THE POLICY PROCESS

ADMINISTRATION POLICY STAFF HAVE BEEN MEETING WITH STAFF AND SOME MEMBERS FROM ALL FIVE MAJOR COMMITTEES AND THE LEADERSHIP IN BOTH HOUSES TO RESPOND TO REQUESTS ABOUT MODIFICATIONS IN THE HEALTH SECURITY ACT.

SO FAR, THEY ARE RESPONSIVE TO OUR ADVICE AND THE MODIFICATIONS THEY ARE CONSIDERING ARE WELL WITHIN OUR END GAME SCENARIOS.

THERE ARE FOUR AREAS OF MAJOR FOCUS:

- FINANCING
- THE ALLIANCES
- PREMIUM CAPS
- THE EMPLOYER/EMPLOYEE MANDATE

END GAME – SCENARIO I

IF WE CAN SUSTAIN THE PUBLIC DEBATE, AND NEGOTIATE WELL, UNDER THE MOST OPTIMISTIC SCENARIO, WE WILL WIND UP WITH THE FOLLOWING TYPE OF COMPROMISE:

- UNIVERSAL COVERAGE PASSED IN THIS BILL ON OUR TIMETABLE WITH AN EMPLOYER/INDIVIDUAL MANDATE AND LARGER SUBSIDIES OR A SLOWER PHASE–IN FOR SMALLER COMPANIES.

- PREMIUM CAPS WHICH ARE SOMEWHAT LESS RIGID THAN THE ONES WE PROPOSE.

- HEALTH ALLIANCES FOR COMPANIES OF 500–1,000 OR UNDER (WHERE THE ONE PERCENT ASSESSMENT GAINED FROM ADDITIONAL CORPORATE ALLIANCES WOULD PAY FOR THE EXTRA SMALL FIRM SUBSIDIES).

- SMALLER MEDICARE AND MEDICAID SAVINGS.

- A SLOWER PHASE–IN OF LONG–TERM CARE AND THE PRESCRIPTION DRUG BENEFIT TO COMPENSATE FOR THE LOWER MEDICARE AND MEDICAID SAVINGS AND A TIE–IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- A FEW HUNDRED MINOR MODIFICATIONS.

END GAME - SCENARIO II

IF WE ARE ONLY MARGINALLY SUCCESSFUL IN THE PUBLIC DEBATE AND SECURE A LESSER BILL WHICH STILL FULFILLS THE PRESIDENT'S PRINCIPLES, IT MIGHT LOOK LIKE THE FOLLOWING:

- UNIVERSAL COVERAGE ON A SLOWER TIMETABLE -- BY 2000, WITH AN EMPLOYER AND INDIVIDUAL MANDATE WITH THE EMPLOYER SHARE REDUCED (WORST CASE, AS LOW AS 50 PERCENT), POSSIBLY LIMITED TO THE LOW COST INSTEAD OF THE AVERAGE COST PLAN, POSSIBLY WITH A SLOWER PHASING-IN OF THE FULL BENEFITS OR WITH ENHANCED SMALL COMPANY DISCOUNTS.

- LESS STRINGENT PREMIUM CAPS WHICH TRIGGER IF COMPETITION DOES NOT PRODUCE A CERTAIN LEVEL OF SAVINGS BY A CERTAIN TIME.

- A SLIMMED DOWN LONG-TERM CARE PACKAGE WHICH PHASES IN MUCH SLOWER AND A MORE SLOWLY PHASED-IN PRESCRIPTION DRUG BENEFIT, AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- LOWER MEDICARE AND MEDICAID CUTS.

- A SMALLER TOBACCO TAX.

END GAME – SCENARIO II (CONTINUED)

- SMALL ALLIANCES -- 100 OR UNDER, POSSIBLY VOLUNTARY, WITH STATES ALLOWED TO GO HIGHER AND A NATIONAL RISK POOL TO REINSURE CASES ABOVE $25 OR $50 THOUSAND PER YEAR.

- REDUCTION OF THE ONE PERCENT CORPORATE ASSESSMENT.

- A FEW HUNDRED MINOR MODIFICATIONS.

FINANCING
CBO DEFICIT ESTIMATES

CBO ESTIMATES OF TOTAL NATIONAL HEALTH SPENDING UNDER THE HEALTH SECURITY ACT ARE VERY SIMILAR TO OURS.

THEY BELIEVE, HOWEVER, THAT STATE AND LOCAL GOVERNMENT AND BUSINESSES WILL SAVE MORE AND THE FEDERAL GOVERNMENT WILL SPEND MORE THAN WE PROJECTED.

THE FOLLOWING CHART SHOWS CHANGES IN THE HEALTH SECURITY ACT WHICH ARE EASILY MADE, WHICH HAVE SUPPORT AMONG FRIENDLY COMMITTEE AND LEADERSHIP STAFF AND WHICH RESTORE SIGNIFICANT DEFICIT REDUCTION TO THE ACT.

POTENTIAL SAVINGS FROM THE HEALTH SECURITY ACT

	5 YEAR DEFICIT	10 YEAR DEFICIT
CBO scoring of HSA	74	126
Lowering alliance size* (community rating pool) to 1,000; provide subsidies to all firms; assess those above 1,000 at 1%	–30	–70
Targeting employer subsidies to low–wage individuals with a 12% cap	–52	–164
Increase cost sharing in benefits package	–29	–78
Phase–in long–term care more slowly	–31	–43
Total savings from HSA	–142	–355
Deficit reduction	–68	–233

*Approximate

3. only get subsidies for low wage ees
CBO agree is $ billion over 5 years for the 1%
4. Now $1,500 cap per person for co-pays / deductibles — } change ~~any~~ many of cap ons / or increase co-pay
more to 2,500 out of pocket
Now fee for service 20% co pay -
more to 25% out of pocket

STATE & LOCAL GOVERNMENT SAVINGS

UNDER THE CBO SCORING OF THE HEALTH SECURITY ACT, STATE & LOCAL GOVERNMENTS REALIZE DRAMATIC SAVINGS ON HEALTH CARE EXPENDITURES.

CONGRESSIONAL COMMITTEES ARE LIKELY TO TRY TO CAPTURE SOME OF THOSE SAVINGS FOR THE FEDERAL DEFICIT AS WELL.

THE SAVINGS COME MAINLY THROUGH LESS SPENDING FOR GOVERNMENT RUN HOSPITALS, CLINICS AND HEALTH PROGRAMS ONCE UNIVERSAL COVERAGE AND THE MEDICARE PRESCRIPTION DRUG BENEFIT ARE ACHIEVED.

POTENTIAL ADDED COSTS TO THE HEALTH SECURITY ACT

INCREASED SUBSIDIES FOR SMALL BUSINESSES OR A SMALL BUSINESS CARVE OUT OR SLOWER PHASE-IN OF PAYMENTS BY SMALL BUSINESSES

INCREASE ACADEMIC HEALTH CENTER SET ASIDES

LOWER MEDICARE CUTS

TOBACCO TAX DEAL

CHRONIC CARE CHILDREN BENEFITS

LOOSENING OF GROWTH RATES UNDER PREMIUM CAPS

ENDING DISCRIMINATION
AND ENHANCING CONSUMER CHOICE

TODAY, PEOPLE PAY WILDLY DIFFERENT AMOUNTS FOR THE SAME INSURANCE COVERAGE BASED ON HEALTH STATUS, GENDER, AGE, WHETHER THEY WORK FOR A SMALL OR LARGE COMPANY OR ARE SELF EMPLOYED, WHETHER A CO-WORKER HAS A SERIOUS ILLNESS, ETC.

HEALTH INSURANCE COMPANIES COMPETE PRIMARILY BY TRYING TO INSURE ONLY PEOPLE WHO ARE LIKELY TO STAY HEALTHY AND THEREFORE, NOT NEED SERVICES.

INCREASINGLY, INSURERS MARKET TO COMPANIES WHO "LOCK" THEIR EMPLOYEES INTO ONE HEALTH PLAN. THE INSURERS SAVE MONEY BY SHAVING BENEFITS, INSTITUTING TIGHT UTILIZATION REVIEWS, CONTRACTING WITH LOWER COST PROVIDERS, ETC.

CONSUMERS HAVE NO CHOICE.

ENDING DISCRIMINATION AND ENHANCING CONSUMER CHOICE

THE HEALTH SECURITY ACT ADDRESSES THESE PROBLEMS IN THE FOLLOWING WAYS:

- CREATES ONE PRICE FOR ALL CONSUMERS IN THE ALLIANCE, REGARDLESS OF HEALTH STATUS AND OTHER DEMOGRAPHICS

- ALLOWS CONSUMERS A WIDE CHOICE OF HEALTH PLANS, EVEN IF THEY WORK FOR SMALL COMPANIES OR ARE UNEMPLOYED

- PROVIDES INFORMATION TO CONSUMERS AND ENSURE FAIR MARKETING BY HEALTH PLANS

- STREAMLINES ADMINISTRATION OF ENROLLMENTS, FUNDS FLOW AND SUBSIDIES

- BLENDS PREMIUMS TO FACILITATE RISK ADJUSTMENT AND REINSURANCE.

IN THE HEALTH SECURITY ACT, MANDATORY ALLIANCES PERFORM THESE FUNCTIONS.

ENDING DISCRIMINATION
AND ENHANCING CONSUMER CHOICE

THESE GOALS CAN BE ACHIEVED THROUGH OTHER MECHANISMS SUCH AS VOLUNTARY ALLIANCES, BUT WILL REQUIRE ADDED REGULATION:

- FAIR MARKETING RULES AND OVERSIGHT ENFORCED BY STATE INSURANCE DEPARTMENT
- ENFORCEMENT OF COMMON PRICE BY STATE INSURANCE DEPARTMENT
- PUBLIC POINT OF ENROLLMENT PROVIDED BY STATE AUTHORITY WHICH GIVES INFORMATION TO CONSUMERS
- CLEARINGHOUSE FOR COLLECTIONS CREATED BY STATE OR INSURANCE CONSORTIUM
- SUBSIDY ADMINISTRATION BY STATES OR HHS OR IRS
- RISK ADJUSTMENT AND REINSURANCE MECHANISMS CARRIED OUT BY A CONSORTIUM OF INSURERS
- SOLVENCY REGULATION BY STATES OR TREASURY
- RULES TO ENSURE CONSUMER CHOICE ENFORCED BY STATE INSURANCE DEPARTMENTS OR HHS

FINANCING LEVERS
COST CONTAINMENT

THE HEALTH SECURITY ACT HAS TWO IMPORTANT COST CONTAINMENT GOALS:

- TO CAPTURE WINDFALL SAVINGS FROM HEALTH REFORM FOR CONSUMERS AND BUSINESSES RATHER THAN ALLOWING A HEALTH INDUSTRY BONANZA.

- TO SLOW THE RATE OF GROWTH OF HEALTH CARE COSTS LONG TERM.

FINANCING LEVERS

CAPTURING THE WINDFALL FROM HEALTH REFORM FOR CONSUMERS AND BUSINESSES

PROVIDING UNIVERSAL COVERAGE TO ALL AMERICANS AND INTEGRATING MEDICAID BENEFICIARIES INTO THE PRIVATE HEALTH CARE SYSTEM COULD RESULT IN A HUGE WINDFALL TO HEALTH CARE INSURERS AND PROVIDERS AT THE EXPENSE OF CONSUMERS AND BUSINESSES.

TODAY, WHEN UNINSURED PEOPLE USE THE HEALTH CARE SYSTEM, THEY PAY ONLY 21% OF THEIR HEALTH CARE COSTS. THE REST OF THEIR COST IS SHIFTED TO THOSE WITH PRIVATE INSURANCE, SOME $25 BILLION PER YEAR, OR 8% OF TOTAL PRIVATE PREMIUMS.

TODAY, MEDICAID PAYS, ON AVERAGE, 17.8% LESS FOR HEALTH CARE SERVICES THAN PRIVATE PAYERS. THE FULL COST OF THEIR SERVICES IS SHIFTED TO PRIVATE PAYERS.

UNDER REFORM, ALL AMERICANS WILL HAVE PRIVATE INSURANCE AND MEDICAID WILL BE FOLDED INTO THE PRIVATE HEALTH CARE SYSTEM. THE HEALTH INDUSTRY COULD REALIZE FULL PAYMENT FOR EVERYONE.

WILL THEY PASS THESE EXTRA PAYMENTS ON TO PRIVATE CONSUMERS AND BUSINESSES WHO HAVE BEEN OVERPAYING OR WILL THEY KEEP THE EXTRA PAYMENTS AS WINDFALL PROFITS?

FINANCING LEVERS
COST CONTAINMENT
CAPTURING WINDFALL PROFITS

THE HEALTH SECURITY ACT DOES NOT RELY ON THE LARGESS OF HEALTH INSURERS AND PROVIDERS TO PASS SAVINGS BACK TO CONSUMERS AND BUSINESSES.

THE HSA BUILDS THESE SAVINGS INTO THE BASELINE PREMIUM AND GUARANTEES THAT THEY WILL OCCUR BY CAPPING THAT BASELINE PREMIUM.

- THE SAVINGS FROM THE UNINSURED NOW ABLE TO PAY THEIR BILLS (UNCOMPENSATED CARE SAVINGS) ARE SHIFTED BACK TO PRIVATE PREMIUMS.

