7/22/57

ED BOARDS

July 20, 1994

MEMORANDUM FOR HAROLD ICKES
THE HEALTH CARE DELIVERY ROOM

FROM: DANA HYDE
JASON GOLDBERG

SUBJECT: CABINET HEALTH CARE EDITORIAL BOARD INTERVIEWS

This week we began a strong push to have members of the Cabinet conduct editorial board interviews with newspapers in all of our key media markets. The following editorial boards have been completed:

7/14	Cisneros	TX	San Antonio Express
7/14	Brown,Ron	CA	LA Times
7/18	Brown,Ron	OR	Eugene Register
7/18	Altman	National	Business Week
7/18	Shalala	ND	Grand Forks Herald
7/18	Shalala	ND	Fargo Forum
7/18	Shalala	ND	Minot Daily News
7/19	Shalala	FL	Miami Herald
7/19	Broadnax	CO	Denver Post
7/20	Reich	OH	Columbus Dispatch
7/20	O'Leary	WV	Wheeling News
7/20	Cisneros	TX	Dallas Morning News
7/20	Babbitt	ID	Idaho Statesman
7/20	O'Leary	PA	Harrisburg Patriot
7/20	O'Leary	OH	Cinncinatti Post
7/20	Cisneros	PA	Pitts Post Gazette

The following editorial interviews have been confirmed for the week of 7/21-8/1:

7/21	Browner	FL	Palm Beach Post
7/21	Tyson	PA	Philly Daily News
7/21	Shalala	DC	Washington Time
7/21	Brown,Ron	MI	Saginaw News
7/21	Pena	CO	Boulder Daily Camera
7/21	Bowles	NC	Charlotte Observer
7/21	Bowles	VA	Newport News Press
7/21	Bowles	VA	Roanoke Times
7/21	Tyson	MI	Detroit Free Press
7/21	Babbitt	AZ	Arizona Republic
7/21	Reich	PA	Allentown Morning

7/22	Shalala	MD	Baltimore Sun
7/22	Pena	AZ	Arizona Daily Star
7/22	Babbitt	IL	Chicago Sun
7/22	O'Leary	IL	Chicago Tribune
7/25	Tyson	MI	Flint Journal
7/25	O'Leary	DE	New Castel Journal
7/25	Browner	FL	Tallahassee Democrat
7/25	Bowles	CT	New Haven Register
7/26	Bowles	IA	Des Moines Register
7/26	Cisneros	LA	The Times Picayune
7/26	Pena	MN	Minneapolis Star
7/26	Shalala	OH	Cleveland Plain
7/27	Tyson	FL	Florida - Times
7/28	O'Leary	CO	Rocky Mtn News
7/28	O'Leary	KY	Courier Journal
7/29	Bowles	NC	Raleigh News
7/29	Bowles	AL	Birmingham News
7/29	Pena	WI	Milwaukee Journal
8/01	Cisneros	FL	Orlando Sentinel
8/01	Babbitt	TX	Austin American

Thirty additional editorial board interviews are in the process of being confirmed. We will forward additional information to you as it becomes available.

THE WHITE HOUSE

WASHINGTON

July 22, 1994

MEMORANDUM FOR HAROLD ICKES
THE HEALTH CARE DELIVERY ROOM

FROM: DANA HYDE
JASON GOLDBERG

SUBJECT: **ADDENDUM**
CABINET HEALTH CARE EDITORIAL BOARD INTERVIEWS

In addition to Ed-boards mentioned in the July 20 memorandum, The following editorial board interviews have been scheduled:

07/22	Bowles	TX	El Paso Times
07/25	Reich	CA	Sacremento Bee
07/28	Rivlin	CO	Colorado Springs Gazette
07/28	Brown, Ron	WI	Wisconsin State Journal
07/28	Brown, Ron	MO	Springfield News Leader
07/28	Pena	AL	Montgomery Advertiser
07/29	Rivlin	CA	San Francisco Chronicle
07/29	Pena	SC	Greenville News
08/01	Cisneros	NV	Las Vegas Review-Journal
08/01	Browner	NH	Manchester Journal-Inquirer
08/01	Browner	FL	Daytona Beach News Journal
08/01	Browner	FL	Sarasota Herald-Tribune

Secretary Espy has committed to completing the following interviews this week (dates TBD):

TN	Memphis Commercial Appeal
TN	The Tennesean (Nashville)
TN	Knoxville News-Sentinel
AL	Huntsville Times

Deputy Secretary Roger Altman has committed to completing the following interviews this week (dates TBD):

NJ	Asbury Park
NJ	The Bergen Record

We will continue to pursue other possibilities.

THE WHITE HOUSE

WASHINGTON

July 22, 1994

MEMORANDUM FOR THE DAYTONA BEACH NEWS JOURNAL

FROM: HAROLD ICKES
White House Deputy Chief Of Staff

SUBJECT: THE CASE FOR UNIVERSAL COVERAGE

The attached document outlines why Universal Coverage is imperative for *real* health care reform.

Environmental Protection Agency Administrator Carol Browner will reference this document in her editorial board interview with you on Monday, August 1 at 3:30 (eastern time).

Opponents of real reform would have us believe that our goals can be met by incremental, piecemeal reform. That approach won't work, and will leave millions of hard working Americans at risk.

The coming weeks will be marked by House and Senate consideration of health care reform legislation. The Administration's position is clear: universal coverage is imperative if we are to deliver on our promise to guarantee true health security to every American.

The Case Against Non-Universal Reforms

- **Message Overview** 1
- **What They Claim, What They Deliver** 2
- **Why Non-Universal Reforms Hurt The Middle Class** 3-4
- **State Experience Shows It's Not Enough** 5-7
- **Hidden Tax On The Middle Class And On Business** 8-9
- **Fails Every Key Test** 10

INTRODUCTION

Making History. We are on the verge of an historic step forward for the American people. Since Franklin Roosevelt, Presidents have been trying to pass health care reform. Three years ago the issue was not on the political radar screen. All that has changed. Amidst polls showing overwhelming popular support for reform, committees in both houses of Congress have approved bills that guarantee health coverage to every American family.

Improvements in the Proposal. The legislative process has transformed our original proposal. We have listened to the ideas and apprehensions of the American people. With Congressional help, many important improvements have been incorporated into the bills now under consideration. While different committees have taken varying approaches, these bills contain a number of features that will ultimately be included in a better and more effective reform plan. Among the improvements under consideration are: cutbacks in bureaucracy and regulation; the transformation of mandatory alliances into smaller voluntary purchasing cooperatives; greater protection for small businesses; and greater choice for consumers and businesses. A stronger fail-safe budget protection device is under consideration, to ensure that the program does indeed pay for itself.

Congressional Challenge Ahead. We have made dramatic progress in our effort to guarantee lifetime health security for every American. But there remains one major stumbling block to overcome. Opponents of true reform would have us believe that our goals can be met by incremental, piecemeal reform. Having bought the land, surveyed the site, and designed the structure, they would have us build the bridge only half way across the river. That approach won't work, and will leave millions at risk.

The coming weeks will be marked by House and Senate consideration of their respective reforms. As the nation watches, they will choose either true reform -- true security for every single American -- or an unfortunate, piecemeal reform that may actually leave working families worse off.

The Administration's position is clear: universal coverage is imperative if we are to deliver on our promise to guarantee true health security to every American.

Today, we want to talk to you about why non-universal reforms just don't work.

NON-UNIVERSAL REFORMS:
What They Claim, What They Deliver

There are several non-universal reform alternatives floating around Washington. They claim to be less filling than universal coverage but taste just as great. These alternatives fall short of what they promise.

DOLE PLAN

CLAIMS: The Dole plan claims that insurance market reforms alone will enable more people to get coverage and that -- according to GOP strategist Bill Kristol -- it will "bring more people into the system and provide more security and flexibility for those already in it."

