedules will not provide an effective means of controlling costs because providers will increase the number of services they provide to make up for lost revenues.

Evidence from this country's Medicare program -- and from the five other countries which use fee schedules -- makes clear that while the volume of certain services may increase some, fee schedules provide an extremely effective way of controlling costs. There are two reasons why this is the case.

The first is that there are several factors that "naturally" limit how much the volume of services and goods will increase. While physicians may well be able to tell a patient to come back in for an "extra office visit", other providers who do not "prescribe what they provide" -- like hospitals and

Highlights of House Democratic Healthcare Reform Bill

I. Universal Coverage

All individuals would be guaranteed coverage under a health insurance plan providing at least a guaranteed national benefit package. Individual choice of health plan and provider would be maintained. Health insurance coverage would be provided under private plans, including a new universal FEHBP, and under a new public insurance program similar to Medicare, which would be created as a safety net for those not served under the present system.

In 1999, all individuals would be responsible for paying the full premium of the health plan in which they enroll, minus their employer's contributions. Low-income families would receive assistance in meeting their premium obligations.

II. Individual and Employer Responsibilities

All individuals would be covered under a plan that covers the guaranteed national benefit package. All individuals would be responsible for paying the full premium of the health plan in which they enroll, minus the amount contributed on their behalf by their employers. The premium obligation would be zero for individuals with incomes below the poverty threshold, and would increase on a sliding-scale basis between 100 and 240 percent of the poverty threshold, when fully phased-in ($38,400 for a family of four in 1994 dollars). Subsidies would be provided for both Medicare Part C and, by certificate, for private plans.

In general, all employers would be required to contribute toward the cost of private health insurance coverage for all employees, effective in 1997 for large employers and in 1999 for small employers. All employers would be required to offer at least one health plan offering unlimited choice of providers and one managed care plan. In addition, employees employed in small firms (of less than 100 employees) that offer private coverage would have the option of choosing coverage under the Federal Employees Health Benefit Program. Small employers could also choose voluntarily to enroll their employees in the new Medicare Part C program. However, any employee in a firm that offers private health insurance would not be permitted to enroll in Medicare Part C, unless that employee is a low-income employee of a small employer.

The minimum employer contribution for a full-time worker would be equal to 80 percent of the premium of a plan providing the guaranteed national benefit package. Employers would also be required to make pro-rated contributions on behalf of part-time, seasonal, and temporary workers on a per-hour worked basis. Employers would not be required to contribute to coverage of workers who are dependent children and covered under their parent's plan, nor contribute to any worker who is expected to earn less

The Congress would be required to vote on the Commission's proposal.

Automobile insurance medical benefits would be coordinated with health plans. Payment for automobile insurance medical benefits would be made by automobile insurers directly to health plans.

XII. Early retirees

Employers would have the option of offering their early retirees health benefits through Medicare Part C. Some assistance will be provided on behalf of present early retirees who have employer-provided health benefits.

XIII. Universal FEHBP

Effective after insurance reforms are instituted, a newly created UFEHBP would contract with community-rated plans within each community-rated area.

A small employer who chooses to offer coverage through private plans would have two choices: offer two private plans and UFEHBP or offer UFEHBP only. If the employer offers two private plans and UFEHBP, the employer contribution would be 80% of the premium of the plan the employee chooses, but no more than 80% of the employer's higher-cost private plan premium. If the employer offers UFEHBP only, the employer contribution would be 80% of the premium of the plan the employee chooses.

Individuals not connected to the workforce could use their Medicare Part C certificates to obtain coverage in a UFEHBP plan.

XIV. Financing Health Care Reform

The rate of growth in Medicare and Medicaid costs would be slowed equitably across sectors. The cigarette tax would be increased by 45 cents per pack on a phased-in basis. An excise tax of two percent would apply to health insurance premiums and the expenses of self-insured plans. Health benefits provided through a cafeteria plan or flexible spending arrangement would not be excludable from an employee's income. A portion of the premiums paid by non-enrolling employers would be retained during a transition period. The current Medicare hospital insurance tax would be extended to all State and local employees.

THE MITCHELL HEALTH CARE REFORM BILL: A MODERATE APPROACH TO ACHIEVING UNIVERSAL COVERAGE

Universal coverage is achieved in two stages. First, market incentives, insurance reforms and assistance for low and middle-income families are provided. These market-based reforms and incentives are allowed to work until the year 2000. Second, if the market reforms do not provide coverage for 95% of Americans by the year 2000, a commission would submit recommendations to the Congress on how to achieve coverage for every American. If the Congress does not then act to achieve universal coverage, employers and employees would be required to contribute evenly to the cost of health coverage. Small employers with fewer than 25 employees would not be required to contribute.

Here are the central elements of the Senate compromise bill:

Affordable Insurance For Working Families. Insurance companies will be forced to compete for business, lowering prices through market forces. There will be a limit on what families pay for insurance. And if you're in between jobs or living paycheck to paycheck, you'll get a discount.

Coverage That Can't Be Taken Away. It will be illegal for insurance companies to drop people from coverage if they get sick, grow old or change jobs. People with insurance will know that they can never lose it.

Choice of Doctor and Insurance Plan. Families will be able to keep their doctor and insurance, or choose a new plan. No one-size-fits-all approach -- people will be able to choose the benefits and plan that best fits their needs.

Preserve and Strengthen Medicare. Medicare will be protected and strengthened. Older Americans have a right to count on Medicare and choose their doctor. Prescription drug coverage will be added to Medicare, and there will be additional help with home- and community-based care.