- THE MEDICAID PAYMENT SAVINGS ARE USED TO FUND THE FEDERAL SUBSIDY POOL FOR LOW-INCOME PEOPLE AND SMALL BUSINESSES.

THESE CONSTRAINTS PREVENT WINDFALLS FROM BEING TAKEN BY INSURERS AND PROVIDERS AND INSTEAD GIVE THE BENEFITS TO CONSUMERS AND BUSINESSES.

COMPETITION ALONE MIGHT PREVENT THE HEALTH INDUSTRY FROM TAKING THIS ENTIRE WINDFALL, BUT IF COMPETITION DOES NOT WORK FULLY OR IN A TIMELY ENOUGH FASHION, THE CONSEQUENCES COULD BE SEVERE.

FINANCING LEVERS
COST CONTAINMENT
CAPTURING WINDFALL PROFITS

IF ALL OF THE WINDFALL WENT TO THE HEALTH INDUSTRY INSTEAD OF TO CONSUMERS AND BUSINESSES, THE COST OF HEALTH REFORM WOULD RISE DRAMATICALLY. PREMIUMS FOR BUSINESSES AND HOUSEHOLDS WOULD RISE AS WOULD GOVERNMENT SUBSIDIES.

INCREASED COST RELATIVE TO HSA

$ BILLIONS

	All uncompensated care savings and increased payments for uninsured go to health industry	All Medicaid cost increases go to health industry	TOTAL
	5-YEAR	5-YEAR	5-YEAR
Government Spending	79	120	213
Household Spending	51	78	132
Business Spending	75	114	199
TOTAL	205	312	544

FINANCING LEVERS

THE DYNAMIC IN THE PREMIUM CAPS

THE COMPETITIVE FORCES AND PREMIUM CAPS IN THE HEALTH SECURITY ACT REDUCE THE RATE OF HEALTH CARE SPENDING GROWTH FROM 8.5% TO 7.7% DURING THE NEXT FIVE YEARS WHILE PROVIDING COMPREHENSIVE BENEFITS TO ALL AMERICANS.

SOME HAVE ARGUED FOR ELIMINATING OR LOOSENING CONSTRAINTS, RELYING MORE HEAVILY ON MARKET FORCES TO CONTROL THE RATE OF INCREASE.

ONCE THE BASELINE IS SET, PROPOSALS TO LOOSEN THE GROWTH RATES SET IN THE HEALTH SECURITY ACT HAVE THE FOLLOWING EFFECTS ON FEDERAL COSTS.

RAISING PREMIUM CAP
COST RELATIVE TO HSA
$ BILLIONS

	5-YEAR COST	10-YEAR COST
Constrained premium, HSA growth plus 1% every year	27	NA
Constrained premium, HSA growth plus 1% in 1999 and 2000	6	NA

GUARANTEED PRIVATE INSURANCE
CONGRESSIONAL MODIFICATIONS UNDER DISCUSSION

THE FOLLOWING MODIFICATIONS TO THE EMPLOYER/INDIVIDUAL MANDATE ARE UNDER DISCUSSION IN CONGRESS.

- KEEPING 80/20 MANDATE BUT PHASING IN SMALL BUSINESS MORE GRADUALLY, STARTING WITH 50/50 AND MOVING TO 80/20.

- KEEPING HSA STRUCTURE BUT TAKING SMALL BUSINESS DOWN TO A 1 OR 2% OF PAYROLL CAP INSTEAD OF 3.5%.

- LOWERING THE 80/20, PERHAPS ULTIMATELY TO 50/50.

- EXEMPTING FIRMS BELOW 10 FROM THE EMPLOYER MANDATE BUT ASSESSING A SMALL PAYROLL TAX FOR THOSE FIRMS WHO DO NOT PROVIDE INSURANCE.

- ESTABLISHING A SMALL FIRM CARVE OUT AT 10 OR POSSIBLY 25 EMPLOYEES.

ALL OF THESE ARE DOABLE, FROM A POLICY POINT OF VIEW, BUT THE "CARVE OUT" IS EXPENSIVE. AT 10 OR UNDER WITH THE ALTERNATE PAYROLL TAX AS IN THE ENERGY & COMMERCE DRAFT, THE POLICY IS OKAY.

IF THE CARVE OUT GETS TOO MUCH BIGGER, IT BECOMES PROBLEMATIC.

EMPLOYER PAYMENTS AS A PERCENT OF TOTAL PREMIUMS AFTER DISCOUNTS IN THE HEALTH SECURITY ACT

UNDER THE HEALTH SECURITY ACT, FIRMS PAY ON AVERAGE, 67% OF PREMIUMS.

FIRM SIZE & TYPE	FIRMS THAT DO NOT CURRENTLY INSURE (%)	ALL FIRMS (%)
AVERAGE SALARY		
<25–<12K	13	
12–15K	20	
15–18K	29	
18–21K	41	
21–24K	53	
>24K	60	
25–99	53	62
100–1,000	63	71
1,000–5,000	72	79
AVERAGE	48	67

NUMBER OF FIRMS, WORKERS AND SIZE OF PAYROLL BY FIRM SIZE

%

	<10	<100	<500	>500
ALL FIRMS	78	98	99.7	0.3
ALL EMPLOYEES	12	39	54	46
ALL PAYROLL	11	35	48	52

FINANCING LEVERS

THE STRUCTURE OF THE EMPLOYER RESPONSIBILITY

ELIMINATING EMPLOYER REQUIREMENT

ELIMINATING THE EMPLOYER REQUIREMENT FOR THE SMALLEST BUSINESSES:

- INCREASES PREMIUMS FOR LARGER EMPLOYERS AS THEY NOW ASSUME THE FULL COST OF INSURANCE FOR FAMILIES WITH A WORKER IN EXEMPT FIRMS.

- INCREASES OVERALL SUBSIDY REQUIREMENTS IF INDIVIDUALS IN EXEMPT FIRMS ARE HELD TO THE 3.9% INCOME PROTECTION AS IN THE HEALTH SECURITY ACT.

- INCREASES THE RISK ALREADY PRESENT IN THE HEALTH SECURITY ACT FOR LARGE FIRMS TO BENEFIT FROM THE EXEMPTION BY OUTSOURCING.

- INCREASES THE ADMINISTRATIVE BURDENS.

- CREATES A CLIFF EFFECT ON HIRING DECISIONS.

THE EASY DEALS
WHAT COULD GO WRONG?

1. PHONY UNIVERSAL COVERAGE -- ACCESS WHICH IS UNAFFORDABLE OR WHICH IS CONTINGENT IS NOT UNIVERSAL COVERAGE.

2. TRIGGER WHICH DOESN'T CAPTURE WINDFALL -- ENHANCED COVERAGE AND BENEFITS WITHOUT SUFFICIENT COST CONTAINMENT COULD BUST THE BUDGET.

3. LIMITED COMMUNITY RATING -- "SWISS CHEESE-LIKE" COMMUNITY RATING LAWS WHICH ALLOW INSURERS TO CONTINUE TO COMPETE ON RISK SELECTION.

4. EMPLOYER CHOICE -- EMPLOYER CHOICE COULD TAKE AWAY CONSUMER CHOICE OF DOCTOR AND HEALTH PLAN, ANGERING PEOPLE AS THEY ARE FORCED INTO PLANS BY THEIR EMPLOYER AND ANGERING PROVIDERS WHO ARE INCREASINGLY DOMINATED BY INSURERS.

5. WATERED DOWN BENEFITS -- PEOPLE WILL PERCEIVE THEIR CURRENT BENEFITS WILL BE CUT.

4/10/94

BACKUP TO COMPETITION

ENHANCED COMPETITION MAY NOT BE SUFFICIENT IN ALL PARTS OF THE COUNTRY TO REDUCE THE GROWTH OF HEALTH SPENDING

- OLIGOPOLIES MAY DEVELOP IN SOME AREAS
- GAMING MAY OCCUR
- COMPETITION WILL TAKE TIME TO DEVELOP IN SOME PLACES AND MAY NOT DEVELOP EFFICIENTLY ELSEWHERE

THE COOPER AND CHAFEE BILLS CALL FOR A TAX CAP AND ALLOW FOR A REDUCTION IN THE NATIONAL BENEFITS PACKAGE IF COSTS RISE TOO RAPIDLY.

THE CLINTON BILL RECOMMENDS PREMIUM CAPS AS A BACKUP TO COMPETITION.

THESE PUT PRESSURE ON HEALTH CARE PROVIDERS AND INSURERS INSTEAD OF ON WORKERS WITH GOOD BENEFITS

THE DYNAMIC IN THE PREMIUM CAPS

RESTRAINING COST GROWTH RESTS ON SETTING BASELINE PREMIUMS IN THE FIRST YEAR. UNDER THE HEALTH SECURITY ACT, PREMIUMS ARE CONSTRAINED ON AVERAGE NATIONALLY BY 10.5% TO REFLECT:

- UNCOMPENSATED CARE SAVINGS
- INSURING THE UNINSURED AT AVERAGE RATES NOT PRIVATE SECTOR RATES
- CONSTRAINING MEDICAID RATES IN THE ALLIANCE

THESE CONSTRAINTS PREVENT WINDFALLS FROM BEING TAKEN BY INSURERS AND PROVIDERS AND INSTEAD GIVE THE BENEFITS TO CONSUMERS AND BUSINESSES.

IF THE LEGISLATION DOES NOT SET A BASELINE, BUT INSTEAD RELIES ON A TRIGGER MECHANISM, SUBSTANTIAL SAVINGS WILL BE LOST. IF A TRIGGER IS USED, ANOTHER MEANS MUST BE FOUND TO CAPTURE FIRST YEAR BASELINE SAVINGS.

PROPOSALS TO LOOSEN THE GROWTH RATES SET IN THE HEALTH SECURITY ACT DON'T UPSET THE BILLS FINANCING (1% HIGHER GROWTH IN 1999–2000 COSTS $6 BILLION MORE. 1% HIGHER GROWTH EACH YEAR 1996–2000 COSTS $28 BILLION MORE.)

ENDING DISCRIMINATION AND ENHANCING CONSUMER CHOICE

THE HEALTH SECURITY ACT ADDRESSES THESE PROBLEMS IN THE FOLLOWING WAYS:

- CREATES ONE PRICE FOR ALL CONSUMERS IN THE ALLIANCE, REGARDLESS OF HEALTH STATUS AND OTHER DEMOGRAPHICS

- ALLOWS CONSUMERS A WIDE CHOICE OF HEALTH PLANS, EVEN IF THEY WORK FOR SMALL COMPANIES OR ARE UNEMPLOYED

- PROVIDES INFORMATION TO CONSUMERS AND ENSURE FAIR MARKETING BY HEALTH PLANS

- STREAMLINES ADMINISTRATION OF ENROLLMENT, FUNDS FLOW AND SUBSIDIES.

- BLENDS PREMIUMS TO FACILITATE RISK ADJUSTMENT AND REINSURANCE.

IN THE HEALTH SECURITY ACT, MANDATORY ALLIANCES PERFORM THESE FUNCTIONS.

ENDING DISCRIMINATION
AND ENHANCING CONSUMER CHOICE

THESE GOALS CAN BE ACHIEVED THROUGH OTHER MECHANISMS SUCH AS VOLUNTARY ALLIANCES, BUT MAY REQUIRE ADDED REGULATION:

- PUBLIC POINT OF ENROLLMENT
- FAIR MARKETING RULES AND OVERSIGHT
- ENFORCEMENT OF COMMON PRICE
- CLEARINGHOUSE FOR COLLECTIONS
- SUBSIDY ADMINISTRATION
- RISK ADJUSTMENT AND REINSURANCE MECHANISMS
- SOLVENCY REGULATION
- RULES TO ENSURE CONSUMER CHOICE

THE EASY DEALS
WHAT COULD GO WRONG?

1. PHONY UNIVERSAL COVERAGE -- ACCESS WHICH IS UNAFFORDABLE OR WHICH IS CONTINGENT.

2. TRIGGER INSTEAD OF PREMIUM CAP -- ENHANCED COVERAGE AND BENEFITS WITHOUT SUFFICIENT COST CONTAINMENT COULD BUST THE BUDGET AND LEAD TO CALLS FOR REPEAL.

3. LIMITED COMMUNITY RATING -- "SWISS CHEESE-LIKE" COMMUNITY RATING LAWS ALLOW INSURERS TO CONTINUE TO COMPETE ON RISK SELECTION AND MAY RESULT IN TWO-TIER SYSTEM.

4. EMPLOYER CHOICE -- EMPLOYER CHOICE ACCELERATES MOVEMENT OF CONSUMERS INTO LOW-COST HMOs AND LEADS TO CONSOLIDATION OF INSURANCE MARKET, REDUCING CONSUMER CHOICE OF DOCTOR AND HEALTH PLAN AND SUBSTITUTING INSURANCE DECISIONS FOR MEDICAL DECISIONS.

5. WATERED DOWN BENEFITS -- PEOPLE WILL PERCEIVE THEIR CURRENT BENEFITS WILL BE CUT.

4/18/94

HEALTH SECURITY ACT
FINANCING – GAP

CBO HAS ESTIMATED A $74 BILLION INCREASE TO THE DEFICIT BETWEEN 1995 AND 2000 BECAUSE OF THE HEALTH SECURITY ACT.