DELIVERS: The Boston Globe said that "a number of health policy analysts from all parts of the ideological spectrum" have reached a "remarkably congruent verdict: It's not likely to do much to expand access to health insurance. And it might make things worse for many who are now insured." *[Boston Globe ~ 3 94]*

A conservative health economist, Mark Pauley at the University of Pennsylvania, predicts that such measures would "probably do almost nothing, or maybe even make things worse" for the millions of people who aren't poor enough to get subsidies. *[Boston Globe ~ 3 94]*

NON-UNIVERSAL REFORM:
Hurts The Middle Class

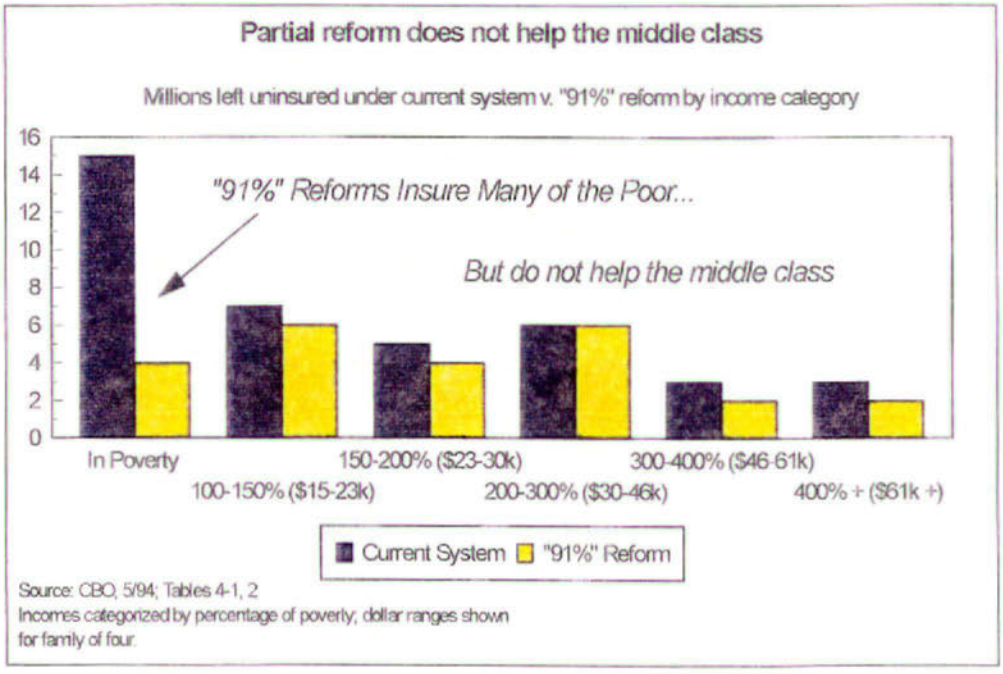
"I'll tell you why I'm fighting so hard for real health care reform...People like Jim Bryant, who told the Boston Globe he works 70 hours a week but has no health insurance for his family. He wonders if it's fair that he misses his sons' soccer games to go to his Saturday job while people who depend on welfare have health benefits. In a moment of frustration, he even suggested to his wife that they might be better off if they broke up, so that she and their sons could get the benefits that working families like theirs can't afford." -- PRESIDENT BILL CLINTON

"I guess I'm a little bitter. It is harder for working people to make ends meet, pay for their own medical, get jobs." -- JIM BRYANT, SOMERVILLE, MASSACHUSETTS.

1) Non-universal reforms cover the poor, but not the middle class.

Half-measures and quick fixes would leave every American at risk of losing their insurance. And at least 24 million Americans, most of whom work for a living, would have no coverage at all. *[CBO analysis, 5/94, p. 20]*

The Congressional Budget Office also says that under a 91% proposal, "health insurance coverage would probably be more limited for middle-income people than the rich or poor." *[CBO analysis, 5/94, p. 17]*



A 91% solution would help 11 of the 15 million uninsured Americans in poverty get health coverage, but would leave 16 of the 18 million middle-class Americans without insurance.

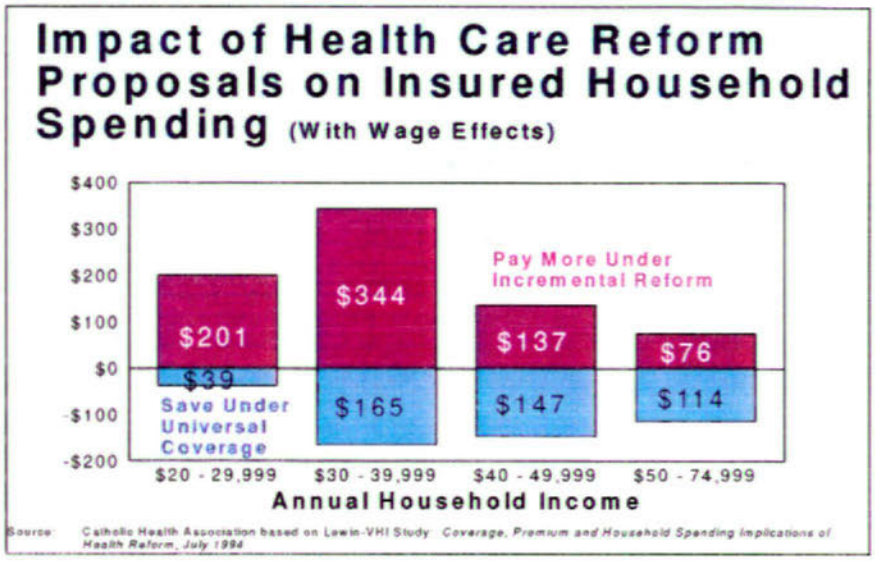
According to a new study by Families USA, over one million Americans a month will lose their insurance under a partial solution . *[Families USA Special Report, 6/94, p.1]* We need universal coverage because all families -- including the middle-class -- must be protected.

While the U.S. population as a whole grew by only 1.3 million between 1988 and 1993, the number of uninsured Americans grew by 6.4 million people. Of the newly uninsured, nearly 4.8 million of them -- more than 75% -- work. *[1988 and 1993 March CPS, Bureau of the Census]*

2) Non-universal reforms increase insurance premiums.

"[W]e estimate that middle income families that currently have insurance will pay more in general for health care under partial reform than under reform that includes universal coverage." *[Lewin-VHI, July 18, 1994]*

"With a portion of the population uninsured, per capita insurance costs for the insured population would be higher, compared to universal coverage." *[CBO, April 1994, p. 9]*



And The Wall Street Journal says: "The result...is the start of an upward spiral in rates" for those who still have insurance.

3) Non-universal reforms tell working Americans that their health is less important than the health of Members of Congress, federal employees, welfare families, and jailed felons.

Think of the message that non-universal reform would send to literally millions and millions of working Americans: If you are very poor, we'll guarantee your health care. If you get elected to Congress, we'll guarantee your health care. If you are employed by the federal government, we'll guarantee your health care. If you get thrown in jail, we'll guarantee your health care. If you are rich, you can guarantee your own health care. But, if you get up every day and work for a living, your health coverage is always at risk.



NON-UNIVERSAL REFORMS:
State Experience Shows It's Not Enough

"At least 37 states have enacted insurance reforms essentially identical to the [non-universal] reforms proposed in Congress. I think any insurance commissioner would say these reforms are a necessary but not sufficient way to decrease the number of uninsured. To say they're going to improve access is a bit misguided." -- PATRICIA BUTLER, HEALTH CARE CONSULTANT, BOSTON GLOBE 7/3/94

Many federal health reform proposals, such as the Dole plan, reject the goal of universal coverage and focus instead on expanding "access" through a patchwork of incremental reforms including small group market reforms, insurance reforms, low-income subsidies, community rating, medical savings accounts, voluntary alliances, tax credits and malpractice reforms. All told, more than 45 states have passed many of the reforms proposed in the Cooper and Dole bills.

However, state-level experience with non-universal reforms, implemented in recent years, has demonstrated no appreciable effect on total coverage levels or costs. Since the late 1980s, state-level health care reform activity has significantly increased, with more than 32 states passing incremental health reform measures between 1989 and 1992, and more than a dozen more acting in 1993 and 1994. *[Intergovernmental Health Policy Project, George Washington University]*

- The recent experience of one state, where community rating was implemented without universal coverage, bears out the unfortunate forecasts. A Wall Street Journal analysis noted that almost one year after this state had *"adopted stiff insurance reforms, fewer people have health coverage than under the old system."* [Wall Street Journal, 5/27/94] The reason: young people dropped coverage as rates went up, causing rates to rise further: between 20-35% for some insurers.

- In Hawaii, however, where reforms include universal employer/employee contributions, coverage approaches universal and, *"health insurance premiums are about 30 percent cheaper, while almost everything else in Hawaii is more expensive than on the mainland."* [New York Times, 5/6/94;]

Nor has the promise of better rates or cheaper benefits brought non-insuring small businesses into the system.

- Beginning in 1986, 11 states and non-profit groups began a demonstration program specifically aimed at increasing coverage by making health insurance more affordable and available to uninsured small businesses and individuals. Of the 11 demonstration projects, all used voluntary measures: 10 developed new, less expensive insurance products or subsidized existing insurance products, and one developed a health insurance information and referral service.