Help For Small Businesses. The smallest businesses will not be required to provide insurance. But they will be able to join voluntary purchasing cooperatives so they can get affordable insurance.

Improve the Quality of Insurance and Care. The guaranteed benefits include preventive care and prescription drugs. And part of each insurance premium will go to medical research -- to ensure the high quality of American medical care.

Improvements in the Mitchell Bill

Complete Freedom of Choice:

- People can just stay with their current doctors and insurance plan, or they can choose from any number of new plans with choice of doctor.

Added Protection Against Rising Costs For Families and Businesses

- Through expanded competition and by creating purchasing cooperatives for small businesses to purchase cheaper insurance, costs will be brought under control.

Extra Protection For Small Businesses

- If employers and employees do end up splitting the cost of insurance, businesses with less than 25 employees will be exempted. There will be voluntary purchasing cooperatves so small businesses can get affordable insurance.

No More Mandatory Government Alliances and Bureaucracy

- There is no more requirement to join government alliances. Instead, there will be voluntary purchasing cooperatives to allow small businesses and individuals to join together to get high-quality insurance at an affordable rate.

More Businesses Can Self-Insure

- Many more companies which do a good job of controlling costs and providing high-quality care may continue to do so through their own health care plans.

Additional Protection For Federal Budget

- Written into the law will be a guarantee that the cost of health reform does not exceed the savings and revenues earmarked for health reform.

8/2/94

SUMMARY OF MITCHELL HEALTH CARE LEGISLATION

The Mitchell health care bill would:

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

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

HEALTH INSURANCE FOR ALL AMERICANS

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

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

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

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

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

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

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

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

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

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

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

CONTROLLING HEALTH CARE COSTS

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

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

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

The bill would more effectively spend federal health care dollars.

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

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

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

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

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

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

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

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

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

GREATER EMPHASIS ON PRIMARY AND PREVENTIVE CARE

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

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

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

MAINTAIN HIGH QUALITY CARE

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

EXPANDS CHOICE OF DOCTOR AND CHOICE OF PLAN

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

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

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

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

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

ALLOWS STATE OPTIONS

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

SIMPLICITY

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

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

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

HOW IS THIS BILL PAID FOR?

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

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

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

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

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

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

Sources of Mitchell Health Care Reform Bill

1. Finance Committee

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

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

2. Labor Committee

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

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

3. Finance and Labor Committees

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

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

Sources of Mitchell Health Care Reform Bill

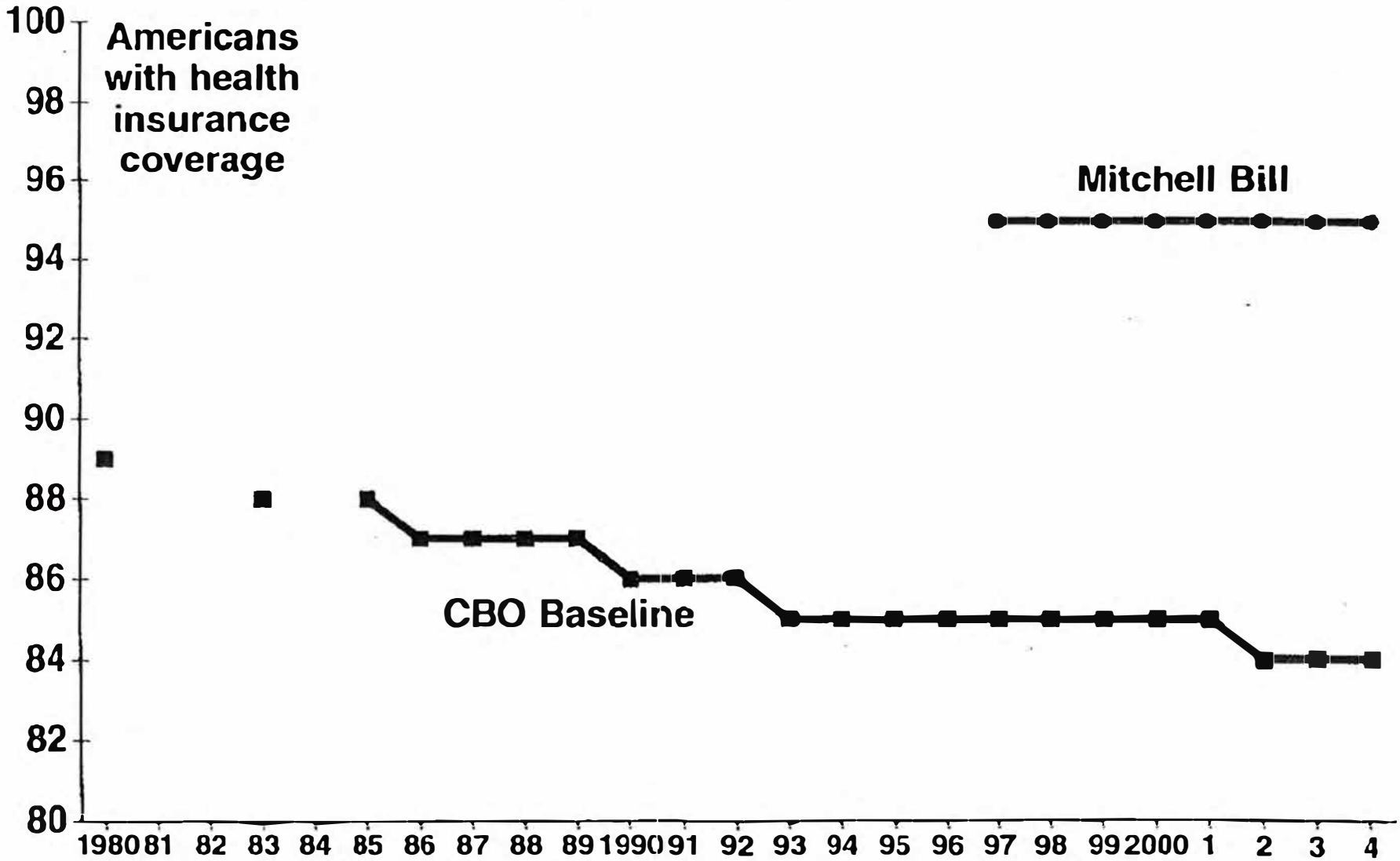
4. Other Provisions

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

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

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 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. National Health Care Cost and Coverage Commission. 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:

- Demographics and employment status of the uninsured and reasons why they are uninsured;
- Structure of health delivery systems;
- Status of insurance market reforms;
- Development and operations of health insurance purchasing cooperatives;
- Success of market mechanisms in expanding coverage and controlling costs among employers and households;
- Success of high cost health insurance premium tax in controlling costs;
- 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. Health Insurance Purchasing Cooperatives (HIPCs). 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. Employer Responsibility. 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. Self-insured plans. 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:

- o 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.
- o eliminates the institutionalization requirement as a condition of eligibility for habilitation services under a home and community based waiver.
- o eliminates the "cold bed" rule for home and community based waiver programs.
- o 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

- o 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.

- o 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.

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

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

B. Biomedical and Health Services Research Fund

- o 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.

- o 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:

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

- o 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.

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

- o 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.

- 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.

- 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

- 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.

- 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.

- o Limitation on prepayment of medical insurance premiums.
- o Tax treatment of voluntary employer health care contributions.
- o Tax treatment of organizations providing health care services and related organizations.
- o 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).
- o Tax treatment of accelerated death benefits under life insurance contracts.
- o Definition of Employee.
- o Increase in penalties for failure to file correct information returns with respect to non-employees.
- o Nonrefundable credit for certain primary health services providers.
- o Expensing of medical equipment used in health professional shortage areas.
- o Tax treatment of funding of retiree health benefits.
- o Tax credit for the cost of personal assistance services required by individuals.
- o 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.

Melanne

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Distribution List

From: Chris Jennings

Date: August 9, 1994

Re: Final CBO Report on Senator Mitchell's bill

Attached is the CBO report hot off the press. As you will note, Mitchell's bill is budget neutral or has some deficit reduction in years 1, 5 and 10 of the budget window.

Distribution List
Leon Panetta
Harold Ickes
Pat Griffin
Ira Magaziner
Steve Ricchetti
Alice Rivlin
Catherine Balsam-Schwaber
Linda Blumberg
Gary Claxton
Judy Feder
Monica Healy
Christine Heenan
Jerry Klepner
Jennifer Klein
Greg Lawler
Jack Lew
Larry Levitt
Lynn Margherio
Lorrie McHugh
Meredith Miller
Nancy Ann Min
Len Nichols
Kim O'Neil
Karen Pollitz
Meeghan Prunty

Distribution List Cont'd
Laura Quinn
Pam Short
Jason Soloman
Gene Sperling
Bridgett Taylor
Ken Thorpe
Eric Toder
Melanne Verveer
Bruce Vladeck
Marina Weiss

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

Robert D. Reischauer
Director

August 9, 1994

Honorable George Mitchell
Majority Leader
United States Senate
Washington, D.C.

Dear Mr. Leader:

Enclosed are estimates of the budgetary and other effects of your health reform proposal. They were prepared by the Congressional Budget Office and the Joint Committee on Taxation based on the text of S. 2357 as printed on August 3, 1994, and on subsequent revisions specified by your staff. Because we have not reviewed all of the final legislative language of the bill you have introduced today, these estimates must be regarded as preliminary.

Tables 1 and 2 of the attachment provide the federal budgetary effects of your proposal without the employer and individual mandates in effect and with the mandates in effect. Tables 3 and 4 contain estimates of the effect of your proposal on state and local budgets. Table 5 provides estimates of the change in health insurance coverage that would occur under your proposal; Table 6 shows its impact on national health expenditures.

The Congressional Budget Office is completing an analysis that briefly describes your proposal and discusses certain aspects of it. We plan to have that report available later in the day.

Sincerely,

Robert D. Reischauer

Enclosures

cc: Honorable Robert Dole, Republican Leader

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	-16.8	-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	43.6	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	-16.5	-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	-16.8	-20.7	-22.9	-25.2
4 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
5 Offset to Medicare Prescription Drug Program	0	0	0.0	0.0	-0.7	-1.5	-1.6	-1.9	-2.1	-2.3
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	a	a	-51.4	-76.0	-84.4	-93.2	-104.3	-114.8	-126.2	-138.3
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.3	-1.6	-3.4	-5.6	-8.0	-10.7	-13.8	-17.4
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.7	-2.1	-2.3	-2.5	-2.8	-3.1	-3.4	-3.7
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
Sole Community Hospitals	a	a	a	a	a	a	a	a	a	a
Part A Interactions	a	a	0.1	0.2	0.4	0.6	0.7	0.9	1.1	1.3
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0.0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Elimination of Balance Billing	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.6	0.7
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Durable Medical Equipment Price Reduction	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.4	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The budgetary treatment of mandatory premium payments is under review.

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

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

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

(By fiscal year, in billions of dollars)

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

SOURCE: Congressional Budget Office.

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

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

(By fiscal year, in billions of dollars)

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

SOURCE: Congressional Budget Office.