IN ADDITION, OTHER POSSIBLE CHANGES MAY INCREASE FUNDING REQUIREMENTS. THESE INCLUDE:

- DEFICIT REDUCTION
- LOOSENING OF PREMIUM CAPS
- MORE SUBSIDIES FOR SMALL BUSINESS
  - DEEPER DISCOUNTS
  - SLOWER PHASE–IN OF MANDATE
  - INDIVIDUAL MANDATE FOR FIRMS BELOW A CERTAIN SIZE
- INCREASES IN ACADEMIC HEALTH CENTER POOL
- OTHER (LOWER MEDICARE SAVINGS, ETC.)

REDUCING THE SIZE OF ALLIANCES

AS ALLIANCE SIZE IS REDUCED, SAVINGS OCCUR IN TWO WAYS:

- FUNDS FROM THE ONE PERCENT CORPORATE ASSESSMENT INCREASE
- SUBSIDIES PROVIDED TO FIRMS IN THE REGIONAL ALLIANCES DECREASE

A VARIETY OF POLICY OPTIONS CAN YIELD SIGNIFICANT FUNDS AS ALLIANCE SIZE IS REDUCED. THE MAGNITUDE DEPENDS ON:

- WHETHER ENTERING REGIONAL ALLIANCES IS ALLOWED OR PROHIBITED FOR COMPANIES ABOVE A CERTAIN SIZE (PROHIBITION PRODUCES GREATER REVENUE)
- WHAT IS THE SIZE OF FIRM MANDATED TO ENTER THE ALLIANCES (THE SMALLER THE THRESHOLD, THE GREATER THE SAVINGS)
- TO WHOM SUBSIDIES ARE EXTENDED (THE SMALLER THE NUMBER OF FIRMS, THE GREATER THE SAVINGS)
- HOW LARGE A CORPORATE ASSESSMENT IS LEVIED (THE LARGER, THE MORE FUNDS RAISED).

EXHIBIT 1

REDUCING ALLIANCE SIZE

DEFICIT REDUCTION POTENTIAL

BILLION $

	25% of Eligible Firms Form Corporate Alliances			100% of Eligible Firms Form Corporate Alliances		
Firm Size Cutoff	Assessment	Subsidy Savings	Total	Assessment	Subsidy Savings	Total
5,000	0	0		19.4	0	19.4
1,000	6.3	2.0	8.3	44.8	15.3	60.1
500	8.1	5.0	13.1	52.2	24.7	76.9
100	12.4	11.0	23.4	69.6	53.5	123.1

*NUMBERS ARE PRELIMINARY. THEY REFLECT FIVE YEAR SAVINGS ABOVE CBO SCORING.

EXHIBIT 2

ALTERNATIVE EMPLOYER SUBSIDIES AND ASSESSMENTS

DEFICIT REDUCTION POTENTIAL

BILLION $

	Size of Firm		
	1,000	500	100
Provide subsidies to all firms whether in or out of regional alliances, and assess all firms above a certain size.	44.8	52.2	69.6
No assessments and no subsidies above a certain size	15.3	24.7	53.5
Provide subsidies to all firms and assess all firms at 1/2 of one percent above a certain size.	22.4	26.1	34.8

*NUMBERS ARE PRELIMINARY. THEY REFLECT FIVE YEAR SAVINGS ABOVE CBO SCORING.

LESS GENEROUS SUBSIDIES FOR LARGE EMPLOYERS

CBO ESTIMATES THAT EMPLOYERS WILL SAVE $80 BILLION NET OVER FIVE YEARS UNDER THE HEALTH SECURITY ACT. FOR THOSE NOW PROVIDING INSURANCE, THE SAVINGS ARE MUCH GREATER.

THERE ARE TWO WAYS THAT SUBSIDIES COULD BE REDUCED FOR FIRMS ABOVE 75 EMPLOYEES WHICH WOULD STILL LEAVE SIGNIFICANT SAVINGS FOR BUSINESS:

- RAISE THE CAP ON EMPLOYER PAYROLL FROM 7.9 PERCENT TO 8.9 PERCENT OF PAYROLL FOR FIRMS ABOVE 75 EMPLOYEES

- SUBSTITUTE AN INDIVIDUAL CAP FOR LOW-WAGE WORKERS. THIS APPROACH IS PREFERRED BY ECONOMISTS BECAUSE IT TARGETS THE SUBSIDIES TO LOW-INCOME WORKERS AND DISCOURAGES OUTSOURCING. THIS APPROACH COULD SOLVE THE COST PROBLEMS OF LARGE LOW-WAGE FIRMS.

EXHIBIT 3

RAISING THE FIRM CAP

DEFICIT REDUCTION POTENTIAL

BILLION $

Firm Cap	7.9%/HSA	8.2%	8.5%	8.9%
Employer Subsidies	179	172	164	155
Subsidy Savings	0	7	15	24

*NUMBERS ARE PRELIMINARY. THEY REFLECT FIVE YEARS SAVINGS ABOVE CBO SCORING.

THERE ARE OFFSETTING REVENUE EFFECTS, NOT YET ESTIMATED. THERE WOULD BE A LOSS DUE TO HIGHER EMPLOYER INSURANCE PAYMENTS AND THEREFORE LOWER WAGES, AND A GAIN DUE TO LOWER INCENTIVES TO OPT-IN FOR LARGE FIRMS.

EXHIBIT 4

INDIVIDUAL WAGE CAP

DEFICIT REDUCTION POTENTIAL

BILLION $

	1996	1997	1998	1999	2000	1996–2000
Health Security Act	5	17	44	55	58	179
Individual Wage Cap (12% of all firms; lower caps for small low-wage firms*)	4	14	36	46	48	148
Savings	1	3	8	9	10	31

*THE SMALL FIRM INDIVIDUAL WAGE CAP SCHEDULE IS AS FOLLOWS:

	Average Wage in Firm					
Firm Size	**<12K**	**12–15K**	**15–18K**	**18–21K**	**21–24K**	**24K+**
<26	5.5%	6.8%	8.1%	9.4%	10.7%	12.0%
26–50	6.8%	8.1%	9.4%	10.7%	12.0%	12.0%
51–75	8.1%	9.4%	10.7%	12.0%	12.0%	12.0%

INCREASING THE COST SHARING

THE HEALTH SECURITY ACT BENEFIT PACKAGE IS ABOUT AT THE MEDIAN PERCENTILE FOR FORTUNE 500 COMPANIES.

BENEFIT LEVELS MUST BE REDUCED SIGNIFICANTLY TO PRODUCE LARGE SAVINGS. INCREASING COST SHARING HAS GREATER LEVERAGE.

THIS MUST BE DONE IN A WAY WHICH KEEPS THE HMO AND FEE-FOR-SERVICE BENEFITS PACKAGES AT COMPARABLE VALUE TO ENSURE AN EVEN PLAYING FIELD FOR COMPETITION.

EXHIBIT 5

INCREASING THE COST SHARING

BENEFIT PACKAGE SCENARIOS

CBO PREMIUMS

	Fee-for-service Premium ($)	HMO Single Premium ($)	Relative Generosity of Plan Relative to Fortune 500 Companies (Percentile)	5-year Premium Subsidies (Billion)	5-year Cost-sharing Subsidies (Billion)	Total Subsidies (Billion)	Deficit Savings (Billion)
Health Security Act	$2,200	$2,200	50th	$384	$12	$396	-
Scenario I Increase cost-sharing • move from 20 to 25% copay for fee-for service; • impose $250 deductible for hospital stay and raise drug copay from $5 to $10 in HMOs	$2,101	$2,101	35th	$355	$12	$367	$29
Scenario II Increase cost-sharing • move from $1,500 annual out-of-pocket limit to $2,500 on fee-for-service • impose $250 deductibles per hospital stay and raise drug copay from $5 to $10 in HMOs	$2,101	$2,101	35th	$355	$12	$367	$29

EXHIBIT 6

DELAY LONG-TERM CARE PHASE-IN

BILLION $

	1996	1997	1998	1999	2000	TOTAL	SAVINGS
HSA long-term care benefit (CBO scoring)	5	8	12	16	20	61	–
1-year slower phase-in	–	6	9	13	18	46	16
2-year slower phase-in	–	–	6	10	14	30	31

OTHER GAP FILLING REQUESTS

- REDUCING STATE WINDFALL.
- REDUCING EARLY RETIREE BENEFIT.
- COMMUNITY RATING SSI.

REDUCING THE EARLY RETIREE BENEFIT

THE EARLY RETIREE BENEFIT IS NOT A SOURCE OF SAVINGS DURING THE REST OF THIS DECADE.

ELIMINATING IT WOULD ACTUALLY COST MONEY DURING THE FIRST FIVE YEARS.

	1996–2000 (B$)
SPECIAL EARLY RETIREE PREMIUM	7.5
ASSESSMENT ON COMPANIES	13.0
NET BUDGET EFFORT	–5.5

MOST EARLY RETIREE BENEFITS ACTUALLY COME FROM THE COMMUNITY RATING AND NATIONAL SUBSIDY PORTIONS OF THE BILL RATHER THAN FROM THE SPECIFIC EARLY RETIREE PROVISION.

· IC Z 140
· VA

1/21/94

UNIVERSAL COVERAGE

- Universal entitlement to coverage for a comprehensive package of benefits
- Most families obtain coverage through regional alliances; some through corporate alliances
- Medicare remains primary source of coverage for those over age 65
  - Medicare beneficiaries who are working receive coverage through alliances
  - Those over age 65 may remain in an alliance health plan, but may pay extra for coverage
- For services in the comprehensive benefits package, Medicaid recipients receive coverage through alliances
- Veterans may choose a health plan in an alliance or a health plan sponsored by the VA
- Native Americans may choose a health plan in an alliance or a health plan sponsored by the Indian Health Service
- Department of Defense
  - Active duty military personnel obtain coverage through DoD
  - Others enroll in a plan sponsored by DoD (if available) or an alliance plan

COMPREHENSIVE BENEFITS PACKAGE

- All health plans in regional alliances and corporate alliances offer the comprehensive benefits package
- Benefits are comparable to those offered by large employers today
- Emphasis on prevention (no copays required), and no lifetime limits or exclusions for pre-existing conditions
- A health care provider may choose not to provide a particular service on moral or religious grounds
- Health plans may choose from among three types of coverage:
  - HMO: No deductible, $10 copay for doctor's visits, $5 copay for prescriptions
  - Fee-for-Service: Deductible ($200 for individual and $400 for family), 20% coinsurance
  - PPO: HMO type coverage within a network of preferred providers, and fee-for-service type coverage outside of the network
- For all types of coverage, annual out-of-pocket payments are capped to $1,500 for an individual and $3,000 for a family
- Plans may separately offer coverage for lower coinsurance/deductibles or additional benefits

FEDERAL ROLE

Health Security Act specifies the guaranteed benefits package and the basic structure of the system

National Health Board is created

- Federal agency with seven members appointed by the President
- Interprets and recommends changes to the benefits package
- Certifies state implementation plans
- Administers premium caps
- Develops a risk adjustment system

♦ Department of Health and Human Services

- Administers Medicare program and remaining components of the Medicaid program
- Establishes and oversees health alliances if a state does not participate
- Provides funding for employer and family discounts to regional alliances
- Establishes management standards for regional alliances and conducts audits
- Administers new public health funding

Department of Labor certifies and monitors corporate alliances

STATE ROLES

- Each state passes legislation to implement reform within the national structure
  - States choose whether to implement an alliance–based system or a single payer system
  - States may begin implementation from January 1, 1996 to January 1, 1998
- There are substantial incentives for state participation and penalties for non–participation
- Primary state responsibilities under an alliance–based system
  - Determine governance and geographic boundaries of regional alliances (there is one alliance in each area, and it may be a non–profit organization or state agency)
  - Certify health plans (similar to licensing insurance companies today)
  - Assure access to a choice of health plans for all residents
  - Maintain payments for Medicaid recipients, with caps on year–to–year increases

REGIONAL AND CORPORATE ALLIANCES

- Regional alliances provide coverage for:
  - Employees of firms with 5,000 or fewer employees and all public employees
  - Unemployed
  - Medicaid recipients
- Certain organizations may form corporate alliances (employers with more than 5,000 employees, certain collectively bargained multiemployer plans, and the U.S. Postal Service)
  - Must provide the comprehensive benefits package
  - Must offer a choice of at least three plans (including a fee for service plan)
  - Must pay 1% of payroll to share in community–wide expenses
- A large employer may elect to join the regional alliances
  - Community rating and discounts are phased in
  - Once in regional alliances, a large employer may not opt out

REGIONAL ALLIANCE ROLES AND POWERS

- Primary roles of regional alliances
  - Contract with health plans (including at least one fee for service plan)
  - Hold annual open enrollment period
  - Provide information to consumers on health plan choices
  - Approve health plan marketing materials
  - Collect premiums from employers and families
  - Administer employer and family discounts
  - Pay health plans (with risk adjustment)
  - Negotiate with providers a fee schedule for fee for service plans
- With the following two exceptions, a regional alliance must contract with all health plans certified to provide coverage by the state:
  - The health plan has violated prior contractual requirements
  - The health plans's premium is more than 20% higher than the premium target for the alliance (which is tied to the average premium)

INSURANCE MARKET REFORM

Goals of insurance reform:

- Guaranteed access to coverage -- no pre-existing condition exclusions or waiting periods
- Elimination of risk avoidance by health plans
- ◆ Community rating
- Cost containment
- ◆ Consumer choice of health plans and providers
- Maintenance of plan and doctor when changing job or becoming unemployed
- Equitable and workable contributions by employers
- Elimination of unnecessary insurance administrative costs

HOW ALLIANCES ARE DESIGNED TO MEET INSURANCE REFORM GOALS

All families in a health plan within an alliance pay the same premium (community rating)

Alliances permit families rather than employers to choose a health plan

- Promotes greater competition
- Provides maximum choice, since families can enroll in any health plan available in an area regardless of who they work for
- Allows families to keep their health plan and doctor when employment changes

Enrollment is through alliances rather than directly through insurance companies

- Insurance access rules are easier to enforce
- Minimizes opportunities for selective marketing and risk selection by health plans
- Without risk avoidance, health plans must compete over price and service

Alliances collect premiums on a "per worker" basis, which fairly shares responsibility for two-worker families across alliance employers

- Alliances achieve economies of scale by consolidating enrollment, marketing, premium collection and other administrative functions

EMPLOYER PREMIUM PAYMENTS

- Employers pay 80% of the weighted average premium in the alliance
  - Employer payment varies by family status (individual, couple, families with children)
  - Calculated on a per worker basis, meaning that both employers pay in families where both spouses are working
  - Pro-rated for part-time workers

Total premium payments for an employer are capped at 7.9% of payroll

Further discounts are available for employers with fewer than 75 employees (capped at 3.5% to 7.9% of payroll based on firm size and average wage) .