These demonstrations reached relatively few of the small businesses and individuals previously uninsured, leading the study to conclude that *"there is little evidence that voluntary efforts alone will close the gap on the uninsured problem."* *[testimony of W. David Helms, Ph.D., before the U.S. Senate Committee on Finance]*

States Have Already Tried Non-Universal Reforms

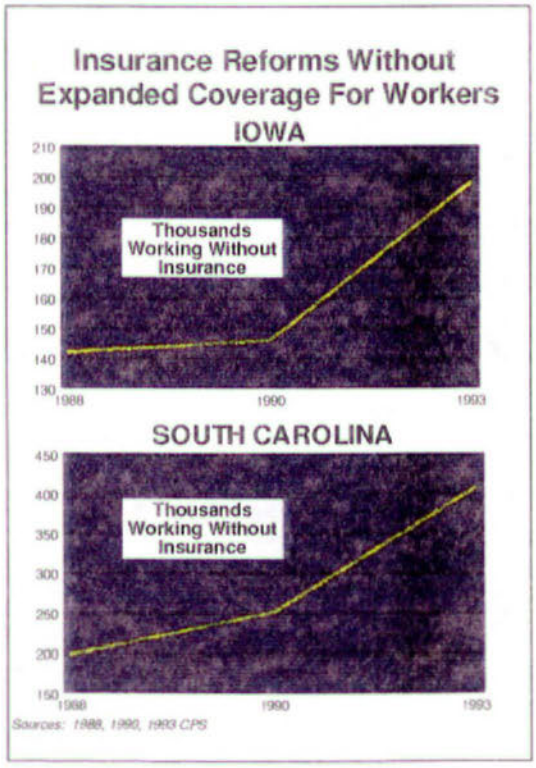
Reform Measure	Number of States
Guarantee Issue	35
Guarantee Renewal	42
Portability	37
Community Rating	19
Rating Bands	34
Voluntary Alliances	20
Tax Incentives	13
Medical Savings Accounts	7
Low-Income Subsidies/Medicaid Expansions	46

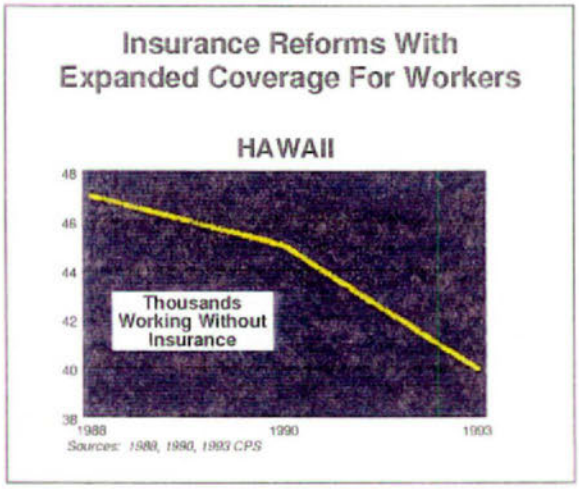
Source: Intergovernmental Health Policy Project, George Washington University, June 1994

The results of these reforms are illuminating: tens of thousands more working people left uninsured, and massive increases in insurance costs. Even in the states that successfully increased the total number of individuals covered from 1988 to 1993, half had a decrease in coverage among working people *[March CPS, 1988 and 1993, Bureau of the Census]*.

A brief examination of representative states gives a taste of the differing outcomes that follow universal and non-universal reforms. Iowa's reforms resemble those suggested by the Dole plan. South Carolina's resemble the Cooper/Finance Committee plans. Hawaii is the state that has come closest to providing universal care.

1) Non-universal reforms leave more working people uncovered.





2) Non-universal reforms have hurt state budgets -- and raised working people's taxes.

Iowa and South Carolina -- states that most closely resemble the Dole and Cooper/Senate Finance plans -- enacted insurance market reforms with subsidies for poor people. Since reform, state spending on health care has continued to increase, forcing state officials to reduce funding for education and crime prevention. In these states, income taxes on working people continue to rise, even as more working people go without insurance. The message is clear: non-universal reform means that working people pay more for insurance and in taxes for the poor -- even as they lose health coverage themselves. [Sources: 1988, 1993 CPS. *State Government Finances* 1988, 1992. U. S. Bureau of Census, *State Government Tax Collection*, 1988, 1992]

NON-UNIVERSAL REFORM IS A HIDDEN TAX ON THE MIDDLE CLASS AND ON BUSINESS

"[S]o long as millions of Americans remain underinsured and uninsured, cost shifting will continue, leaving a mechanism for unwarranted price inflation in health care." -- MINNEAPOLIS STAR TRIBUNE, 6/16/94.

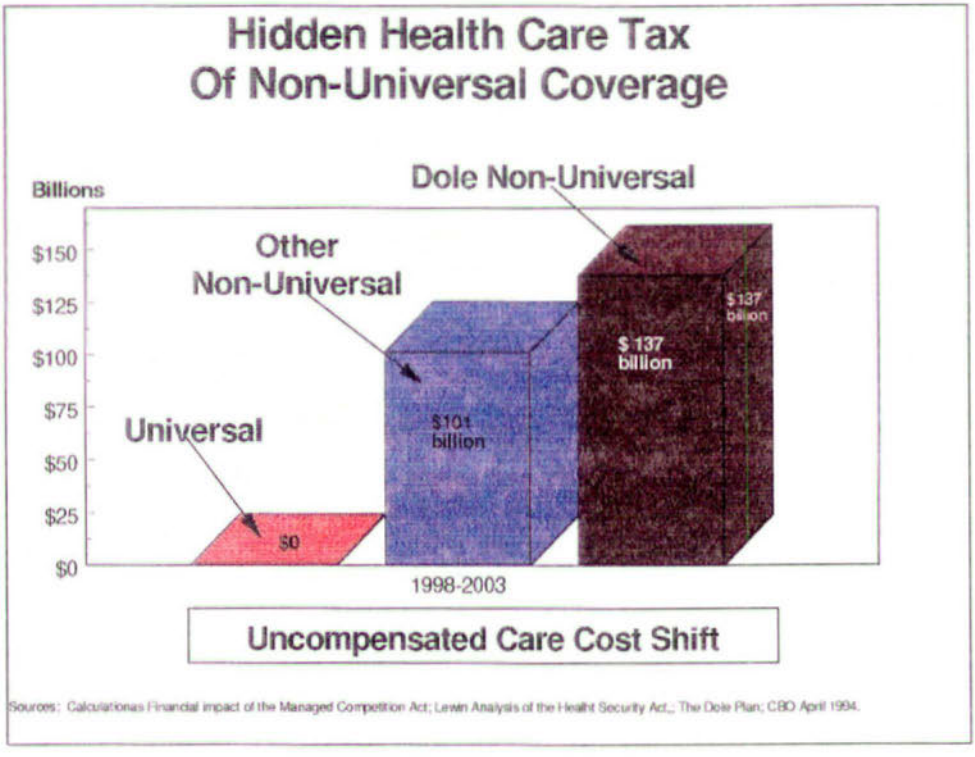
1) Non-universal reform leaves a hidden tax on working families.

People without health care coverage still get health care. But many of them don't pay for it. Their costs are shifted onto everyone who does pay an insurance premium. And their costs are higher because the uninsured often seek treatment after a problem has become a crisis, in a hospital emergency room.

A recent Department of Health and Human Services Study found that of the 90 million emergency room visits in 1992, fifty million were for ailments that could have been treated in a doctor's office -- at one-third the cost. [Source: National Hospital Ambulatory Care Survey; 1992 Emergency Department Summary; HHS, National Center for Health Statistics]

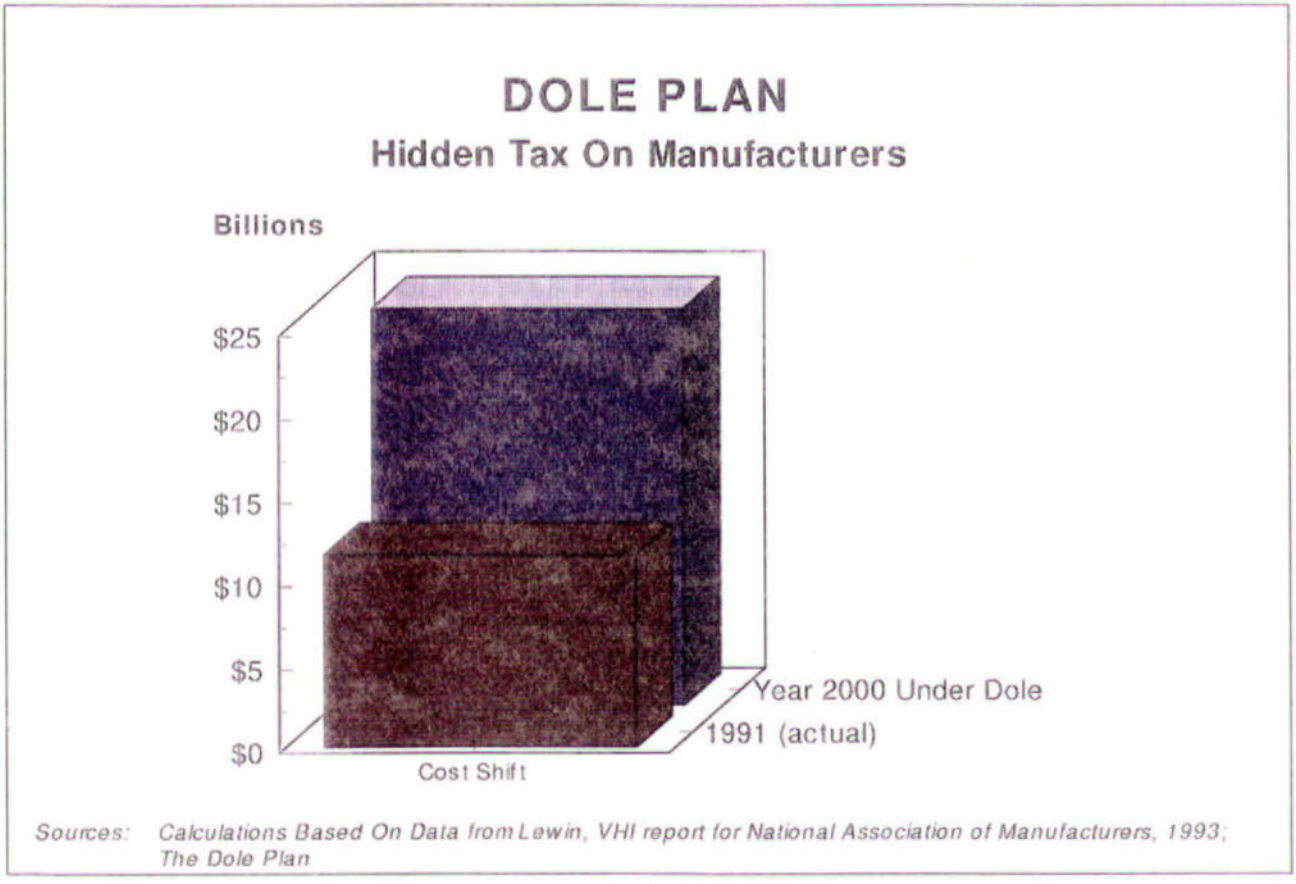
The methodology used by the Congressional Budget Office to analyze a similar plan indicates that the Dole plan would cover only 1 in 5 uninsured.