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

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

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

SOURCE: Congressional Budget Office.

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

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.

MITCHELL vs. DOLE: What's the Difference?

(What they achieve)

WITH MITCHELL "YOU'RE COVERED"	WITH DOLE "YOU'RE OUT OF LUCK"
* restores peace of mind for working middle class families	* every family remains at risk
* clear steps with failsafe for guaranteeing coverage to all Americans that can never be taken away	* 30 million Americans would be out of luck -- and the number would climb
* have kids? -- affordable coverage is guaranteed	* xx million kids would be out of luck
* lose your job? -- affordable coverage is guaranteed	* lose your job? -- you're out of luck
* trying to get off welfare? -- get a job and affordable coverage is guaranteed	* trying to get off welfare? -- get a job and you're out of luck
* small business owner trying to buy coverage? -- subsidies help you get covered	* small business owner trying to buy or keep coverage? -- no subsidies, you're out of luck

(How they achieve it)

MITCHELL PROTECTS PEOPLE BY STANDING UP TO INSURANCE COS.	**DOLE PROTECTS INSURANCE COS. AND LEAVES PEOPLE AT RISK**
* closes loopholes and bans limits on coverage	* protects insurance company loopholes and limits
* Taxes insurance companies companies that spike up rates	* protects insurance company radical rate hikes
* pays for new coverage by taxing smokers $57 billion and insurance companies $146 billion	* protects insurance company profits [to the tune of $x billion] and leaves 30 million people without coverage
AND MITCHELL PROTECTS SENIORS	**WHILE DOLE STEALS FROM SENIORS**
* uses Medicare savings to provide prescription drug and long-term care benefits to seniors	* cuts $60 billion out of Medicare without giving seniors anything back
* limits how much insurance companies can charge seniors	* lets insurance companies charge seniors twice as much as younger people

8/10/94

THE MITCHELL BILL

Principle Rationale

To allow every American affordable insurance that will be there when they need it.

1. Provide people with real security by making insurance affordable for every American.

2. Protect consumers from the worst abuses of the insurance companies.

3. Penalize insurance companies that abuse the marketplace and use this money top pay for expanding coverage for pregnant women and children.

4. Maintain what works in the system -- particularly for seniors.

How does it work?

Reforms will increase incentives and competition using the private marketplace to drive private premiums down and increase choice. Smokers will be taxed to pay for subsidies make insurance affordable for low wage workers and those who lose their jobs. Insurance companies that spike up rates will be taxed and the money will be used to expand coverage for pregnant women and children.

Principal Contrasts

We suggest highlighting three Mitchell strengths and three lines of attack against Dole.

With Mitchell "you're covered"
With Dole "you're out of luck"

1. Mitchell provides security to people.

   Dole protects the status quo for insurance interests.

2. Mitchell protects seniors -- enhancing Medicare with prescription drug and long-term care coverage.

   Dole punishes seniors -- cutting Medicare without giving anything back to seniors.

3. Mitchell takes on the insurance industry -- taxing those that continue to abuse the marketplace by spiking up rates.

   Dole protects the insurance industry's worst abuses including loopholes, limits and arbitrary rate hikes.

Republican Attacks

They are attacking on two "classic" fronts:

Taxes
Big Government

[specific rebuttals being prepared]

All attacks should be minimized by allies on the Senate floor and in outside media events. Opponent attacks should be characterized as:

scare tactics -- the same worn fear-mongering that has been used for more than 60 years, designed to protect the status quo for those who profit from it.

More specific in-person rebuttals will only guarantee that our opponents control the debate.

Specific rebuttals should be distributed widely on paper. And specific rebuttals must be updated and distributed each day to refute each salvo by the opponents. The War Room is now monitoring Senate floor debate, tracking each attack, preparing a specific rebuttal and distributing the daily line up before news deadlines in the Senate press gallery.

General rebuttals should be crafted for all the following topic areas and distributed to all allies:

Taxes
Young and healthy forced to pay for the old and high-risk
New entitlements
Quotas on doctors
Government control
`One size fits all' benefits
Job-killing mandates

Reassurance

In defending the Mitchell Plan we must use a good portion of our communication time to reassure the public about what price they will pay to achieve this good result. People want universal coverage and security, only if the costs are bearable -- in terms of premiums, taxes, risks to employment, and threat to health care quality. The most important reassurances:

Freedom of Choice: you can keep your plan and doctor, or choose new options that could save your family money. This plan expands choice.

Costs under Control: This plan forces insurance companies to compete and empowers people with more choices to bring premium costs down. By expanding coverage, the insured will no longer be paying for the uncompensated costs of the uninsured.

Small business: This plan protects small business by providing subsidies to their low wage workers to buy their own insurance, and gives any small business trying to expand coverage new subsidies. The plan is voluntary and phased-in, with incentives for participation.

Phased-in: This plan is phased-in and tries to achieve 95 percent coverage over seven years. It is a reasonable approach that allows people to adjust. However, at a date certain, 2000, states must achieve 95 percent coverage or new requirement will be triggered to ensure the gap is closed and all Americans are covered.