Self-employed pay like a small employer

ENROLLMENT CLASS	PREMIUM	EMPLOYER PREMIUM
Individual	$1,932	$1,546
Couple	$3,865	$2,125
Single Parent	$3,893	$2,479
Dual Parent	$4,360	$2,479

FAMILY PREMIUM PAYMENTS IN REGIONAL ALLIANCES

- Premium payments vary by family status (individual, couple, single parent, dual parent)
- Each family receives a "credit" equal to 80% of the weighted average premium, and pays the difference between the premium for the chosen plan and the credit
- Example where the average premium in an alliance is $4,000:

	CREDIT (80% OF AVERAGE PREMIUM)	HEALTH PLAN PREMIUM	FAMILY PREMIUM PAYMENT
HEALTH PLAN 1	$3,200	$3,600	$400
HEALTH PLAN 2	$3,200	$4,000	$800
HEALTH PLAN 3	$3,200	$4,400	$1,200

- Discounts cap the family's payment at 3.9% of income for the average cost plan and provide further reductions for families with income below 150% of poverty
- Families without a full year of work:
  - Are responsible for the 80% employer share of the premium of the period of time not working
  - Are eligible for sliding scale discounts up to 250% of the poverty level
  - Income does not include unemployment compensation or wages under $5,000 per month

TAX TREATMENT OF HEALTH BENEFITS

- Employers may provide supplemental coverage or contribute more than the required premium contribution (subject to certain non-discrimination rules)
- All employer contributions are fully tax deductible
- Employer contributions for the comprehensive benefits (for premiums or coinsurance and deductibles) continue to be excluded from employee income
- Beginning in 2004, employer contributions for supplemental benefits count as income to the employee

EARLY RETIREES

- Beginning in 1998, the federal government assumes responsibility for the 80% share of the premium for early retirees (age 55 to 65)
- Very high income retirees do not receive the discount
- Employers now providing early retiree health coverage:
  - Pay a three year assessment to recoup half of the savings they receive as a result of the new retiree discount
  - Pay the 20% share of the premium for existing early retirees

FEDERAL PAYMENTS FOR DISCOUNTS (CAPPED ENTITLEMENT)

Alliances collect premiums from employers and families (less any discounts) and pay health plans

The federal government makes payments to alliances for the discounts provided to employers and families

- Total federal payments for all alliances are subject to an annual cap
  - Caps for 1996–2000 are specified in the Act, and grow at CPI plus population plus real GDP per capita thereafter
  - Surpluses are carried forward

Caps are based on reasonable cost estimates, including a 15% "cushion"

If the cap is expected to be reached:

- President must submit to Congress specific recommendations for bringing the system into balance
- Congress considers the recommendations through an expedited process

COST CONTAINMENT

- The expectation is that creation of a more competitive market for health coverage will bring premium increases in line with targeted levels

  - Reduced administrative costs for health plans and providers
  - Consumers shifting to lower cost health plans
  - Changes in provider behavior in response to competition (e.g. reductions in ineffective care)

  Premium caps act as a backup to competition to limit the increase in the average premium in each alliance

  Caps are automatically triggered based on a formula in the Health Security Act, with no discretion on the part of alliances

  Enforcement of premium caps occurs according to a stepped process

  - Caps are triggered only if the average premium in an alliance grows too rapidly
  - Health plans in "non-complying" alliances are subject to premium reductions
  - Providers in health plans whose premiums are reduced are also subject to payment reductions

  Allowable increases in premiums are phased in from CPI plus 1.5 in 1996 to CPI in 1999 and 2000, with a more flexible process after the year 2000

MEDICARE

- Medicare remains a separate program
- A prescription drug benefit is added to Medicare

Those eligible for Medicare but working receive coverage through alliances

Newly eligible persons generally may choose to remain in an alliance health plan (but possibly with a higher premium payment)

States may apply to the federal government to integrate Medicare into alliances

Specific initiatives reduce the increase in Medicare spending by $124 billion

- 60% from reduced hospital spending
- 13% from reduced physician spending
- 13% from beneficiaries
- 14% from other sources

MEDICAID

- Medicaid recipients receive coverage through regional alliances and have the same choices of health plans as other participants
  - Those receiving cash assistance (AFDC and SSI) pay nothing for any plan below the average premium and pay lower copayments in HMOs and PPOs
  - Those now receiving Medicaid but not cash assistance are treated like other low-income persons
- States continue current funding levels for Medicaid, but with lower rates of increase over time
  - States and the federal government make premium payments to alliances for AFDC and SSI recipients
  - States make lump sum payments to alliances based on current spending for Medicaid recipients not receiving AFDC or SSI
- The financial responsibility for covering AFDC and SSI recipients in alliances is spread evenly across all health plans
- Long term care benefits under Medicaid continue

LONG TERM CARE

The Health Security Act creates a new universal program for home and community-based long term care services

- The program is largely state administered and designed
- Federal funding is capped (with small state matching payments)
- Program is targeted to people with severe disabilities of all ages
- No income or asset test

Medicaid nursing home coverage continues, with improvements

Standards for private long term care insurance and tax incentives are established

QUALITY

The Health Security Act creates a performance–based system of quality management and improvement

- The National Quality Management Council establishes national measures of quality performance

Consumers are provided with a "report card" based on these national measures for each health plan

States establish quality criteria for certification of health plans

Regional professional foundations foster collaboration among health plans and providers and disseminate information relating to quality improvement

MALPRACTICE REFORM

Health plans must establish alternative dispute resolution systems, which are required to be used before filing a malpractice claim

Contingency fees are limited to one–third

Pilot projects are established for:

- Enterprise liability
- Use of provider practice guidelines as a defense under malpractice claims

WORKERS COMPENSATION AND AUTO INSURANCE INTEGRATION

- People injured on the job or in an accident must obtain services from their health plans
- The financing of workers compensation and auto insurance remains unchanged
- Workers compensation and auto insurers pay health plans for services based on the fee for service fee schedule negotiated by the alliance
- A commission is established to report by 1995 on the feasibility of fully integrating the financing of medical benefits now provided under workers compensation and auto insurance

THE WHITE HOUSE

WASHINGTON

August 8, 1994

MEMORANDUM FOR PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON
LEON PANETTA
HAROLD ICKES

FROM: IRA C. MAGAZINER Ira

SUBJ: "MAINSTREAM SENATE GROUP CRITIQUE OF MITCHELL PROPOSAL"

Attached are criticisms by the "mainstream" Senate group about Senator Mitchell's proposal and his responses.

As you can see, the "mainstream" group has once again backed away from some of their own positions as Senator Mitchell has reached out to them.

MAINSTREAM GROUP
OBJECTIVES FOR HEALTH REFORM

ACHIEVE UNIVERSAL COVERAGE
NOT INCREASE THE DEFICIT
LOWER HEALTH CARE COSTS
MAINTAIN QUALITY
EXPAND CHOICE FOR ALL AMERICANS
THE MAINSTREAM AMENDMENT WILL:

Achieve universal coverage through:

- effective insurance reforms -- portability, renewability, eliminate preexisting condition limitations, adjusted community rating in small group market;
- expanded tax deductions; and
- subsidies for low-income families that make health care affordable for ALL Americans.

Limit government intrusion/bureaucracy/regulation:

- NO market-distorting price controls
- NO prescriptive regulations that stifle innovation
- NO new big mandated state or federal bureaucracies.

Protect against deficit growth through:

- full financing of new health spending; and
- effective "fail-safe" mechanism that prohibits deficit financing of health spending.

Lower health care costs by making health plans compete on quality and price through:

- standard benefits packages;
- better consumer information and health plan accountability
- voluntary purchasing cooperatives
- administrative simplification
- measures to eliminate fraud and abuse
- aggressive malpractice reform.

WHY MITCHELL HEALTH CARE LEGISLATION FALL SHORT OF MAINSTREAM OBJECTIVES

IMPOSES MARKET DISTORTING PRICE CONTROLS

- Premium Assessment relies on Government imposed price caps
- New National Health Care Cost and Coverage Commission has power to recommend government price controls under an expedited procedure

IMPOSES NEW MANDATES

- Triggered Employer/Individual mandate
- All employers with less than below 500 employees must join "Voluntary" purchasing cooperatives

EXPENSIVE NEW SPENDING

- New non-means tested entitlement for prescription drugs
- New non-means tested entitlement program for long term care
- New employer subsidies to encourage expanded coverage
- New subsidies to fund health benefits for families up to 300% of poverty
- New subsidy for the temporary unemployed
- New subsidies for cost sharing for low income participants
- New authorizations for existing Public Health Programs
- Six new trust funds for medical workforce (a superfund for medical education) and new trust fund for research funded by a 1.75% tax on premiums
- Expanded private remedies for benefit delay and denial destroys ability of health plans to control costs
- Deep cuts in Medicare exacerbates cost shift onto private sector
- Fail safe not established until massive new entitlements have been incorporated into baseline
- Fail safe subject to manipulation by the Executive Branch by changing baseline and setting inflation factors

SUBSTITUTES GOVERNMENT REGULATION FOR PRIVATE MARKET FORCES

- 500 Employee threshold herds majority of employees and employers into large collectives and destroys employers' ability to control costs
- Gives National Health Board excessive power to practice medicine
- Pure community rating beginning in 2002 penalizes the young and dooms the voluntary system

- The new employer subsidy decreases incentive to control costs once payment limit is reached
- Premium assessment is not used to provide consumer incentive to save costs and undermines competition be setting a Government imposed target
- Opening of FEHBP creates Federal Government run purchasing cooperatives that could become a back door single payer system
- Creates Federal Government central planning of health work force
- Creates an unlevel playing field in the marketplace by mandating all employers and HIPCs offer a Fee -For -Service plan
- Requires employers to offer only standard benefit package-- only individuals can use "alternative standard plan"
- Triggered mandate creates counterproductive business and hiring incentives by exempting employers with less than 25 employees
- Creates a government run long term care health insurance system
- Undermines competition in the prescription drug industry with a mandatory rebate agreements
- Provides no incentive for Medicare seniors or providers to choose cost effective private systems
- Destroys ability to manage health costs by requiring health plans to contract with a wide range of "essential" community providers
- Uncertain scope of "State Option" may severely hamper multi-state employers and providers
- Institutes bureaucratic Federal and State inspection and reporting systems for providers and health plans
- Weak malpractice reforms ensure continued defensive medicine

HIDDEN COST SHIFTS

- Federal Government shifts costs of insuring Medicaid population onto private health plans and States
- Underfunded mandate to States to administer subsidies
- Institutionalizes cost-shifting by requiring self-insured employers to risk adjust and subsidize the community rated system

FEDERAL BUDGET EFFECTS OF MITCHELL PROPOSAL

	10-Year Estimate ($ billions)	
Outlay increases:		
Low-income subsidies (Finance)	$ 924	*
Prescription drugs for Medicare Beneficiaries (Mitchell)	$ 99	
Home and Community Based Care Program (Mitchell)	$ 48	
GME/AHC initiatives	$ 75	
Total outlay increases	$1,146	
Funding Sources:		
Eliminate Medicaid acute care (Mitchell)	$ 516	
State maintenance of effort payments (Mitchell)	$ 232	
Medicare cuts (Mitchell)	$ 278	
Means test Medicare Part B premiums (Finance)	$ 22	
Tobacco tax (rough estimate)	$ 50	
High Cost Plan Assessment	$ 40	
Eliminate Section 125/Flexible Spending Arrangements (Finance)	$ 35	
1.75% premium assessment	$ 75	
Other revenue changes (net)	$ 0	
Total funding sources	$1,248	

* The bill approved by the Finance Committee did not include the subsidies to employers or the subsidies for short-term unemployment.