With 80% still uninsured, uncompensated care will remain at $18 billion in 1998 alone. So the Dole plan leaves $18 billion to be paid by working people who do have insurance.



2) Incremental reform is a hidden tax on businesses that provide coverage.

Another way to think of this Dole cost-shift is as a tax on businesses who provide coverage. Since most Americans get their insurance through work, businesses are forced to cut dividends, divert money from needed R&D, and cut back on hiring.



Sources: Calculations Based On Data from Lewin, VHI report for National Association of Manufacturers, 1993; The Dole Plan

The middle class gets squeezed coming and going -- either paying higher premiums themselves, or seeing jobs lost as employers cut back to cover costs shifted onto them by businesses that don't insure their employees.

INCREMENTAL REFORM FAILS OTHER KEY TESTS

1) Half-measures perpetuate "job-lock" by failing to ensure portability.

"I have great trouble seeing how you get portability without universal coverage." --U.S. SENATOR JOHN CHAFEE

- If you move to a new job and your new employer doesn't contribute, all incremental reforms give you is the right to assume the full burden by yourself -- whether or not your family can afford it. Incremental reform means millions could still lose coverage when they change jobs, be dropped if they can't afford their premium, or forced to wait six months for new coverage. That's not portability.

- Until we have *true* portability, we will never eliminate "job lock". Surveys suggest that as many as one in three working Americans are trapped in their current jobs because they fear losing the health insurance their families depend on. The CBO concluded that incremental reforms can *"reduce"* -- but not solve -- this problem. [*"Health Benefits Found to Deter Switches in Jobs."* The New York Times, 9/26/91; CBO, 4/94, p. 28]

2) Non-universal reform cannot eliminate pre-existing condition exclusions.

"It will be nearly impossible without universal coverage . . . to outlaw the common industry practice of refusing to cover people with known medical problems, so called pre-existing conditions."
-- THE WALL STREET JOURNAL 6/15/94

- Without universal coverage, pre-existing exclusions would mean many healthy people would choose to "ride free" and go without insurance, knowing they could buy it when they get sick. This would drive up costs for all the people in the system. (Wall Street Journal, 6/15/94)

3) Incremental reforms perpetuate welfare lock and discourage work.

"At least one million adults and children are on welfare because it's the only way their families can get health care coverage" -- MOFFIT AND WOLFE, 1/90. "[an incremental approach] *would produce devastating disincentives to work . . . the creation of a near poverty trap . . . would result."* -- AARON IN NEW YORK TIMES, 2/13/94

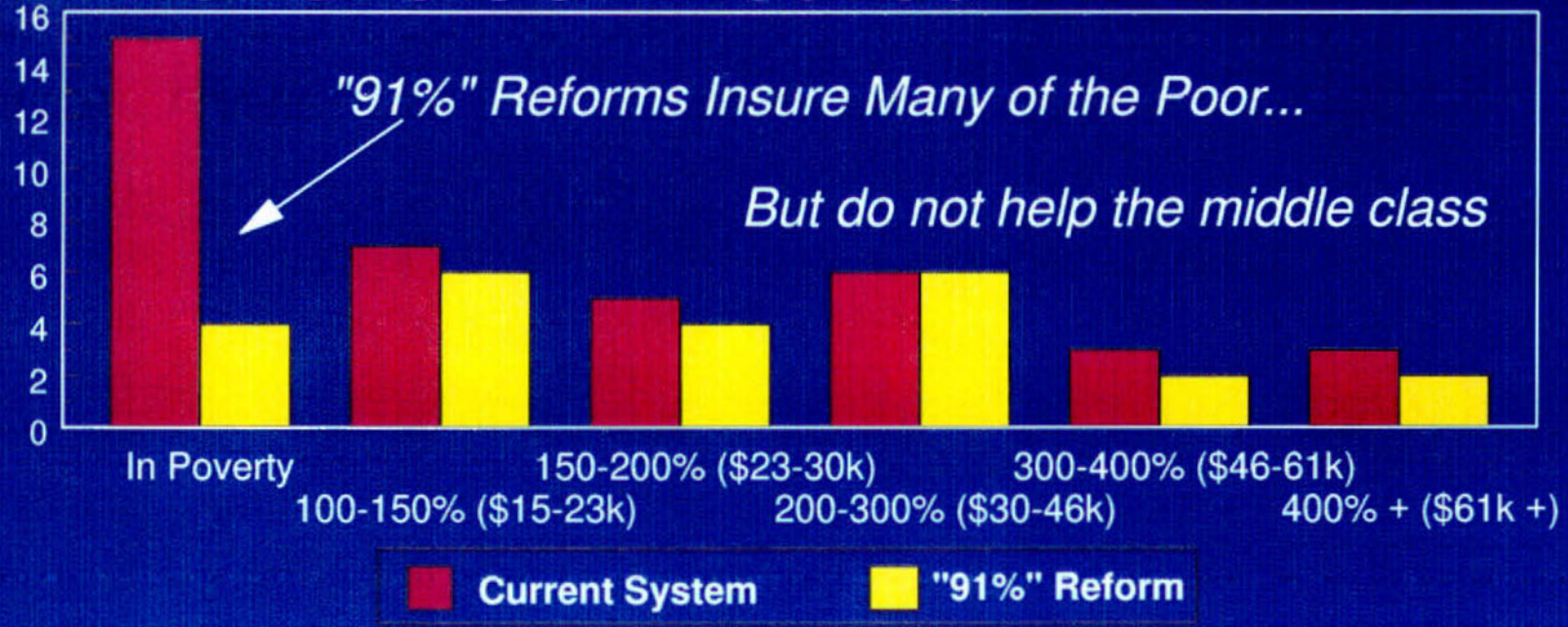
- Even if the Dole proposal were fully funded -- which it is not -- it would only subsidize a portion of the premium for those families and individuals well below the poverty line. Welfare mothers going back to work would not only pay their own premiums, their taxes would pay for health care for those still on welfare. One expert says that the Dole plan would "make working irrational." On the other hand, an analysis of the effects of a universal proposal estimates that at least 840,000 people -- 15% of welfare rolls -- will seek jobs if the President's reform passes. *[Wolfe, University of Wisconsin, L.A. Times, 11/18/93; Boston Globe, 7/3/94]*

Introduction

- Making History
- Improvements in the Proposal:
  - No More Mandatory Alliances
  - Choice: You Can Keep What You Have
  - Extra Protection for Small business
- Congressional Challenge Ahead:
  - Universal Coverage?