A PRELIMINARY ANALYSIS OF SENATOR MITCHELL'S HEALTH PROPOSAL

August 9, 1994

The Congress of the United States
Congressional Budget Office

INTRODUCTION

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

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

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

FINANCIAL IMPACT OF THE PROPOSAL

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

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

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

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

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

Health Insurance Benefits and Premiums

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

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

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

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

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

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

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

Subsidies

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

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

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

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

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

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

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

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

Medicaid and Medicare

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

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

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

Other Spending

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

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

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

Revenues

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

Fail-Safe Mechanism

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

Budgetary Treatment of the Mandate

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

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

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

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

OTHER CONSIDERATIONS

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

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

Risk Adjustment

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

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

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

States' Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The System of Multiple Subsidies

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

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

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

The Tax on High-Cost Health Plans

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

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

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

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

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

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

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

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

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

The Effects of Invoking Mandates

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

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

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

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

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

Reallocation of Workers Among Firms

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

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

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

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

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

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

Work Disincentives

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

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

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

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

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

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

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

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

Effect on Employment

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

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

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

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

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

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

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

Continued

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

(By fiscal year, in billions of dollars)

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

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The budgetary treatment of mandatory premium payments is under review.

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

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

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

(By fiscal year, in billions of dollars)

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

SOURCE: Congressional Budget Office.

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

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

(By fiscal year, in billions of dollars)

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

SOURCE: Congressional Budget Office.

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

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

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

SOURCE: Congressional Budget Office.

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

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.

MEMORANDUM

TO: Hillary Rodham Clinton **August 5, 1994**
FR: Chris Jennings
RE: Effect of the Mitchell Proposal on Washington/Oregon
cc: Melanne

Yesterday you asked how Senator Mitchell's bill would affect the ability of states such as Washington and Oregon to proceed with their health reform plans. The following is a quick assessment based on several conversations with Senate staff.

Background

Senator Mitchell's bill gives authority to states to implement universal coverage before 2002. States that want to move ahead of the universal coverage timetable laid out by the legislation may apply for expedited approval to do so through HHS and Labor. This authority will allow Washington, Oregon, and other states to overcome the ERISA (and Medicare and Medicaid) roadblocks that have prevented the enactment of comprehensive reform. At this time, according to Senator Leahy's and Senator Murray's office, Washington and Oregon seem to be supportive of the language that was included and hope to strengthen it further during the conference. (They apparently feel it is the best they will likely get out of the Senate.)

The "fast-track" authority largely removes ERISA as the main barriers to the enactment and financing of comprehensive reform in Oregon, Washington, and other states. The streamlined approval authority allows states to require employers to contribute to the health insurance of their employees. However, states are only allowed to mandate employer contributions that are consistent with the post-2002 federal requirements, and this restriction may require some changes in the Washington and Oregon plans. Washington state is largely consistent already: a 50-50 requirement with additional subsidies for firms with less than 25 employees. However, the Mitchell bill provisions have a carve-out for small employers and has a lower community rated firm size pool (500), so the Washington plan may require modest modifications. Similarly, the Oregon employer requirements would likely have to be modified to become consistent with the federal requirements.

Fast-track states would be required to provide a standard benefits package that meets the requirements specified in Mitchell's bill; it is not clear whether Oregon's prioritized list would be construed to be consistent with these requirements. (Although the administration has already approved the Oregon Medicaid waiver, the acute care portion of Medicaid is largely repealed under the Mitchell bill, so the effect of that waiver on the Oregon plan is unclear).

Finally, under Senator Mitchell's bill, reform-minded states would be required to "establish the subsidy program under this Act." It is not clear which subsidy program this refers to (pre- or post-mandate). This would likely require some change in Washington's and Oregon's legislation. Further analysis is needed to determine how much money this would require, and how much of this money the federal government would make available under the 'budget neutral' provision of the fast-track authority. The fast-track authority is designed to be budget neutral for the federal government: the federal government would pay the state the amount of subsidies that would otherwise have been paid in subsidies for state residents (net of any estimated decrease in Federal revenues due to the state program).

Conclusion

Senator Mitchell's bill goes a long way to removing the major impediment to state level implementation of comprehensive health care reform -- ERISA. States may be required to make modest changes to their reform programs to comply with the requirements of Senator Mitchell's proposed fast-track authority.

To reduce problems in this area, Senator Leahy, Senator Graham, Senator Murray, and others will attempt to expand the definition of "consistent" as it relates to whether states have to change their current laws relative to the new Federal template. At this time, however, they appear to have concluded that the best course of action is to protect the language they now have and try to amend it in conference. (They fear a floor amendment might well jeopardize what they have.) John Hart and Intergovernmental Affairs are working directly with the states to make certain that these and other states agree with this strategy and he will keep us informed of any changes.

p.s. The state of Hawaii should be very pleased with the language included in the Mitchell bill. It seems everything they need in order to go ahead with their planned modifications to their system. Lastly, a full analysis of the impact of Senator Mitchell's bill on Washington will be completed on Monday, August 8th and should it come to any inconsistent conclusion with this memo, we will forward it on to you at that time.

Why the Mitchell Bill Gets Us To Universal Coverage

"The Mitchell bill continues to move toward universal coverage; let's understand that. Although he would go to 95%, the fact is he has a commission then that requires that they come back and ensure that all Americans will ultimately be covered."

-Leon Panetta, White House Chief of Staff

Contrary to press reports, the Mitchell plan has a guaranteed path to universal coverage. Senator Mitchell's bill does not set 95% as a goal -- it sets 95% as a yardstick to measure how quickly we are heading toward universal coverage, and what other steps are then needed to finish the job. Under the Mitchell bill, the Congress does not rest until every American is covered.

Voluntary measures and incentives

Senator Mitchell's bill represents a compromise with moderates who believe that market incentives can lead the voluntary approach to dramatically increase coverage. A combination of discounts on insurance, new incentives for employers not now providing coverage, and the better rates that come with purchasing in big groups should increase the number of employers who provide insurance and the number of families who enroll.