RESPONSE TO MAINSTREAM OBJECTIONS

IMPOSES MARKET DISTORTING PRICE CONTROLS

Claim: Premium Assessment relies on Government Imposed Price Caps

Response: The premium assessment is borrowed from the approach in the Finance Committee bill except that the fundamental problems with the assessment in that bill are addressed so that experience rated health plans are not penalized for having an older and/or sicker population. The premium assessment in the Finance bill promoted by the so-called "Mainstream Coalition" imposes a tax on the 40% highest cost plans without regard to what kind of job they are doing controlling costs. No matter what happens, the most expensive 40% of all plans are always taxed. The Mitchell bill premium assessment starts with average market costs for plans in a community rating area, and actual costs for experienced rated plans, and determines whether there is an assessment by measuring their deviation from the target rate of growth. That is no more a "Government imposed price cap" than the mainstream proposal that sets a completely arbitrary standard of taxing the 40% most expensive plans. Furthermore, the 62% effective tax rate in the Finance Committee/mainstream proposal acts must more like a government imposed cap than the 25% rate in the Mitchell bill.

Claim: New National Health Care Cost and Coverage Commission has power to recommend government price controls on an expedited procedure.

Response: The process in the Mitchell bill for consideration of such a proposal is the same procedure as is included in the Finance Committee/mainstream bill for consideration of legislation to reach 95% health insurance coverage. Such legislation still requires a majority to pass both the House and the Senate and a presidential signature.

IMPOSES NEW MANDATES

Claim: All employers with less than below 500 employees must join "Voluntary" purchasing cooperatives.

Response: Under the Mitchell bill, health insurance purchasing cooperatives are voluntary because while small firms are required to offer a HIPC, no one is required to purchase through a HIPC. Individuals and firms can always purchase plans without going through HIPCs.

EXPENSIVE NEW SPENDING

Claim: New non-means tested entitlement for prescription drugs.

Response: Medicare Prescription Drug Benefit - this Medicare outpatient prescription drug benefit offers three options to beneficiaries: fee-for-service, Pharmaceutical Management Benefit, and an HMO option. Each option includes cost containment provisions; each option requires a premium payment and out-of-pocket co-payment for beneficiaries, and includes provisions for rebates from drug manufacturers to hold down the cost of the program.

Claim: New non-means tested entitlement program for long term care.

Response: Long Term Care - the Long Term Care benefit is nearly identical to the provision offered as an amendment in the Finance Committee which was approved on a vote of 16-4. The majority of the Mainstream group including Senator Chafee, voted for the amendment. The benefit is available to persons of all ages and income levels but the out-of-pocket costs are based on the income of the individual.

Claims: New Employer Subsidies to encourage expanded coverage.
New subsidies to fund health benefits for families up to 300% of poverty.
New subsidy for the temporarily employed.

Response: Exactly what their point is here is not clear. The Finance/mainstream proposal includes subsidies and so does the Mitchell bill. The difference in cost for the subsidy provisions in the two bills is quite minor; the Mitchell bill is less than 10% more expensive but expands coverage by about 40% more than the Finance bill; about 8 million people.

Claim: New subsidies for cost sharing for low-income participants.

Response: The Finance Committee bill also included new subsidies for cost-sharing. In fact, many advocacy groups believe that cost-sharing subsidies in the Finance Committee bill are more generous than those in the Mitchell bill.

Claim: New authorizations for existing public health programs

Response: New authorizations are not made solely to existing public health programs. A majority of the funds are allocated for new programs, including grants for community network development in underserved areas, the prevention of chronic illnesses and the prevention of domestic violence.

Claim: Six new trust funds for medical workforce and a new trust fund for research.

Response: Over half of the funding ($35-37 billion over 5 years) for graduate medical education and academic health centers is not new funding. It would be spent by Medicare under current law. The Finance, Labor, and Mitchell bills broaden funding for such teaching centers to all insurance payers.

Claim: Expanded private remedies for benefit delay and denial destroys the ability of health plans to control costs.

Response: The Mitchell bill remedies for benefit denial or delay provide simple justice for those patients who believe they are denied a benefit. It requires health plans to have an internal procedure and independent review of denied claims. It provides for State-run Claims Review Offices to help resolve complaints before they get into court. If health plans can deny benefits to cut costs, patients must be able to have redress. This will foster competition on the basis quality, rather than competition that hurts patients. This is a matter of simple justice.

Claim: Deep cuts in Medicare exacerbates cost shift onto private sector.

Response: Nearly all of the reductions in Medicare included in the Mitchell bill were also included in the Finance bill. All members of the Mainstream group voted for final passage.

Claim: Fail safe not established until massive new entitlements have been incorporated into baseline.

Response: Every penny of new entitlement spending in the Mitchell bill is completely paid for and does not increase the deficit. If the new program's costs exceed current estimates and would increase the deficit, the fail safe will automatically cut back spending to offset the deficit increase.

Claim: Fail safe subject to manipulation by the Executive Branch by changing baseline and setting inflation factors.

Response: The fail safe requires the Office of Management and Budget to compare updated estimates of health care spending to estimates of health care spending made when health care reform is passed. OMB's final comparison of these two baselines takes place on September 10th of any given year, based on data for the upcoming fiscal year (October 1 through September 30) and the current fiscal year (October 1 of the previous year through September 30), for which considerable actual data is already available. Including such actual data in the OMB estimate minimizes their ability to manipulate the data.

SUBSTITUTES GOVERNMENT REGULATION FOR PRIVATE MARKET FORCES

Claim: 500 Employee threshold herds majority of employees and employers into large collectives and destroys employers' ability to control costs.

Response: Setting the community rating threshold at 500 protects many medium-sized firms who do not have enough market power to negotiate lower rates. In fact, the National Association of Insurance Commissioners, a bipartisan group of state insurance officials, recommends that Congress set the threshold at 500. Their "recommendation is founded in part upon the need to maximize the size of the community-rated pool to spread risk broadly and to absorb premium costs."

The so-called "Mainstream"Group's proposal set the community rating threshold at 100. The Senate Finance Committee Chairman's Mark proposed a threshold at 500. The Senate Finance bill, as amended by the "Mainstream"group reduced the threshold down to 100.

But under the Finance bill, according to CBO, "some moderate-sized firms--those with 100 to 300 or 400 employees--might face relatively high costs for coverage. Just as they do under the current system, such firms would have to either self-insure or offer coverage through the experience-rated market. Moreover, they would be required to provide their employees with a choice of three plans, including a fee-for-service plan. Thus, the enrollment in some of those plans could be extremely small, especially since some employees in families with two workers could obtain their coverage elsewhere."

"Small enrollments would, in turn, result in high administrative costs. Furthermore, because the firm's premiums would be experience-rated, a single employee with a costly medical problem could raise the firm's premiums significantly. Some plans could end up with ever-increasing premiums and shrinking enrollment as people who could obtain cheaper coverage through their spouse's employer left the plan, raising its premiums further. At a minimum, employees would no longer have a realistic choice of three plans, and in extreme cases, all three plans might be quite expensive. In principle, individuals with income below the poverty level enrolled in such plans would be fully subsidized, but in fact they might have to contribute the costs of their coverage if premiums for all three plans were above the average for the community-rated market, which determines the maximum possible subsidy." [CBO Report on the Finance Committee Bill]

Claim: Gives the National Health Board excessive power to practice medicine.

Response: There is no National Health Board in the Mitchell bill. There is a part-time, National Health Benefits Board which will design the three cost sharing schedules that will be offered to consumers. It does not have excessive power and it certainly doesn't have the power to practice medicine. It encourages consistency of coverage, to avoid risk selection. It must go to Congress, if it wants to change the categories of benefits or increase the actuarial value of the benefits package.

Claim: Pure community rating beginning in 2002 penalizes the young and dooms the voluntary system.

Response: During the transition to full coverage, plans may vary premiums for family size, geography, and age. Variations for age are limited to 2:1 in 1997 and are gradually phased out when full coverage is achieved. Maine and several other states are already moving, or have moved, towards eliminating age rating in today's voluntary system.

Claim: The new employer subsidy decreases incentives to control costs once payment limit is reached.

Response: It is not clear what they are talking about here because the bill currently includes no employer subsidies except the limited provision in the voluntary system that subsidizes employers to the extent they insure all their employees. However, only the additional employees covered are subsidized and then only to the extent their income is under around $22,000. Therefore, many employees remain unsubsidized and this statement if flat wrong.

Claim: Premium assessment is not used to provide consumer incentive to save costs and undermines competition by setting a government imposed target.

Response: It is not clear what they mean by the first point that the assessment is not used to provide consumer incentive to save costs. How does the Mainstream/Bradley proposal differ in that regard, whatever it means? The argument that it undermines competition by setting a Government imposed target is absurd; what it suggests is that a plan will decide not to control costs because it will be taxed if its costs exceed a target. There is no sense to that argument.

Claim: Opening FEHBP creates Federal Government run purchasing cooperatives that could become a back door single payer system.

Response: The federal government will not run purchasing cooperatives unless there is no state-certified purchasing cooperative through which federal workers (and non-federal individuals) can obtain coverage. Even then, the federal government can contract with local organizations to perform the duties of a purchasing cooperative. In most areas of the country, FEHBP will designate a locally established and operated, state-certified HIPC through which federal workers will have access to the same plans as non-federal individuals.

Claim: Creates Federal Government central planning of health workforce.

Response: The Mitchell bill strikes a compromise between academic medicine and the public need for more primary care doctors. For the investment of funding in academic medicine from all payers, academic medicine agrees to facilitate the shift toward more primary care physicians. It is important to state this in legislation, since market forces have contributed to the problem of creating too many specialists and too few primary care doctors. The Mitchell bill encourages specialty groups to voluntarily reduce training positions. It also creates a mechanism for establishing national workforce goals to judge progress toward the overall goal of increasing primary care physicians. Many national commissions, such as the Physician Payment Review Commission (PPRC), the Pew Health Professions Commissions, the Council on Graduate Medical Education (COGME), have endorsed this approach.

Claim: Creates an unlevel playing field in the marketplace by mandating all employers and HIPCs offer a Fee-for-Service plan.

Response: The Finance Committee bill also requires that employers and HIPCs offer a Fee-for-Service plan.

Claim: Requires employers to offer only standard benefit package--only individuals can use "alternative standard plan".

Response: The Mitchell bill specifies three standard benefit packages, similar to fee-for-service, preferred provider organization or point-of-service, and a health maintenance organization. The advantage of a standard benefit package is that consumers can easily compare plans and their costs. It helps consumers shop, increases competition and facilitates choice of quality and price. The very high deductible alternative standard plan is sold only to individuals to avoid risk selection.

Claim: Triggered mandate creates counterproductive business and hiring incentives by exempting employers with less than 25 employers.

Response: There is some truth to that statement.

Claim: Creates a government run long term care health insurance system.

Response: The long term care insurance standards contained in the Mitchell bill are virtually identical to the provision in the Finance Committee bill. All members of the mainstream group voted for final passage of the Finance bill.

Claim: Undermines competition in the prescription drug industry with a mandatory rebate agreement.

Response: The Medicare prescription drug benefit includes three options to allow beneficiaries more choice of delivery and to create a competitive environment for the delivery of pharmaceutical benefits. The fee-for-service benefit would be in direct competition with the HMO and Pharmaceutical Benefit Management options, which encourage competition between pharmaceutical companies and health plans.

Claim: Provides no incentive for Medicare seniors or providers to choose cost effective private systems.

Response: The plan allows individuals "aging" into the Medicare program to remain in their current managed care plans if they have Medicare risk contracts or are eligible to become Medicare risk contracts.

Claim: Destroys ability to manage health care costs by requiring health plans to contract with a wide range of essential community providers.

Response. The purpose of this provision is to ensure access to the underserved population. Only a narrowly defined group of providers with a proven track record of serving this population are included. Moreover, health plans are given the option of entering into a contract or paying the essential community providers directly for services provided.

Claim: Uncertain scope of "State Option" may severely hamper multi-state employers and providers.

Response: States that wish to move ahead early toward the federal plan outlined in the Mitchell bill may do so. States that want to opt out of the proposal to implement single payer systems instead may do so. States that have existing waivers under Medicare, Medicaid and ERISA are "grandfathered."

Claim: Institutes Bureaucratic Federal and State inspection and Reporting systems for providers and health plans.

Response: It is the consumers that discipline health plans and providers based on the choices they make. Plans, and not the government, are responsible for overseeing the quality of care provided. Based on a federal framework, states are given the flexibility to use private organizations to ensure that health plans meet the standards.

Claim: Weak malpractice reforms ensure continued defensive medicine.

Response: The Mitchell bill includes major malpractice reforms. It requires a certificate of merit, in which an independent physician certifies there is a medical basis for the claim, before going to Court. It requires mandatory Alternative Dispute Resolution techniques to resolve issues before going to Court. It limits attorney's fees. All of these efforts will serve to reduce defensive medicine. Those that call for caps on damages, are simply taking away the one tool that injured patients have to receive some compensation for their pain and suffering.

HIDDEN COST SHIFTS

Claim: Federal Government shifts costs of insuring Medicaid population onto private health plans and States.

Response: Like the Finance Committee bill, the Mitchell bill integrates Medicaid recipients into private health plans at full private premium costs.

Claim: Underfunded mandate to States to administer subsidies.

Response: States can continue using existing infrastructure to administer subsides. In addition, states can use Medicaid savings to improve upon their existing subsidy administration infrastructure.

Claim: Institutionalizes cost-shifting by requiring self-insured employers to risk adjust and subsidize the community rated system.