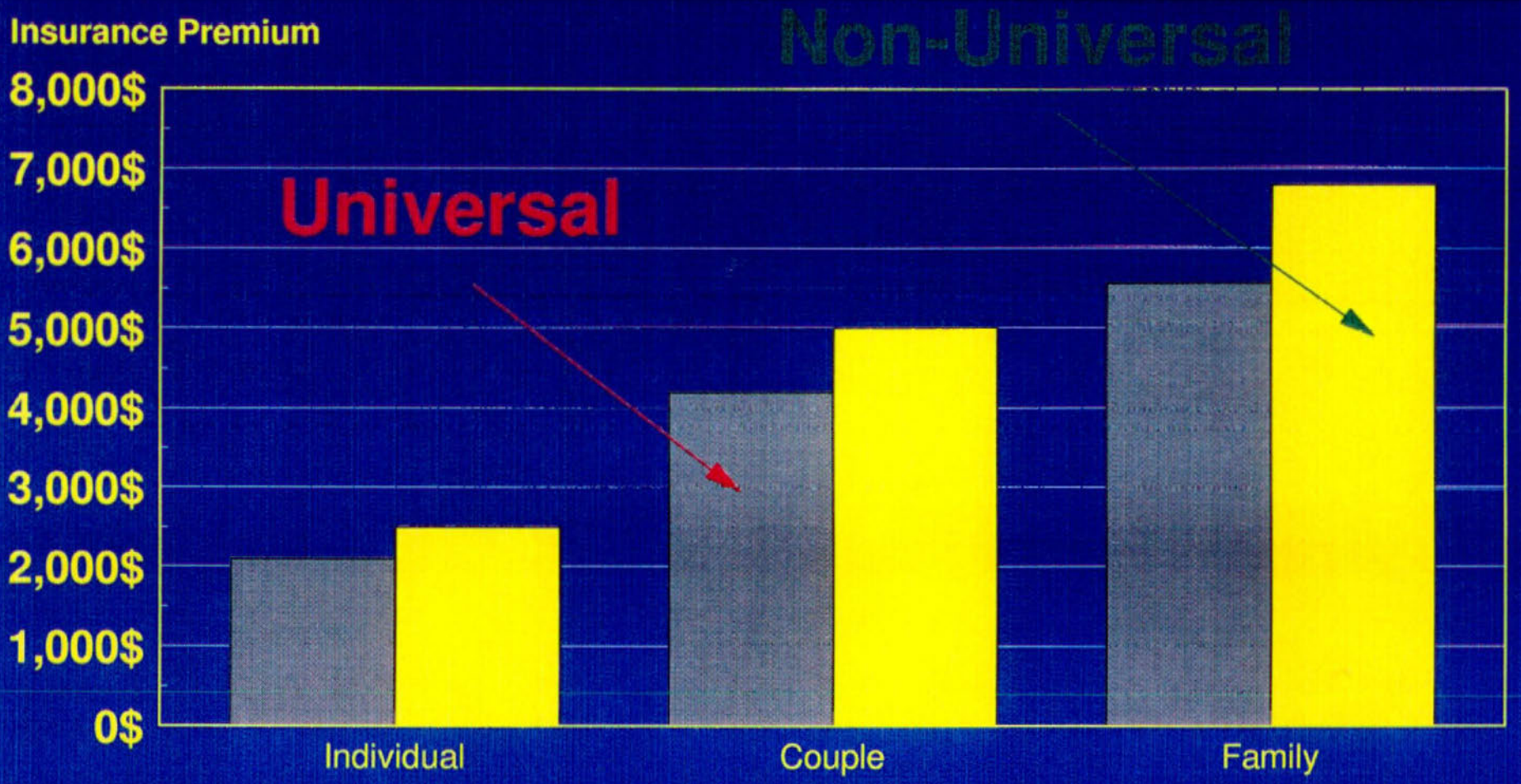
Partial Reform Does Not Help The Middle Class

Millions left uninsured



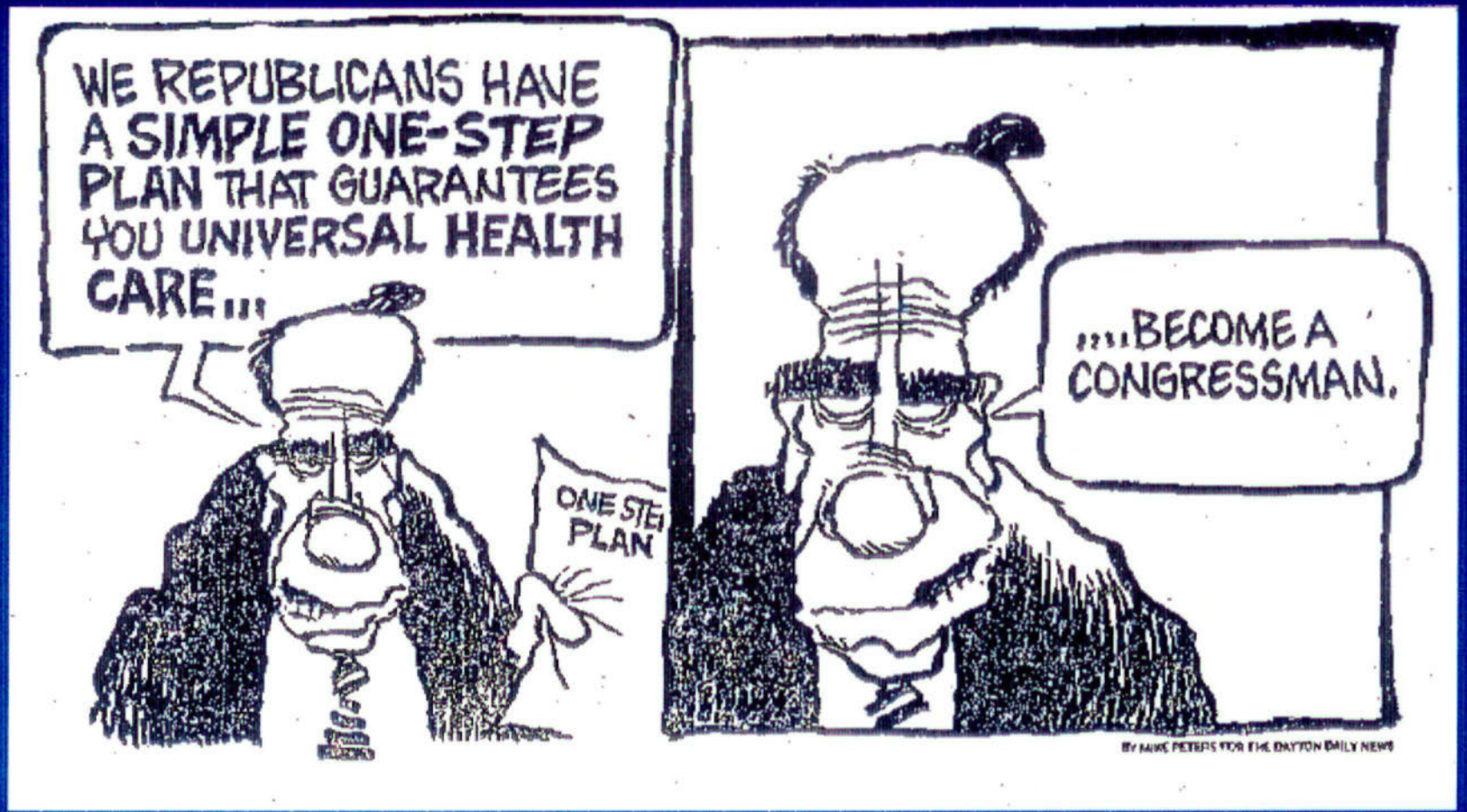
Source: CBO, 5/94; Tables 4-1, 2
Incomes categorized by percentage of poverty; dollar ranges shown for family of four.

Without Universal Coverage Everybody Pays More



- **The Insured pay more to offset the costs of the Uninsured**

Source: CBO, February 1994;, April 1994



- **Non-Universal Reforms Leave Four Ways to Get Guaranteed Health Care:**
  - Become a Member of Congress
  - Go to Work for the Government
  - Go on Welfare
  - Go to Jail

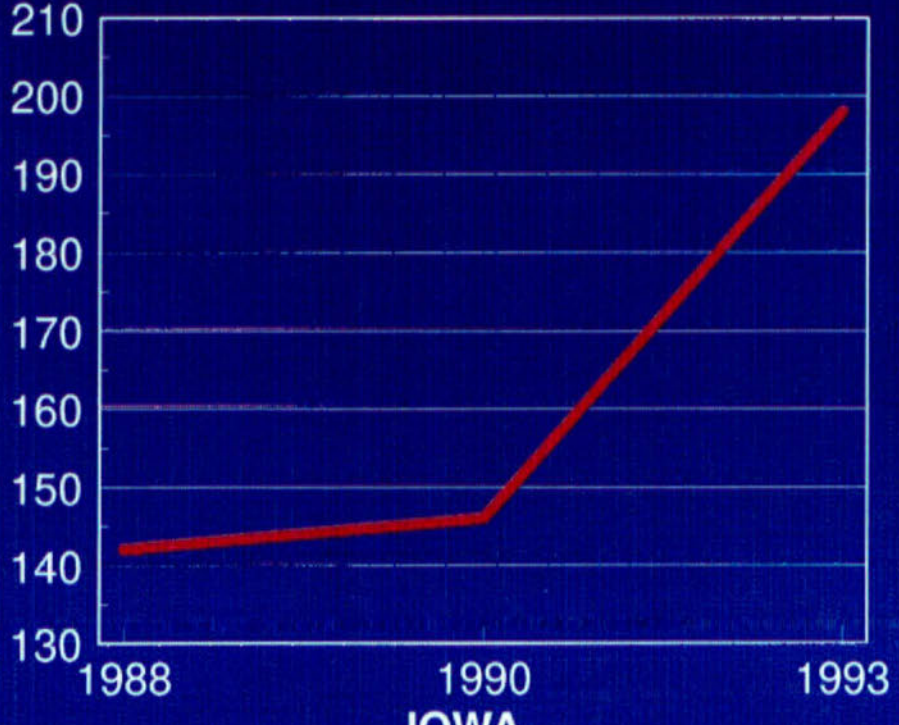
States Have Already Tried Non-Universal Reforms