Fairer insurance laws and special subsidies for people out of work will mean that people won't have to worry about losing insurance when they change jobs or lose their job. Senator Mitchell believes -- and the Congressional Budget Office apparently agrees -- that this combination of incentives and special protections will dramatically increase the number of Americans with insurance, extending coverage for more than 25 million people who don't now have coverage in four years.

If total coverage does increase at this rate, we will clearly be heading at a fairly rapid pace toward full coverage. But just to make sure this is the case, the Cost and Coverage Commission will evaluate progress year by year, and make sure we finish the job.

Trigger to a Mandate

On January 15, 2000 the National Health Care Cost and Coverage Commission will determine whether the voluntary system has achieved 95% coverage. The charge of that Commission is universal coverage -- to evaluate our progress toward that goal, and to make recommendations for achieving it. If 95% is not reached, then a system of shared responsibility is automatically enforced, getting us to universal coverage.

Additional Efforts Even If 95% Is Reached

Even if 95% coverage is achieved, the Commission will still send Congress recommendations on how to insure the remaining uninsured.

Every plan that goes to the Congress for consideration would have to show a certified path to universal coverage. All bills eligible for consideration must meet certification by the General Accounting Office that, ***"if implemented, the legislative proposals in such bill would expand health care coverage to cover the remaining uninsured population."***[Mitchell bill Sec. 10004 (2)]

Incentives For States To Achieve Full Coverage On Their Own

The bill also includes incentives for states that are ready to implement full coverage -- states like Oregon and Washington -- to do so right away, with no federal barriers. This includes the option for states to implement single-payer systems if they so choose. Not only does the Mitchell plan allow states to achieve full coverage early; it rewards them financially if they do, by letting the states keep the federal savings to the Medicaid program.

The Mitchell bill sets a clear, definable path to full coverage, and provides businesses, families, and states with incentives to cover everyone as soon as possible.

THE NEW YORK TIMES, MONDAY, JULY 18, 1994

Washington at Work

For Majority Leader, a Quest For a Health Care Consensus

A1

By ROBIN TONER
Special to The New York Times

WASHINGTON, July 17 — Being majority leader of the House is a fine job when a majority exists behind a bill. But building a majority is an entirely different experience, a painstaking exercise in ego stroking, family therapy, ideological fire-walking and endless nudging toward compromise among members passionately at odds.

This is one of those moments for Representative Richard A. Gephardt, the man who must build a consensus for a health care bill in the next four weeks. His task is variously described as "herculean" and "almost undoable" by his colleagues; it is clearly not for the faint of heart or the short of temper.

"I often say to people that my great fear as majority leader is that there is no majority, that we'll be unable to act, that there isn't enough agreement to find a majority," Mr. Gephardt said in an interview last week. "People have begun to expect that it's easy to find agreement."

The Missouri Democrat, who has spent 18 of his 53 years in the House, added: "It isn't so easy and it can't be so easy. It has to be hard. Because the disagreement is deep; it's fundamental."

This is not merely the protective playing down of expectations. The challenge facing Mr. Gephardt is immense as he makes his way from meeting to meeting, caucus to cloakroom, seeking a political formula that satisfies the goal of health insurance for every American — still the bottom line of the Democratic leadership and the White House — and gets 218 votes.

The Republicans are considered all but certain to vote as a bloc against the "consensus" bill put forward by Mr. Gephardt and the rest of the Democratic leadership. That means he is essentially confined to the 256 Democrats in the House. And, as Representative Jim Mc Dermott, Democrat of Washington, put it, "Peeling off 40 votes in here is not very hard."

Already, to cite just one issue, 35 Democrats have signed a letter declaring they will bolt if the bill covers abortion services; 70 others have made a similar threat if it does not.

"As always, we have tensions in both ends of our party," said Mr. Gephardt, somewhat delicately assessing the situation inside the Democratic caucus. In fact, rarely have the ideological and philosophical divisions among House Democrats been more apparent. The caucus ranges from minimalists like Representative Roy Rowland, a former family doctor from Georgia who believes in a modest package of new insurance industry laws, to the maximalists like Mr. McDermott, a former psychiatrist from Seattle who believes in a Canadian-style system of national health insurance called single payer that is financed by taxes.

There are formidable personalities that must be accommodated, like Representative Pete Stark of California, the chairman of the Ways and Means Subcommittee on Health, who is a proud and protective architect of that committee's bill. Mr. Gephardt showed up last week at a dinner at Mr. Stark's town house to pay tribute to the subcommittee's work.

And there are restless conservatives and moderates, like Representative Jim Cooper of Tennessee, who are pushing for a more limited bipartisan bill without universal coverage or a requirement that companies pay for insurance

There are also the members who wish, in their heart of hearts, that this big, unpleasant, risky issue would simply go away. Or that the White House would strike some compromise on universal coverage that would make the process easier. Or that the Senate would take the hard votes first for a change.

The Universal Soldier

Mr. Gephardt, at least so far, has drawn a line in the sand on universal coverage, which essentially means that members will not be spared a vote on some form of a requirement that companies pay for their workers' insurance, since that is the primary means of paying for such coverage. Why not just give on universal coverage, as some prominent Democrats in the Senate, including Senator Daniel Patrick Moynihan of New York, already have?

"We believe, the President believes and a lot of other people believe that it lies at the heart of your ability to get other important reforms done," Mr. Gephardt said. "If there was a way to get costs moderated and contained without it, if there was a way to get the system to work more competitively and efficiently without it, then it would be fine to put it as a backburner goal or a subsidiary goal. But unfortunately, it lies at the heart of being able to get the system reformed."