Response: The Finance Committee/mainstream bill is in many ways the product of blind idealogy rather than good policy. Driven by that ideology, they divide the community rated pool from the experience rated pool at 100 employees, thus creating a much smaller and less stable market. They then put much of the existing cost shift, new costs shifts, and higher risk populations in the under 100 market. You might think of it as polluting the under 100 market. The result is that the average family policy premium costs about $700 more in the community rated market as it does in the experience rated market. That is a recipe for disaster that increases costs for small businesses and others in the market while also greatly increasing federal subsidy costs (since most of the subsidized population is in the community rated market).

The Mitchell bill addresses that problem in a couple of ways. First, it creates a considerably larger community rated market. Second, through a risk adjustment mechanism that is the subject of this point. The Mitchell bill measures the extra costs imposed on the community rated pool through the inclusion of the noncash AFDC population, the Medicaid categorically eligible population, retirees, and other nonworkers. It then distributes those extra costs on a per capita basis among all health plans, including experience rated health plans. That means the experience rated plans will make per capita payments to the community rated plans. Through this mechanism we adjust for the greater costs foisted on the community rated plans which are currently distributed throughout the entire health system. We don't impose a new cost on experience rated plans, we simply measure a benefit that we are giving and recapture it through the risk assessment. Large companies accept that this is appropriate although they naturally want to see the details of our provision. This was part of the justification for the 1% of payroll assessment that was earlier proposed to be on experience rated employer. This is a substitute for that although much smaller, maybe one-fifth the amount, under $100 a per premium.

7-30-94

Shared Responsibility: The American Way

Shared responsibility is the American way -- part of the American tradition of work and reward. Nine out of ten Americans with private insurance already get it through their workplace. Real health care reform will continue this tradition, building on the existing system and expanding it to include all Americans.

And shared responsibility will lower costs for businesses that already insure their workers. Small businesses who pay the most today will benefit most from reform. And studies reveal that real reform will not slow the economy, and may even create jobs.

This health care reform debate is coming down to a choice between two approaches. One builds on our American system of workplace health benefits, and makes sure employers live up to their responsibilities. The other approach leaves every family at risk of being dropped. For middle class Americans, its an obvious choice.

The American people overwhelmingly support Universal Coverage: 78% according to a recent *ABC News/Washington Post* Poll [June 27, 1994]. And shared responsibility is the fairest, and least disruptive way to get there.

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Sports

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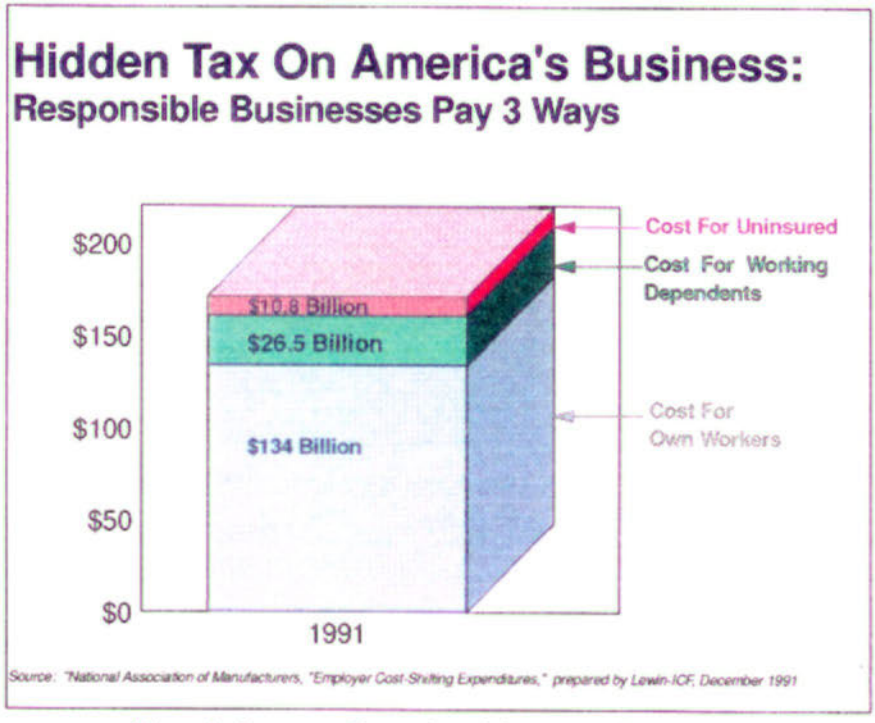
I. WITHOUT SHARED RESPONSIBILITY, COST SHIFTING WILL PUNISH RESPONSIBLE BUSINESSES

There is often cost-shifting among firms in the same industry, "*creating a situation where some employers may actually subsidize health care provided to employees in competing firms.*" [National Association of Manufacturers, *"Employer Shifting Expenditures,"* prepared by Lewin ICF, December 1991]

The current system forces responsible employers to pay for insurance three times: First, for their own employees. Second, for dependents of their employees who work, but don't get health care from their own jobs. And third, for the uninsured -- many of them working people -- who show up in America's emergency rooms, and whose unpaid costs are added to the bills of those who do have insurance. **Cost shifting is a hidden tax on responsibility and on employment.**

- In 1991, employers who took responsibility for employees and their families **paid $26.5 billion to cover working dependents whose employers did not offer insurance to their workers.** [National Association of Manufacturers, *"Employer Cost-Shifting Expenditures,"* prepared by Lewin-ICF, December 1991]

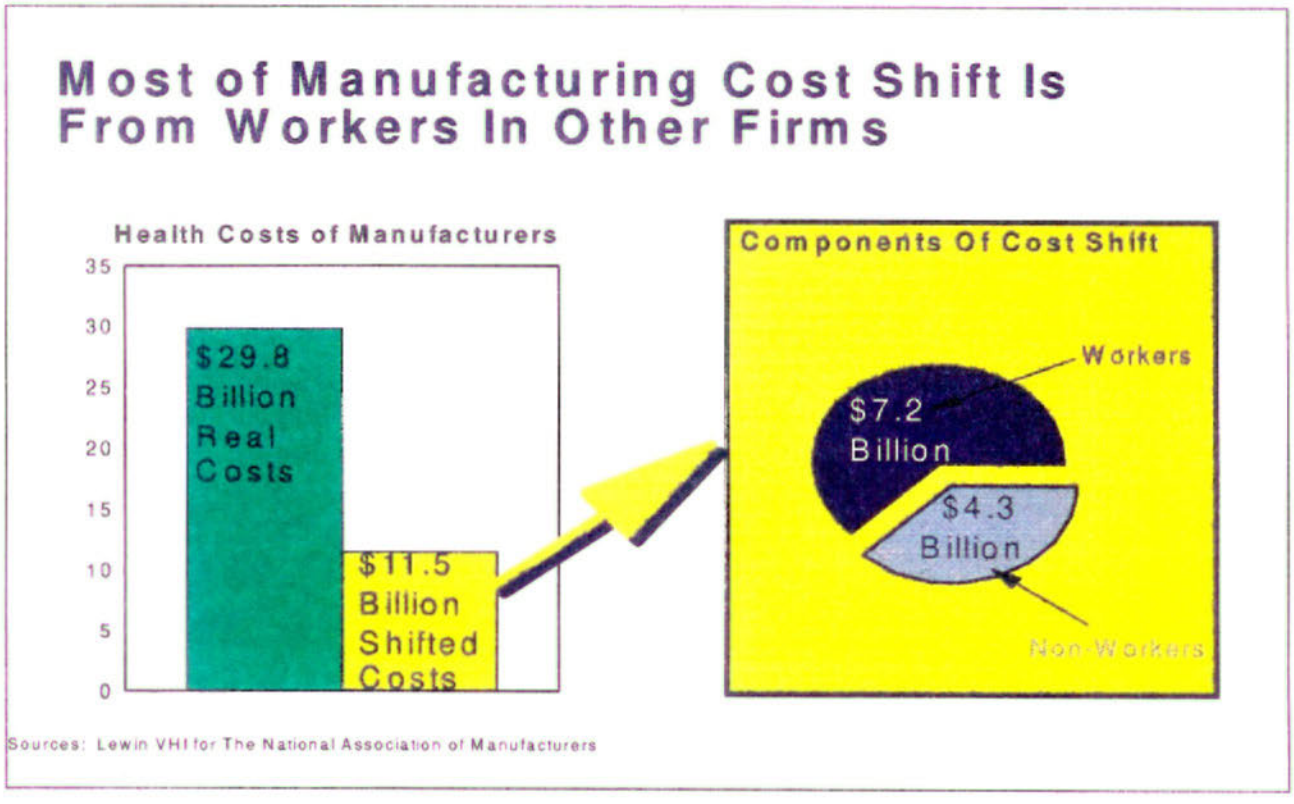


- That same year, employers who took responsibility for their employees' insurance also had an additional $10.8 billion added to their premiums to cover the uncompensated hospital costs of people without any insurance. Nearly half of these were to pay for **"workers, or dependents of workers, in firms that didn't provide coverage."** [National Association of Manufacturers, *"Employer Cost-Shifting Expenditures,"* prepared by Lewin-ICF, December 1991]

The manufacturing industry -- a critical source of high-wage jobs and export-quality American goods -- has been hard hit by cost shifting. America's manufacturers are among the nation's most responsible business, covering almost all of their workers. They must compete against foreign manufacturers with stable, insured, productive workforces, while carrying the extra burden of companies that do not provide coverage.

- **Bethlehem Steel has 20,000 employees but pays insurance for 160,000 people**. Although locked into a competitive battle with Canadian steel producers just across the border, Bethlehem is burdened by **$65 million in additional health care costs** -- almost a third of their total health care bill -- because of cost-shifting. [Testimony of B. Boyleston, V.P. for Human Resources, before Congressional Steel Caucus, 6/23/94]

- One study estimates that 28% -- or $11.5 billion -- of the health care costs paid by manufacturing companies are a result of cost-shifting. Manufacturers buy insurance for over 3 million workers in other industries. [National Association of Manufacturers, *"Employer Cost-Shifting Expenditures,"* prepared by Lewin-ICF, December 1991]



- **Universal coverage will eliminate the penalty on businesses that provide coverage.** *"Universal coverage would mean that those firms that now offer insurance would no longer need to pay indirectly through higher doctor and hospital bills for the care given to uninsured workers and their families. On the other hand, firms that do not now provide insurance could no longer ride free."* [CBO, 2/94]

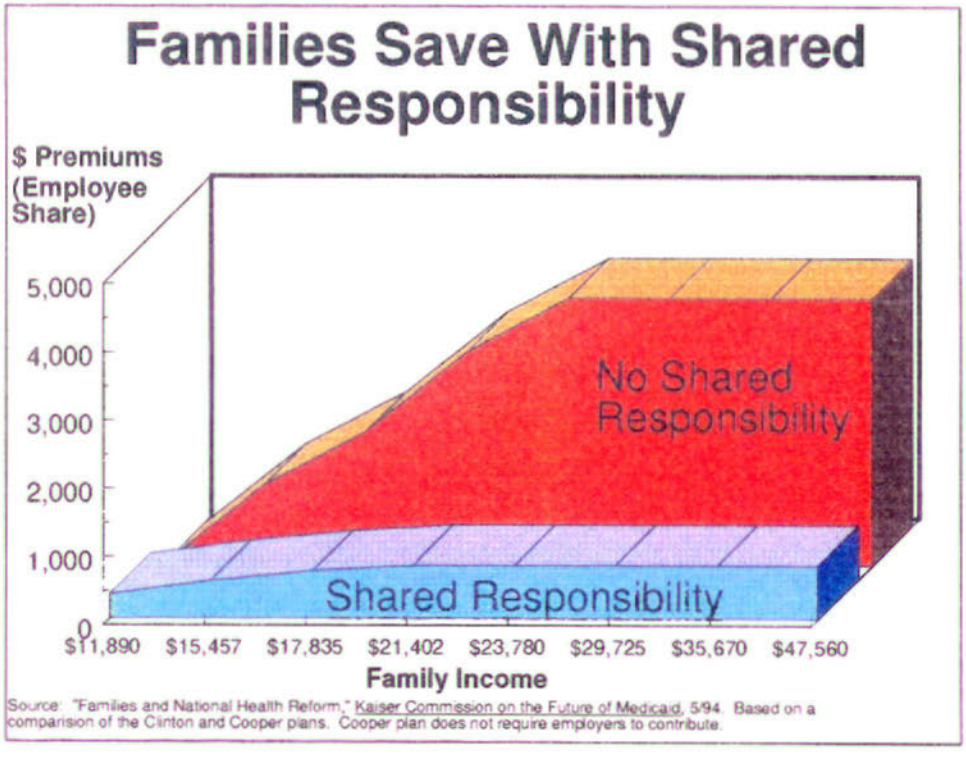
II. AVOIDING SHARED RESPONSIBILITY MEANS MORE WORKERS WILL LOSE THEIR COVERAGE

"For those who have suggested that the best policy may be to muddle through with only small, incremental changes, our analysis suggests that the number of uninsured workers in small businesses will continue to grow. If our survey proves true, in the years ahead ***30 percent of small businesses currently providing insurance will drop their insurance coverage because of the high cost."*** [Health Affairs, Spring 1992]

- Under one proposed plan, where benefits were not guaranteed at work, two million workers in small businesses would lose their employer's contribution. [CBO, 2/94]