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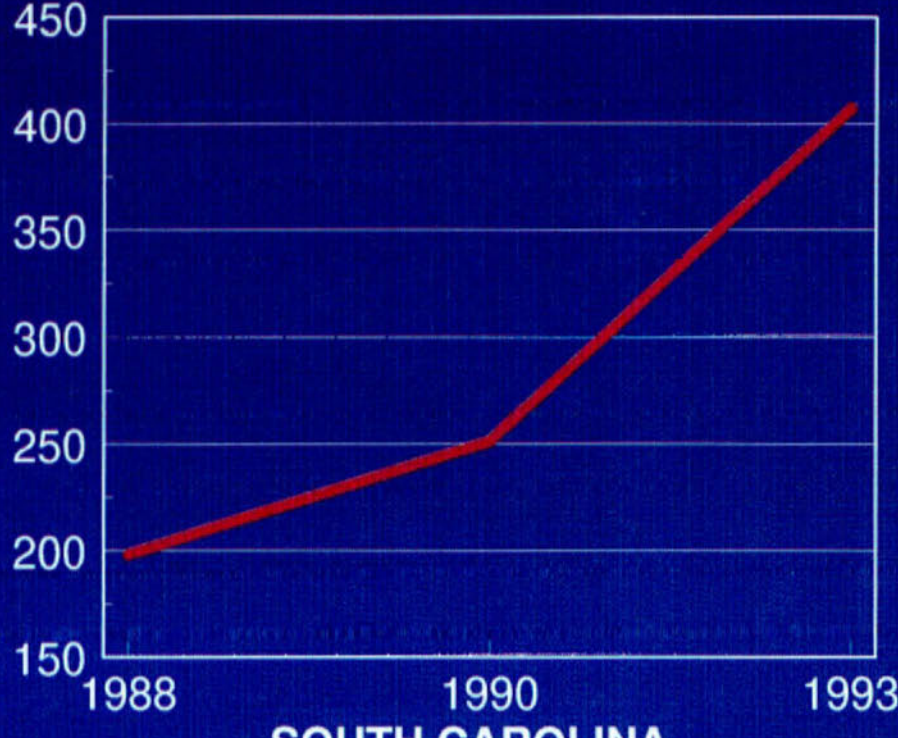
Source: Intergovernmental Health Policy Project, George Washingotn University, June 1994