There is another reason, he added, which sometimes gets lost in the political calculations: for many Democrats, particularly the 90 in the House who back a Canadian-style system, covering everyone is simply the right thing to do. "It's a moral issue," Mr. Gephardt said. "They've fought for this for years. They think it's very important."

Particularly during his unsuccessful 1988 bid for the Democratic Presidential nomination, Mr. Gephardt himself has often been accused of being too willing to adjust his views to fit the times or the demands of the moment. But he does not come lightly or lately to the health issue. He has worked on health policy for many years, dating back to the Carter Administration, when he led the fight against President Jimmy Carter's hospital cost containment measures, a move he came to regret. He tried unsuccessfully to reach a Democratic consensus on a health care plan before the 1992 election.

Now, for his generation of Democrats, who came to Congress in the 1970's and spent a dozen years yearning for a chance to make a mark on domestic policy, Mr. Clinton's embrace of the health care issue is a rare opportunity to do just that.

From a political standpoint, Mr. Gephardt argues that guaranteed and affordable health insurance is exactly the kind of middle-class benefit the Democratic Party ought to be fighting for.

From a personal standpoint, he and his wife, Jane, saw the problems of the uninsured firsthand 20 years ago, when their son, Matt, was struggling with cancer as a child. Today Matt, who is 23, is in remission.

"There were lots of parents whom we got to know well, who every time they came to Children's Hospital had to raise $300 for the treatment," Mr. Gephardt said. "What we saw them go through with a dying child was enough, but add to that a financial stress, and it just broke up families. It was a horrible thing."

A commitment to universal coverage, however, means that Mr. Gephardt must find some version of an employer mandate that can get a majority in the House.

How does he get there? Mr. Gephardt is very much a creature of the modern House, in which party leaders build consensus as much by persuasion as by raw power. Modern politics makes it harder for leaders to exercise much raw power over their rank and file anyway.

Mr. Gephardt does meetings. Meetings with groups of 10 Democrats, chosen from across the ideological spectrum, to encourage members to listen to different views. Meetings with individual members. Meetings with large blocs of members, like the single-payer group.

"He came out of that post-Watergate politics in which he understands everyone wants to play a role," said Thomas Mann, an expert on Congress at the Brookings Institution.

Representative Benjamin L. Cardin, a Maryland Democrat, said: "He has a great deal of intelligence already done. He pretty well knows where everybody is on critical issues." At the same time, Mr. Gephardt is exploring various permutations of an employer mandate, like lengthening its phase-in time.

And he, like other Democratic leaders, is watching to see what Senator George J. Mitchell of Maine, the majority leader, can assemble backing for in the more resistent Senate.

Sometimes, Purely Partisan

For all his supposed empathic abilities, Mr. Gephardt has a decidedly partisan edge when the action moves to the floor. And to many Republicans in the House, he is part of a leadership structure that is intent, issue after issue, on ramrodding Democratic policies through and trampling the rights of the minority.

Already, the positioning is under way for another fight over the fairness of Democratic rules and procedures: Representative Newt Gingrich of Georgia, the number two Republican in the House, has joined with other party leaders to request that members be given ample time to review any Democratic bill before the floor debate begins. They are also seeking the promise of a floor vote for their bipartisan alternative.

Mr. Gephardt argued that once the floor debate begins, the public's support for universal coverage and employer-based benefits will make itself felt. Moroever, he said, regardless of the outcome, it is simply important to have that debate.

He dismissed the idea, advanced by many of the pundits and the more worldly Democrats, that the party ought to short-circuit the floor debate over universal coverage and come up with some deal to ease the burden on the members. "Harry Truman said the test of leadership is to get people to do things they don't want to do," Mr. Gephardt said.

Still, the risk of the current strategy, for the party and for Mr. Gephardt himself, is breathtaking.

And the majority leader, in the end, must be governed by the numbers.

Richard Andrew Gephardt

BORN: Jan. 31, 1941; St. Louis.

HOMETOWN: St. Louis.

EDUCATION: Southwest High School; B.S., Northwestern University; J.D., University of Michigan Law School.

CAREER HIGHLIGHTS: 1965-77, practicing lawyer; 1971-76, St. Louis Alderman; 1976, elected to the United States House of Representatives; June 1989, elected House majority leader.

FAMILY: Married to Jane Ann Byrnes; one son and two daughters.

HOBBIES: Baseball fan, particularly the St. Louis Cardinals; reading; jogging.

In a Panic, Rwandans Die in Stampede

U.N. Says Help for a Million Is Needed A1

By RAYMOND BONNER
Special to The New York Times

GOMA, Zaire, July 17 — A day that began in desperation and chaos turned into one of panic and death, as the rebels who control most of Rwanda advanced toward the border with Zaire, and terrified refugees stampeded, killing at least 30.

At midafternoon, rebel mortar shells began exploding in Gisenyi, in northwestern Rwanda, where refugees had jammed the border crossing hoping to escape the civil war.

The number of refugees crowding Goma was estimated at nearly a million today, severely straining international relief efforts.

"Within 48 hours, I am afraid we are going to have hundreds of people dying daily," said Panos Moumtzis, a spokesman for the United Nations High Commissioner for Refugees.

As they ran along dusty roads and across fields on the shore of Lake Kivu, the fleeing refugees raised a choking dust. The air was filled with the cacophony of crying children — crying from pain, from lack of food, from fear, from simple exhaustion. Many refugees have been on the run for more than a week.