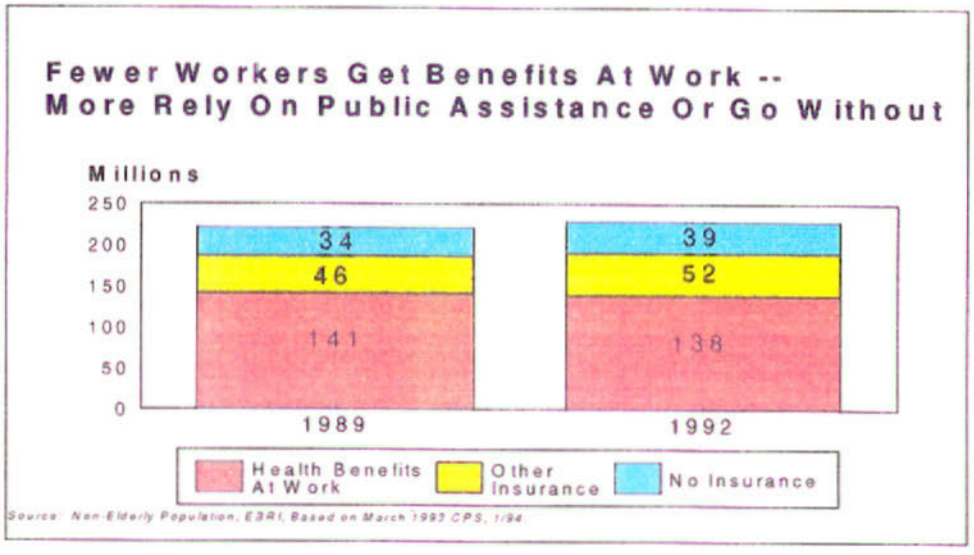
- Another reform alternative would cost 1.3 million Americans their insurance every month. And 1.8 million Americans a month would lose their coverage under yet another leading alternative. [Lewin-VHI estimates for Families USA]

- If employers do not take responsibility, every worker in the United States will be at risk of having to bear the entire burden of health insurance alone -- $3,900 or more each year. ["Families and National Health Reform," Kaiser Commisission on the Future of Medicaid, 5/94]



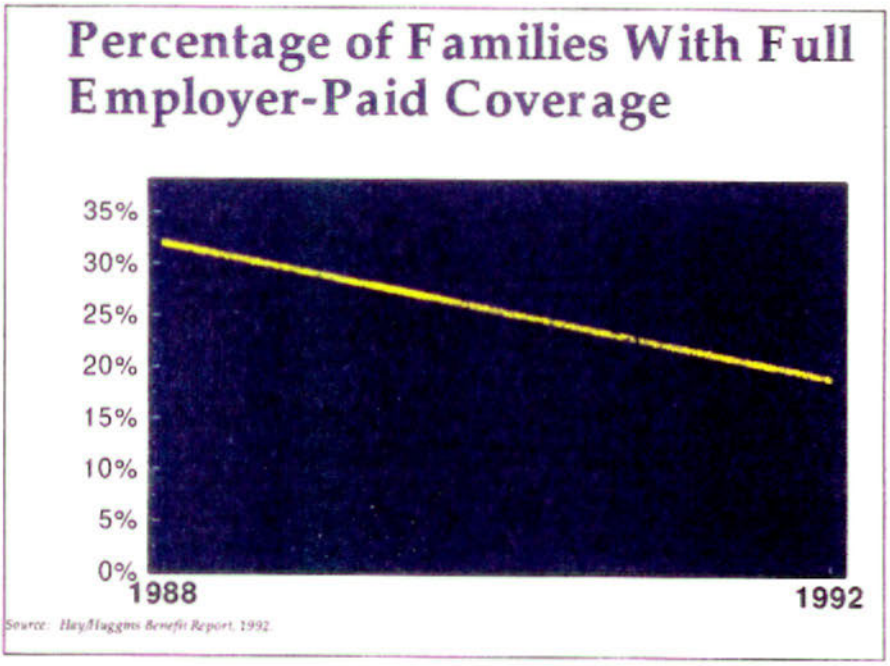
More and more, employees are being hurt as rising costs force companies that take responsibility to cut back.

- The percentage of workers whose employers sponsor a health insurance plan is already falling -- from 81% in 1988 to 78% in 1992. In 1978, 23% of new companies offered health benefits to their employees. In 1992, that percentage had dropped to 15%. [Department of Labor, 5/94; University of North Carolina, 8/92]



- Nearly six in ten Americans earning between $30,000 and $50,000 a year have experienced health benefit cutbacks in their households. The percentage of families with full employer-paid coverage fell from 32% in 1988 to 19% in 1992. [New York Times/CBS News Poll 4/7/93; Hay/Huggins Benefit Report, 1992]

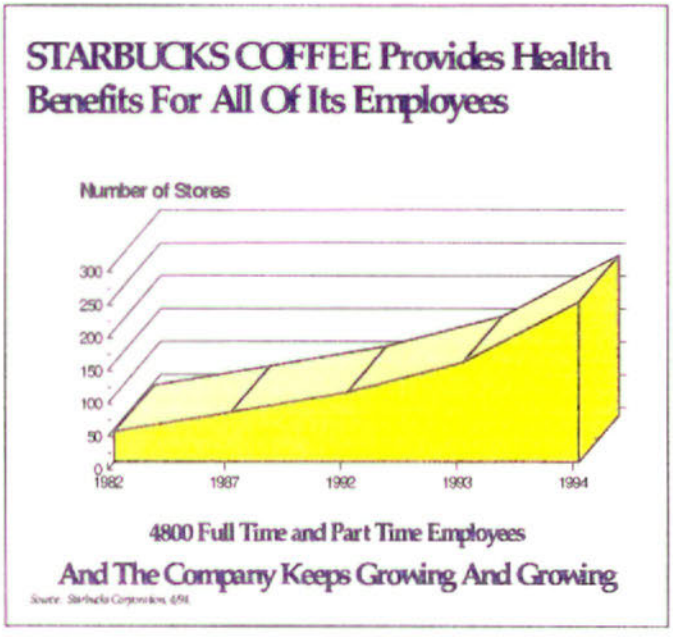
- Steve Burd, President and Chief Executive Officer of **Safeway** Inc. -- one of the world's largest food retailers -- said his company competes "*with some very large companies that don't offer the same kind of coverage.*" If health reform doesn't pass with the employer mandate, Burd fears that Safeway might be forced to curtail its coverage "*to level the playing field.*" [LA Times Friday July 22, 1994]

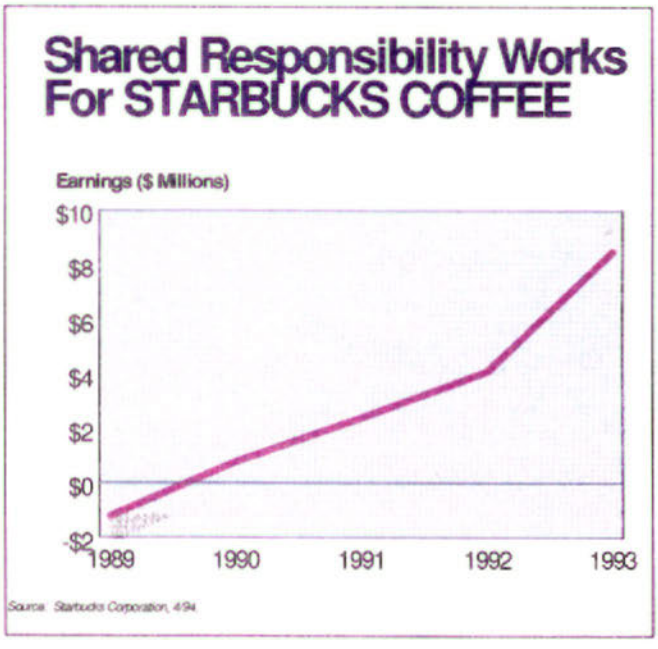


III. SHARED RESPONSIBILITY IS GOOD BUSINESS

"The simple math is it saves the company money. It costs about $1,500 per year to cover each employee, part time and full time, and the cost of attrition if we have to hire and retrain a new employee is over $3,000." [Starbucks CEO Howard Schultz]

- **Starbucks Coffee**, 4,800 employees, was named one of the fastest growing companies in America in 1993 by Fortune Magazine. CEO Howard Schultz believes that a comprehensive employee benefits package for all workers is the key to competitiveness: *"At Starbucks Coffee Company adding benefits for part-time and full-time employees is leading to a healthier workforce and bottom line. The longer an employee stays with us, the more we save."* Starbucks posts higher profits every year, sales have grown almost 80% over the last three years, and the stock price continues to climb.





- **PictureTel**, the technology and market leader in video conferencing, has doubled the number of its employees since 1991 to 865. They are able to provide health care benefits to all their employees and yet still grow at world class rates -- an astonishing compounded growth rate of 97% over the past five years. PictureTel is the market leader both in the U.S. and in Europe.

Shared responsibility works around the world.

"[Pizza Hut and McDonalds] are living proof that shared responsibility works for employers and employees, and as a means for a nation to achieve universal coverage," ["Do As We Say, Not As We Do," The Health Care Reform Project, July 1994]

- **Pizza Hut**, which earned a net profit last year of $372 million, does not contribute to health insurance for many of its hourly restaurant workers in the United States. The company does make a group insurance plan available, but employees are required to pay the full amount. After six months, the company will contribute to the cost of supplemental coverage, but paying for the basic plan is still the responsibility of the employee.

  By contrast, in Germany, Pizza Hut is required to pay 50 percent of its employees' premiums. As of 1991, there were 64 Pizza Hut restaurants in Germany with revenues of $39 million and 2,100 employees. In Japan, Pizza Hut is required to pay 50 percent of the premiums for employees who work at least 30 hours per week -- as most do at any of the company's 65 restaurants there. Pizza Hut is doing so well there that two years ago the company announced its intention to quadruple the number of Pizza Huts in Japan by 1997.

- **McDonald's** does not cover hourly or part-time workers at its restaurants in the United States. However, McDonald's does pay for coverage for its workers in Belgium, Germany, Japan, and The Netherlands. Germany is one of McDonald's six largest markets, with 27,000 employees and revenues of nearly $1 billion in 1992. Likewise, in The Netherlands, McDonald's now has 100 stores -- a 17.6 percent increase over last year. In Japan, the number of McDonald's restaurants (1,048) has increased 8 percent since 1993.

IV. SHARED RESPONSIBILITY HAS A SMALL IMPACT ON BUSINESS

"In the past, we have taken similar actions to assure workers a minimum wage, to provide them with disability and retirement benefits and to set occupational health and safety standards. Now we should go one step further and guarantee that all workers will receive adequate health insurance protection." [President Richard M. Nixon, "Special Message to the Congress proposing National Health Strategy," 2/18/71]

"I can assure you that there's not going to be a single job lost if the insurance plan you are proposing goes into effect." [Eric Sklar, Owner, Burrito Brothers Restaurants]

- A system of employer-employee shared responsibility makes sense because it builds on the existing system. Nine out of ten Americans with private insurance get it through employers. [EBRI, 1/94] 85% of firms with more than 25 employees offer their workers health benefits. [HIAA, "Source Book of Health Insurance Data," 1992]

- A recent survey of over 1,000 major employers, including Fortune 100 and Fortune 500 companies, found that "*almost all provided medical coverage to full time salaried employees.*" [Daily Labor Report, 3/1/94]

- Many businesses that already provide coverage could see costs actually drop as the burden of cost-shifting is lifted. Small businesses -- who can currently pay as much as 35% more than large businesses for the same coverage for their employees -- would benefit most dramatically. [Hay Higgins Report]

- The President's original proposal capped contributions at 7.9% of payroll and, with discounts, many small businesses would have paid only 3.5%. Every congressional proposal pending contains even greater protection for our nation's smallest companies. All of the proposals would cost far less than the 90 cent per hour minimum wage increase signed into law by then-President George Bush.