Insurance Reforms Without Expanded Coverage For Workers

Thousands Working Without Insurance



IOWA
Dole Style Reform

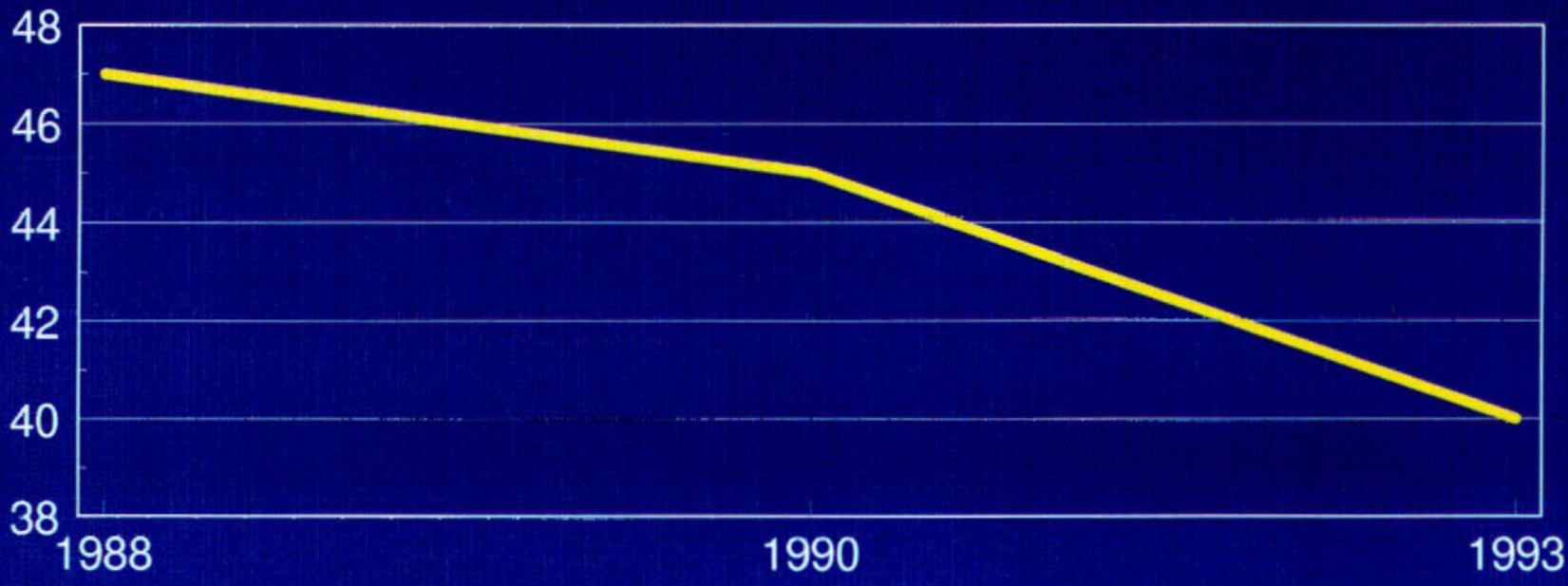


SOUTH CAROLINA
Cooper Style Reform

Sources: 1988, 1990, 1993 CPS

Insurance Reforms With Expanded Coverage For Workers

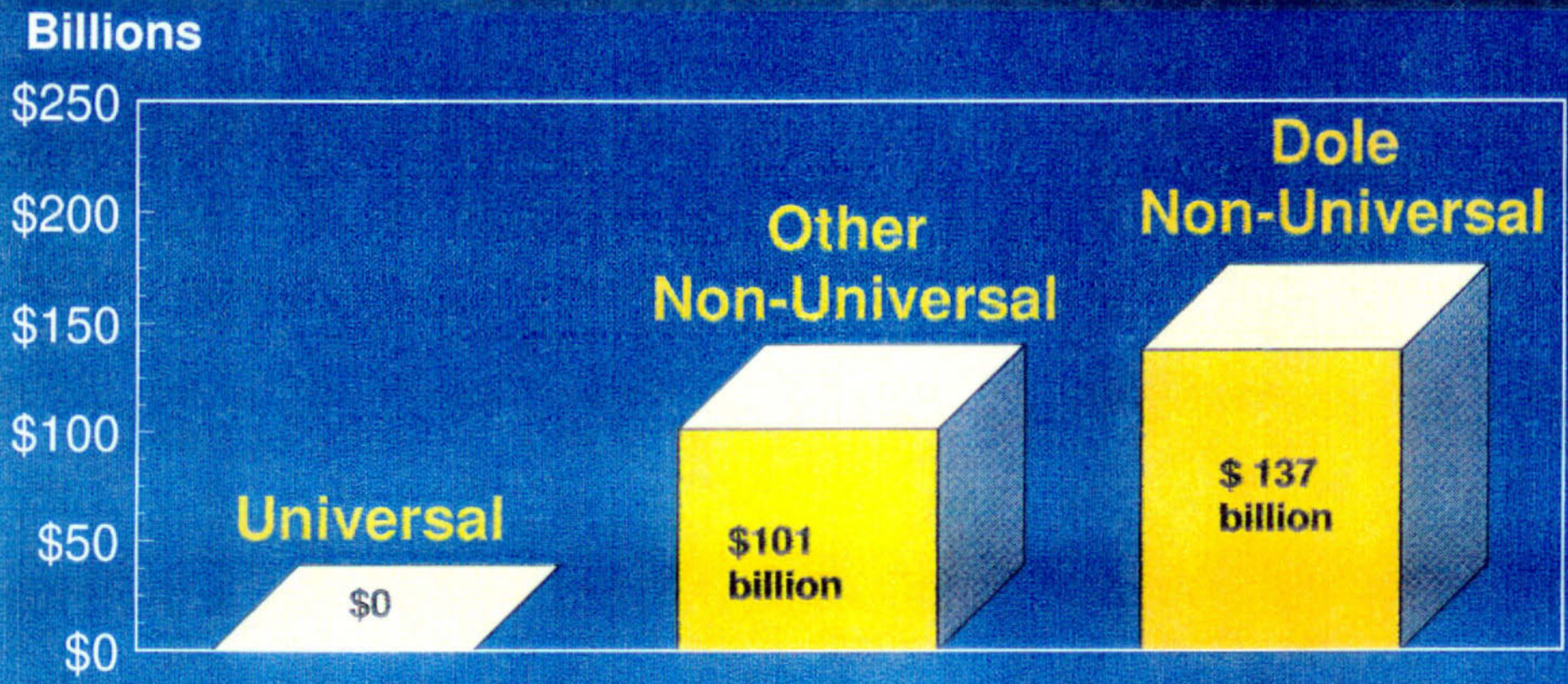
Thousands Working Without Insurance



HAWAII

Near Universal Coverage

Hidden Health Care Tax Of Non-Universal Coverage

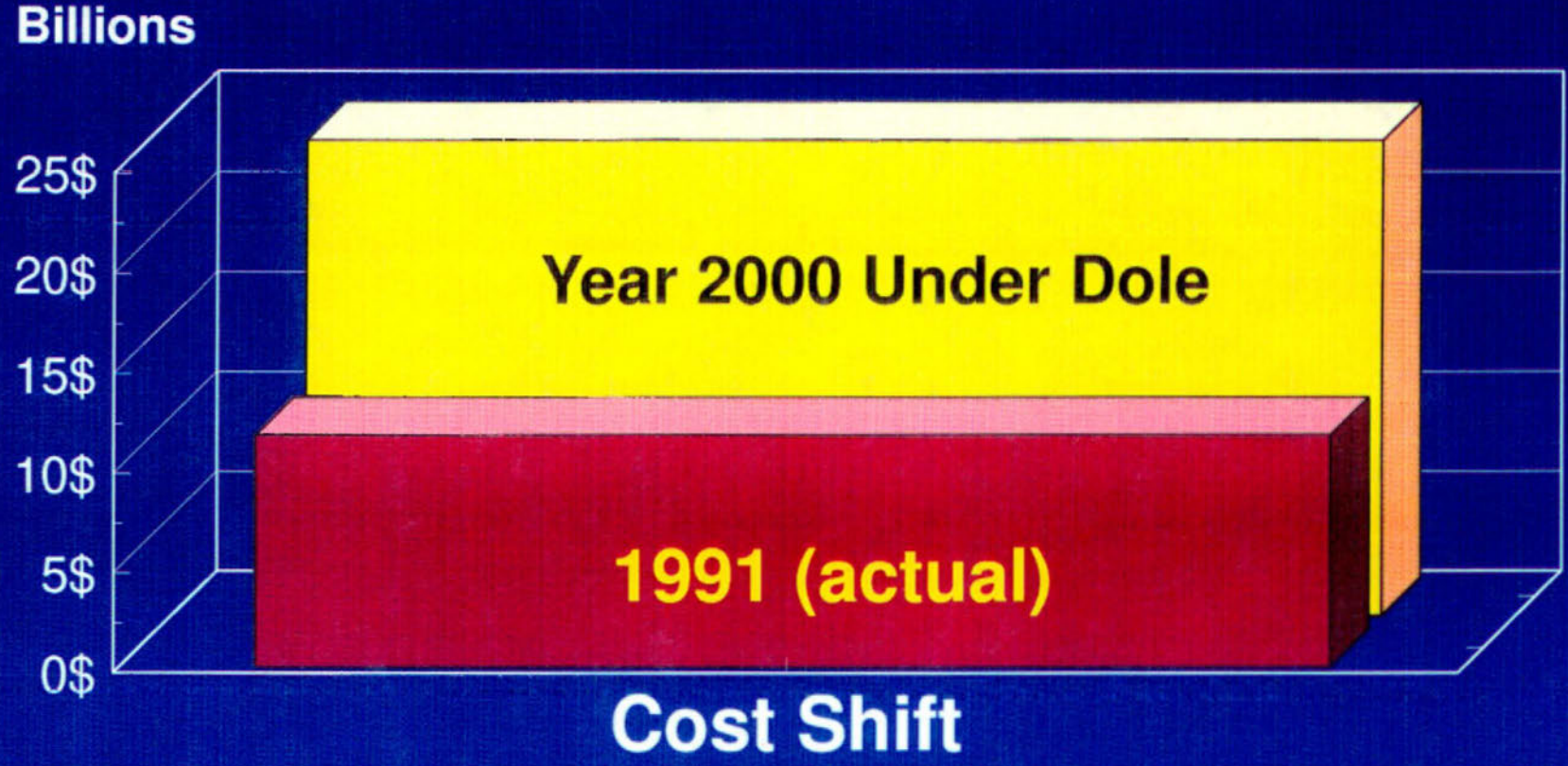


1998-2003 Uncompensated Care Cost Shift

Sources: Calculations based on "Financial impact of the Managed Competition Act";" Lewin Analysis of the Health Security Act,; The Dole Plan; CBO April 1994.

DOLE PLAN

Hidden Tax On Manufacturers



Sources: Calculations Based On Data from Lewin, VHI report for National Association of Manufacturers, 1993; The Dole Plan

Non-Universal Reforms Fail Other Key Tests

- **Portability:**

"I have great trouble seeing how you get portability without universal coverage." *- Sen. John Chafee (R-RI)*

- **Eliminating Pre-existing Condition Exclusions:**

"[I]t will be nearly impossible without universal coverage."
- The Wall Street Journal

- **Incentives to Work:**

The Cooper plan would create "devastating disincentives to work," resulting in a "near poverty trap."
-Henry Aaron, Brookings Institution

The Dole plan would "make working irrational."
- David Super, Center on Budget and Policy Priorities

THE WHITE HOUSE

WASHINGTON

Memorandum

From: Health Care Delivery Room

The attached news clips demonstrate why Universal Coverage is imperative in real health care reform. Opponents of real reform would have us believe that our goals can be met by incremental, piecemeal reform. That approach won't work, and will leave millions of hard working Americans at risk.

Included in this packet:

o Community-Rated Health Plans Prove Popular, But Success May Depend on Universal Coverage
o Health Bill Seen Falling Short of 95% Coverage
o Let the Employer Provide
o New York Finds Fewer People Have Health Insurance a Year After Reform
o With Dole's Mainstream GOP Proposal, the Debate is Joined.
o An Unpleasant Choice if Employers Won't Pay for Health Care
o Peril Seen in Reform Limited to Insurance

Community-Rated Health Plans Prove Popular, But Success May Depend on Universal Coverage

THE WALL STREET JOURNAL WEDNESDAY, JUNE 15, 1994

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — It's the health-care proposal everyone loves: the notion that insurance companies shouldn't be allowed to jack up rates for sick people or others at risk of piling up big medical bills.

So attractive is the concept, known as "community rating," that even many Republicans and conservative Democrats say Congress should go ahead and enact it, along with a set of other insurance-market revisions, and forget about universal health coverage for now. A new GOP television advertising campaign pushes for bipartisan insurance-market reforms to "fix health care."

There's just one problem with the idea, experts insist and real-life evidence shows. It probably won't work without universal coverage. Indeed, several of the insurance changes that reformers are clamoring for may depend for their success on bringing nearly everybody into the insurance pool.

For the past year New York state has tried community rating without a law requiring everyone to have health insurance. The result has been a rise in insurance premiums for younger, healthier people and a drop in rates for older, sicker individuals. Consequently, young people have bailed out of the system, figuring they either won't need coverage or they'll be able to get it at a reasonable price when they do.

Older, Sicker People

Now, insurers are raising prices again in order to cover the medical needs of those older, sicker people left in the pool. State insurance department figures show that as of Jan. 1, nine months after the new law took effect, 25,477 fewer people had health insurance individually or in small-employer groups. That's a 1.2% decline.

The only way to avoid this chain reaction, many experts say, is to set up a system where people can't drop out. Uwe Reinhardt, a Princeton University health economist, says that when he heard Republican calls to enact insurance market reforms alone ... way to vastly improve the current system he reacted with "total disbelief." Community rating without universal coverage "will trigger the worst kind of behavior among insurers and patients," he says.

"If you can go in and out of a system at will, then the only people who will buy insurance are those who need it," says Barbara Ragle, legal counsel at Central Reserve Life Insurance Co.

Nor is community rating the only popular insurance reform that would be nearly impossible without universal coverage. The same thing is true of proposals to outlaw the common industry practice of refusing to cover people with known medical problems, so-called pre-existing conditions. Most health bills that stop short of universal coverage, such as the bipartisan Managed Competition Act championed by Democratic Rep. Jim Cooper of Tennessee, allow insurance companies to exclude coverage of a pre-existing condition for up to six months unless the prospective policy holder is switching from one policy to another. Again, the reason is that if the government requires companies to cover pre-existing conditions without requiring everyone to have insurance, people will buy policies only when they expect high medical expenses.

Seeing the Insurer's Side

Even Gail Shearer, who as manager of policy analysis for Consumers Union is usually no friend of insurance companies, says: "You can understand why the insurers want protection."