Here and there were piles of automatic rifles, abandoned by fleeing soldiers of the Rwandan Army. The scrambling refugees stumbled over live hand grenades. Many soldiers were taking off their uniforms. Hundreds rode atop trucks.

In a field just off the road from the border was the body of a man, covered with black dust. Further along in a confusion of garbage and people was the body of a boy who looked about 10 years old. In the pandemonium it was impossible to know whether they had died from disease, or had been trampled to death, or had died of exhaustion. Nearby lay a pair of crutches. A tiny emaciated child sat at an open fire.

A French photographer, Charles Caratini, found at least 30 and perhaps as many as 50 bodies, mostly children, who had been killed in a stampede about 300 feet from the border. Another photographer said two mortar shells had fallen on the Zairian side of the border about 5 P.M. today, killing at least 20 refugees, but it was not known who had

Continued on Page A7, Column 1

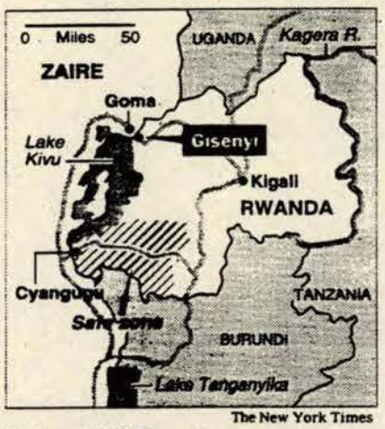
Continued From Page A1

fired them.

It was impossible to enter Gisenyi to determine how many civilians have been killed in the town, the last major community to fall to the rebels of the Rwandan Patriotic Front. But Gisenyi was jammed with refugees, and some Rwandan Army troops were still there.

The front, dominated by the Tutsi ethnic minority, continued to reject international calls for a cease-fire and threatened to attack the "safe haven" in southwestern Rwanda where the French are protecting at least a million Hutu.

"Moving in is our ambition unless the French hand over the criminals," a spokesman for the front, Maj. Wilson Rutiyisire, said in the capital, Kigali. The "criminals" are the Government officials and militia leaders whom the front considers responsible for the massacre of possibly hundreds of thousands of Tutsi since early April by the mostly Hutu Rwandan Army and by Hutu militias.



The New York Times

At least 30 Rwandans were trampled as they fled from Gisenyi.

In Goma today, three mortar shells landed near the airport, but it was not known who had fired them.

[The United Nations suspended its emergency airlift to Goma, Reuters reported from Paris, quoting a French television report.

[The report also said there had been several clashes during the day between French troops and members of the Rwandan Patriotic Front in the French-patrolled zone in southwestern Rwanda. "No infiltration by any armed elements will be tolerated," the Foreign Ministry said.]

As night fell in Goma, tracer rounds lit up the sky and there was heavy shooting on the streets, which were clogged with refugees. Like so much on this tumultuous day, it was impossible to know what the shooting was about or who was firing. A French officer was seriously wounded when a ricocheting bullet struck him in the chest.

Even before this afternoon's mayhem, relief officials were staggering under the refugee burden.

"We fell absolutely exhausted and desperate," Mr. Moumtzis, the United Nations spokesman, said earlier in the day. "Somehow we feel there is no end to it."

When the Rwandan Patriotic Front began to move in on Gisenyi late Saturday night, the refugees began swarming toward the border, and by noon today more than 300,000 had crossed, bringing to nearly a million the number who have arrived here in the last five days, United Nations workers estimate.

"It is impossible to find enough camps for one million people," Mr. Moumtzis said. "The land is volcanic; we can't drill for water. What are we going to do about latrines? It is an absolute nightmare. I don't know how we are going to deal with it."

Beyond Aid, a Cease-Fire

He said eight million gallons of water and at least 800 tons of food a day were needed, four times what the United Nations is providing for Sarajevo, he added.

But more than aid is needed, he said: the international community has to exert political pressure "for an immediate and unconditional cease-fire."

Though Mr. Moumtzis was careful to say that "we blame both sides" for continuing the war, it has become increasingly clear that it is primarily the R.P.F. that has chosen to continue the war, and it is the front's advances that are pushing the refugees into Zaire.

"It is difficult to understand" why the front continues to advance, Mr. Moumtzis said.

Another United Nations official, speaking on the condition of anonymity, was more direct. "There is no need for the R.P.F. to keep fighting," he said. "They've got the country. They are giving credence to the charges that they want to force all the Hutu out of the country, that they want the land to resettle Tutsi." Virtually all of the refugees here are Hutu.

Searching for His Son

In the mob of fleeing refugees today, Jean Damascene Kamyamuhanda held up a stick with a piece of paper on the end of it on which he had written that he was offering a reward for anyone who could locate his son. "His name is Gasore," the handwritten note said. "He is 8 years old."

Mr. Kamyamuhanda, a farmer, who has been on the run from advancing rebel forces for more than a week, became separated from his son on Saturday evening. On Friday he had become separated from his wife and another child.

"So many people have been killed on the road, I really have no hope to find them," he said.

A 10-year-old girl, Zuba, held the hand of Wenant Mpabnyanga, 30, and cried as she told about having become separated from her parents.

"I found her on the road and took her with me," Mr. Mpabnyanga said. "I don't know her."

Mr. Mpabnyanga was separated from his wife and three sons on Friday afternoon. His daughter sat on the ground, shivering with malaria.

Nearby, Sephine Nyiransengimana, who was separated from her husband and 3-year-old daughter, sat on a volcanic rock, nursing her 6-week-old son. She has named him Niyonsenga, which means "to God I pray."

"I said to myself, I will keep on praying to God," she said. "I will pray to God to save me during this war."