- Recent studies of the minimum wage increase show negligible effects on employment. A study comparing fast food employment in New Jersey where the minimum wage increased, and Pennsylvania where wages stayed stagnant, found a greater employment increase in New Jersey. [Card and Krueger. Princeton University]

- Studies have estimated that reform with shared employer-employee responsibility will <u>create</u> jobs -- as many as 258,000 in the manufacturing sector, and as many as 750,000 in home health care. ["The Impact of the Clinton Health Care Plan on Jobs, Investments, Wages, Productivity and Exports," Economic Policy Institute November 1993; Reuters, from Brookings Institute study, 9/17/93]

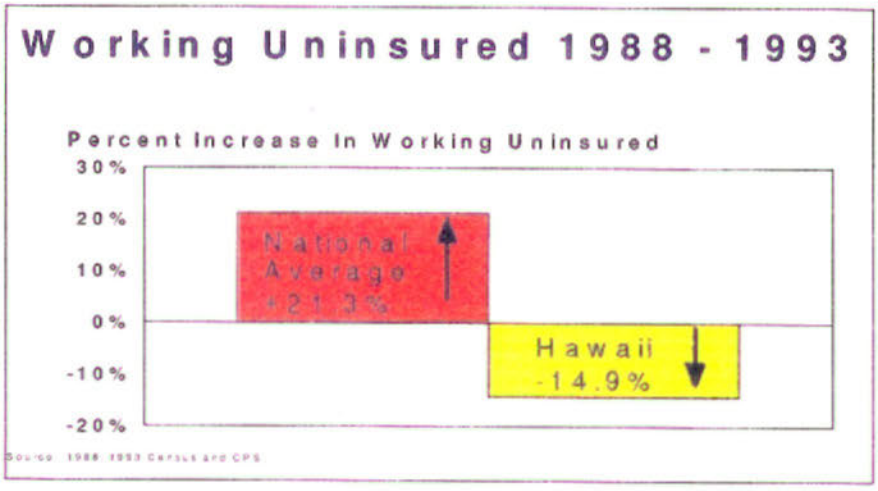
V. HAWAII: HEALTHIER BUSINESSES, HEALTHIER PEOPLE

"It is clear that the employer mandate, . . . has succeeded in bringing Hawaii to the threshold of universal health insurance coverage. That seems to have helped restrain health care inflation, a serious problem here but less critical than on the mainland: ***health insurance premiums are about 30 percent cheaper here****, while almost everything else in Hawaii is more expensive. "*
[*"Hawaii is a Health Care Lab as Employers Buy Insurance"*, New York Times, 5/6/94]

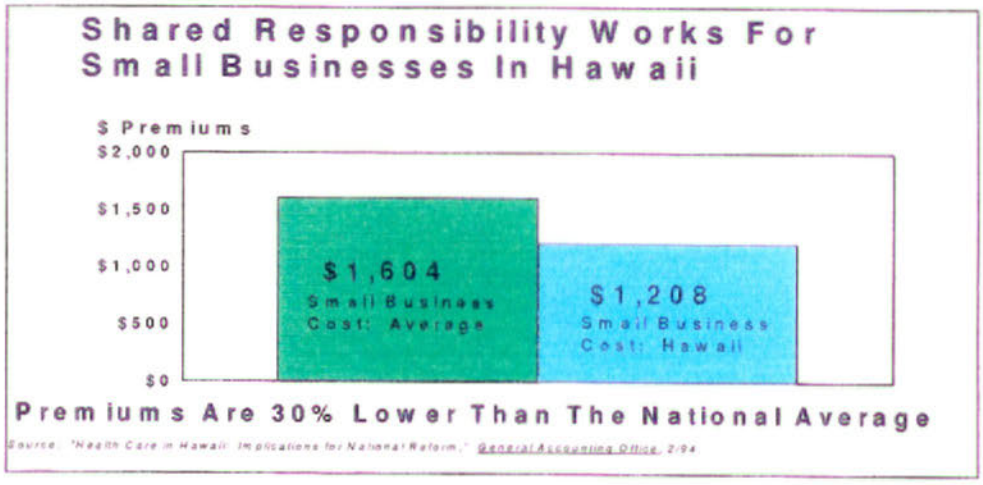
Shared responsibility is neither an untried novelty nor an exotic import unsuited to the American way of business.

Hawaii (1974), Oregon (1989) and Washington State (1993) are the only states with a current commitment to universal coverage. All have chosen employer-employee shared responsibility as the most practical way to achieve it.

- Since 1988, the number of working uninsured in America has increased by 21%. But during that same period Washington enjoyed a 19% decrease in its working uninsured, Hawaii saw a 15% drop in working uninsured, and Oregon saw a 2% decline. [CPS and Census data, 1988, 1993]



- Hawaii, the state that's had shared responsibility the longest, has 96% coverage. Employer-paid premiums are 30% lower than they are on the mainland. [GAO, 2/94; Hawaii Department of Health, 11/92].



- Since Hawaii began asking all employers to provide insurance in 1974: the unemployment rate has dropped to one of the lowest in the nation; small business creation has remained high; and the rate of business failures was less than half the national rate. [Hawaii Department of Labor and Industrial Relations; Dun and Bradstreet, *Monthly New Business Incorporation Rate*; Journal of the American Medical Association, 5/19/93]

"Universal access is in itself a cost-containment strategy. Because virtually all of Hawaii's people have access to primary care through the employer mandate and the state programs it has made possible, utilization of high-cost services is well below the rest of the nation. This leads to low health care costs, comparatively low small business insurance rates, and a lower portion of gross domestic product spent on health care when the state is compared to the rest of the nation." [*"Hawaii 's Employer Mandate and it's Contribution to Universal Access"* JAMA, 5/19/93]

8/5-94

Real Health Care Reform
LOUISIANA

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Why Louisiana Needs Universal Coverage:

Under the current system...

- **51,000** people in Louisiana lose their insurance each month. [Lewin-VHI estimates, 1993. Families USA, "How Americans Lose Their Health Insurance," April 1994.]

- **725 thousand** working families in Louisiana have no health insurance -- a **55.19% increase** since 1988. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94; 1988, 1993 CPS]

- Of the 932 thousand people without health coverage in Louisiana, 725 thousand are in working families -- that's **77.79%** of all the people without coverage in Louisiana. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]

- **208,353** children are without health coverage. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94. Calculated from March 1993 CPS and 1990 Census data]

- **17.0%** of family income is spent on health care each year -- an average of **$8,554** per family. [Lewin-VHI estimates. Families USA, "Skyrocketing Health Inflation," December 1993.]

- **23.2%** of the state budget is spent on Medicaid. [1992 State Expenditure Report -- National Association of State Budget Officers]

Why Louisiana Needs Universal Coverage:

With UNIVERSAL COVERAGE...

- **Every middle-class family** earning between $20-75,000 will save, on average, $621.53 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 730,398 families in Louisiana. [Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]

- **725 thousand** working families in Louisiana will no longer go without coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]

- **208,353** children will no longer go without coverage. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94. Calculated from March 1993 CPS and 1990 Census data]

- **1,410,157** people with pre-existing conditions will no longer be at the mercy of insurance companies. [United States Departmant of Health and Human Services estimate]

- **571,646** people will no longer have life-time limits on their coverage. [US DHHS estimate]

- As much as **$625 million** will be saved by doctors and hospitals when care is fully compensated. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94.]

- As many as **2,205,000** people will receive mental health benefits. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]

- As many as **29,308** two-year olds will have improved coverage for immunization. [US DHHS estimate]

- As many as **1,110,967** women will have improved coverage for mammograms. [US DHHS estimate]

- As many as **304,000** Medicare recipients gain prescription drug coverage. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]

- As many as **53,000** people will be able to get help with home and community based care. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]

Why Louisiana Needs Universal Coverage:

Louisiana can't afford *Non-Universal reform...*

- **31,000** people in Louisiana will continue to lose their insurance each month. [Lewin-VHI estimates. Families USA Special Report, "The Phony 91% Solution," 6/17/94.]

- Under non-universal reform, **every middle-class family** earning between $20-75,000 will be forced to pay, on average, $621.53 more each year on insurance premiums than they would under universal reform-- that's 730,398 families in Louisiana. [Lewin-VHI for the Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]

- **$2,496,455,196** in additional costs will be shifted to Louisiana's state budget under a Dole-style Medicaid cap by the year 2003. [American Federation of State, County and Municipal Employees and Citizen Action, "Squeezing the States," 7/15/94.]

Louisiana Wins With *Shared Responsibility...*

- Without shared responsibility that ensures universal coverage, **477,536 families** in Louisiana will have to pay as much as **$3,900** more each year if they want insurance. [1993 CPS; "Families and National Health Reform," Kaiser Commission on the Future of Medicaid, 5/94.]

- With shared responsibility, Louisiana businesses that now provide insurance will save as much as **$630 million** in premium costs for their employees each year -- an average of $448 per worker. [U.S. Department of Health and Human Services, "State-by-State Analyses: Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]

- Workers employed by firms that offer insurance will save as much as **$763 million** and earn **$504 million** in higher wages. [U.S. Department of Health and Human Services, "State-by-State Analysis Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]

- Louisiana will save as much as **$929 million**. [U.S. Department of Health and Human Services, "State-by-State Analysis Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]

State Data Profile

4,219,973	Total state population [1990 Census]
13.11%	Medicare recipients [U.S. Department of Health and Human Services, HCFA unpublished data]
16.64%	Medicaid recipients [HHS, HCFA]
265,770	Persons with disabilities [Area Resources File, 9/93. people betweent the ages of 16-64]
9,093	Doctors total [Area Resource File, 9/93.]
2	Doctors per 1000 people
15,209	Nurses [Area Resource File, 9/93]
240	Hospitals [American Hospital Association]
10	Community and Migrant Health Centers [HHS, Health Resources and Services Administration]
33.4%	Population underserved [HHS, Health Resources and Services Administration]
40	National Health Service Corps members [HHS, Health Resources and Services Administration]
10	National rank of infant mortality rate per 1000 births [Area Resources File, 9/93. Five year average infant mortality rate, 1984-1987.]

Louisiana Supports Health Reform

Please do not use the groups and individuals listed on the following pages before contacting the Health Care Delivery Room for additional information.

Groups For Health Reform Campaign for Women's Health

Louisiana Federation of Teachers

League of Women Voters

Health Care Campaign

AFL-CIO

LA Health Care Campaign

Citizen Action of Louisiana

AARP

NASW

League of Women Voters

LA Association of Educators

Louisiana Federation of Teachers

LA Retired Teachers Association

Campaign for Women's Health

Agenda for Children (CDF)

Businesses For Health Reform
Rhodes Enterprises

Medical Professionals For Health Reform
Dr. Charles White
- Professor and Chair of OB/BYN, Louisiana State Univerisity, New Orleans, LA

Dr. John Lewy
- Medical Director of Tulane Hospital for Children, Tulane University Hospital
- Chairman, Department of Pediatrics, Tulane Medical School.
- Pediatric Nephrologist

Community Leaders For Health Reform
J. William Hankins

H. Gerald Smith

Robert Davidge

Arnold Lupin

Steven Smith

Elliott Roberts, Sr.

William Mohon

Gary Crockett

Roy Bostick

Philip Rome

James Morgan

Lawrence Dorsey

William Bankston

Steve Worley

Senator Diane Bajoie

Byron Harrell

Robert C. Davidge

Dudley Romero

H.Gerald Smith

Rep. Bob Livingston

Why Rep. Bob Livingston's District Needs Universal Coverage:
R-Louisiana, New Orleans, LA01

Under the current system...

- **99 thousand** people in working families in Rep. Bob Livingston's district have no health coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- 80.49% of all people without health coverage in Rep. Bob Livingston's district are in working families. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- **27 thousand** children in Rep. Bob Livingston's district have no health coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]

With UNIVERSAL COVERAGE...

- **99 thousand** people in working families in Rep. Bob Livingston's district will no longer go without coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- **27 thousand** children will no longer go without coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- Every middle-class family earning between $20-75,000 will save, on average, $624.53 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 127,590 families in Rep. Bob Livingston's district. [Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]
- 40,950 women will have improved coverage for breast cancer screening. [US DHHS estimate]
- 3,718 two-year olds will have improved coverage for immunization. [US DHHS estimate]
- $92 million will be saved by doctors and hospitals when care is fully compensated. [US DHHS estimate]
- 178,358 people will no longer have lifetime limits on their coverage. [US DHHS estimate]
- 93,873 people will no longer have pre-existing condition exclusions on their insurance. [US DHHS estimate]

Rep. Bob Livingston's District can't afford *Non-Universal reform...*

- With non-universal reform, every middle-class family earning between $20-75,000 will be forced to pay, on average, $624.53 more each year on insurance premiums -- that's 127,590 families in Rep. Bob Livingston's District [Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]

District Data Profile

602,859	Total district population [1990 Census]
71,179	Americans over 65 [U.S. Department of Health and Human Services, HCFA unpublished data]
37,260	Persons with disabilities [Area Resources File, 9/93. people between the ages 16-64, 1990.]
1,500	Doctors total [Area Resource File, 9/93]
2	Doctors per 1000 people
2,505	Nurses [Area Resource File, 9/93. Registered nurses, licensed practical nurses in 1980.]
35	Hospitals [American Hospital Association]
124	Infant mortality rate per 1000 births [Area Resources File, 9/93. Five year average infant mortality rate, 1984-1987.]

Rep. Livingston' District Supports *Real* Health Reform

Please do not use the groups and individuals listed on the following pages before contacting the Health Care Delivery Room for additional information.

Community Leaders For Health Reform
Gary Crockett

Concerned Constituents For Health Reform
Poole, Sigrid
4349 Loveland St., Apt. A
Metairie LA
Sigrid Poole's husband was initially refused treatment for lung cancer because they were uninsured. He died five weeks after diagnosis, and she is having trouble dealing with the loss, especially because she feels that if they had insurance things might be different.

"How can this country have gotten so callous that a life means nothing, that a dollar means more to some medical personnel than a human, even if that life could only be extended by a few months or years."

America Under Non-Universal Reform
A District By District Analysis

Rep. Bob Livingston
R-Louisiana, District LA01

- **39,608 families earning between $20,000 - $29,000 will be forced to pay, on average, $240 more in premiums each year than they would under Universal Coverage.**

- **32,924 families earning between $30,000 - $39,000 will be forced to pay, on average, $509 more in premiums each year than they would under Universal Coverage.**

- **24,211 families earning between $40,000 - $49,000 will be forced to pay, on average, $284 more in premiums each year than they would under Universal Coverage.**

- **30,847 families earning between $50,000 - $74,999 will be forced to pay, on average, $190 more in premiums each year than they would under Universal Coverage.**

Source: Based on the Managed Competition Act. Catholic Health Association based on Lewin-VHI Study: "Coverage, Premium and Household Spending Implications of Health Reform," July 1994.