In a pure community-rated insurance system, everyone in a region would pay the same premium for the same package of health benefits, regardless of age, sex, medical history, lifestyle or place of residence, despite cancer or severe disability—or perfect health.

Some supporters of community rating are pushing to allow some adjustments, such as for age and habits that affect health, like smoking. And for all the rhetoric embracing community rating, most of the actual bills under consideration in Congress would adopt only a modified version of the concept.

"Nobody is proposing pure community rating," says Henry Aaron, an economist at the Brookings Institution in Washington. Even the sweeping Clinton proposal would allow four different types of regional risk pools, based on family type — for individuals, for single parents with children, for couples and for two-parent families with children.

The House Ways and Means Committee, under pressure from the insurance industry, is considering a bill with five different market sectors, based largely on a person's employer. Each sector would be community rated, but insurers wouldn't have to sell policies in every sector. The leading Senate Republican bill, written by John Chafee of Rhode Island, allows insurers to adjust for age and geography in some markets.

In fact, many people argue that the only legislation that guarantees a true community-rated approach are bills establishing a "single-payer" health system, where the government pays people's medical bills with tax revenues.

Other things that make community ratings work are also opposed by supporters of the concept. A successful community-rated system requires a bureaucratic structure to oversee it. Yet many of the people calling for insurance-market reforms are the same ones decrying the large regional health alliances that President Clinton has proposed.

The alliances, which would be set up by the states, would include employees of all businesses with fewer than 5,000 workers. The White House says they were conceived to establish a large pool over which to spread insurance risks. And they are also intended to take care of a difficult but critical job known as risk adjusting.

"Community rating violates basic actuarial principles," says Princeton's Prof. Reinhardt. "A community-rated system forces a competing private insurer to look at a deathly ill patient, seeing a $100,000 bill, and cheerfully enroll that person for $2,000. It goes against human nature. So in order to overcome normal human nature, you need some coercion."

That means that while everyone pays the same amount into a community-rated system, a mechanism must be set up so insurance companies receive varying amounts, depending on the risk levels of their beneficiary pools. Otherwise, a plan that for some reason was chosen by a disproportionate number of, say, HIV-positive people, would be in bad financial shape. Ultimately, health plans overloaded with bad risks who pay low premiums could collapse. Risk-adjusting basically requires plans with better risk pools to subsidize those with worse risk pools.

The administration proposed health alliances to accomplish that task. However, most of the people pushing insurance reforms are balking at alliances. Consequently, large mandatory alliances are all but dead in Congress.

Alliances aren't the only entities that could perform such functions. "It could be done through state insurance regulation," says Mr. Aaron. The virtue of alliances, Prof. Reinhardt points out, is that they also would collect the health-insurance premiums, and could then turn around and pay money out to plans in the form of a "risk-adjusted premium." He says, "That's a lot different than having to go in there and fight with their lawyers."

Rating the Proposals

How the major health-reform plans deal with the issue of community rating:

- **CLINTON:** No premium variations allowed for age, medical status, geography or lifestyle. Separate pools according to family size.
- **SENATE LABOR AND HUMAN RESOURCES (approved June 9):** Same as Clinton but phased in over four years.
- **CHAFEE:** Health plans must offer a modified community rate premium for people and businesses of under 100 workers who buy insurance through a purchasing cooperative.
- **HOUSE WAYS AND MEANS (currently under consideration):** Community rating in four separate pools: individuals, employers with 2-250 employees; employers with more than 250 workers; association plans and health alliances.
- **SENATE FINANCE (currently under consideration):** Premium variations according to family size, geography and age. Highest age-adjusted premium may be no more than twice the lowest age-adjusted premium.
- **COOPER-BREAUX:** No adjustments allowed for medical status or number of past medical claims; premiums can be varied according to geography and, to some degree, age.

Health Bill Seen Falling Short Of 95% Coverage

Democrats, Republicans Say Senate Finance Proposal Outspends Its Provisions

THE WALL STREET JOURNAL FRIDAY, JULY 8, 1994

By David Wessel
And Hilary Stout
Staff Reporters of The Wall Street Journal

WASHINGTON – The slapdash health bill that the Senate Finance Committee approved last week promises health insurance for 95% of Americans, but doesn't raise enough money to achieve that goal, administration and congressional officials say.

The bill was heralded as proof the government could get close to President Clinton's goal of universal coverage without requiring employers to provide health insurance as Mr. Clinton proposes.

But Democratic and Republican congressional staffers and administration officials privately say the bill can't deliver what it promises. The bill even provides a mechanism for breaking the promise: a fail-safe provision designed to avoid increasing the federal deficit would automatically scale back subsidies and new tax deductions if the financing proved inadequate.

States Slow the Pace

States ranging from Florida to Washington continue to be laboratories of health-care innovation, but they increasingly are opting for a step-by-step approach instead of aiming for an across-the-board revamping. **Article on page A12.**

The Finance Committee hasn't provided any cost estimates for the bill even to the senators on the committee, several of whom acknowledged they were voting on it with even less than the usual analysis. But estimates prepared for comparable proposals and preliminary calculations circulating within the government suggest that, over the next five years, the program the bill envisions would cost tens of billions of dollars more than it provides – perhaps as much as $100 billion more.

"Without additional funding, I don't think there's any way the bill will lead to 95% coverage," says Thomas Scully, who oversaw health spending for the Bush administration's budget office and now represents a number of clients in the health-care industry. "There's a big financing gap, and it's not any fun to close it. Your choices are A: raise taxes, which isn't doable; or B: cut entitlements, which is also highly unpleasant."

The Finance Committee's bill is one of two health-reform measures approved by Senate committees. The other promises universal coverage by requiring employers to pay part of the tab for their workers' insurance, but it's unlikely that a majority of the Senate would vote for such a mandate. Senate Majority Leader George Mitchell of Maine has said he will meld the two measures and bring a bill to the Senate floor by the end of this month.

In the more liberal House, two committees have approved bills with employer mandates. A floor vote also is expected on a bill that would create a government-run, taxpayer-financed health system.

To make health insurance affordable to lower-income Americans and to encourage them to buy it, the Finance Committee's bill would offer subsidies for all families with incomes up to twice the poverty level (up to about $29,500 in today's dollars for a family of four). The poorest of those would get insurance free; the government would pick up part of the premium for others.

A Congressional Budget Office analysis of a rival program crafted by Rep. Jim Cooper (D., Tenn.) and Sen. John Breaux (D., La.) puts the five-year price for a similar subsidy plan at $400 billion to $500 billion, depending on the scope of the benefit package. And the CBO says that sum would lift the fraction of Americans with insurance to only 91% from the present 85%.

The Senate panel's bill appears to aim at a benefit package in the middle of the CBO's range, suggesting the promised subsidies will cost roughly $450 billion over five years. (There are differences between the Cooper and Finance Committee plans, but some would make the Senate version more costly and others would make it less costly.)

After rejecting a number of tax increases suggested by Chairman Daniel Patrick Moynihan (D., N.Y.), the Finance Committee Saturday approved a bill that appears to raise little more than $100 billion in revenue over five years, after accounting for the cost of expanded tax deductions for the self-employed and those workers who buy their own policies.

The biggest chunk would come from higher tobacco taxes, about $65 billion over five years. Another $30 billion or so would come from a new 1.76% tax on health-insurance premiums, though the bill would dedicate that money exclusively to research. Another $4 billion would come from raising Medicare premiums for upper-income elderly people. The hardest tax to estimate in the legislation is Sen. Bill Bradley's (D., N.J.) tax on high-cost insurance plans. The Treasury's top tax official has indicated the tax might produce $14 billion to $17 billion over 10 years.

The remaining $350 billion or so needed to provide the subsidies would have to come from money-saving changes to Medicare and Medicaid, the federal insurance programs for the elderly and the poor. Medicaid spending would fall because many beneficiaries would be shifted to government-subsidized private insurance under the Senate committee's bill, but none of the preliminary estimates suggest the Medicare and Medicaid savings come close to making up the shortfall.

During the committee deliberations, Sen. Robert Packwood (R., Ore), who voted against the bill, said back-of-the-envelope calculations by GOP staff found the bill $91 billion short over five years. Afterward, Sen. Bradley, who voted for it, said he was "concerned that this bill is short on funding." Under the fail-safe provision if financing is inadequate, phasing in subsidies and expanding tax deductions would be delayed beyond 2000. The bill also creates a commission to make recommendations to Congress if fewer than 95% of Americans have health insurance in 2002; Congress would have to vote on those recommendations.

The Finance Committee bill isn't the only proposal that would deliver less than coverage for 95% of Americans. There essentially are three ways to assure universal coverage: require individuals to obtain it, require employers to provide it, establish a government program, or some combination. None of those seems to attract a majority in the Senate, so the alternative is to offer subsidies to encourage the uninsured to buy insurance. With more generous subsidies, more of the uninsured are expected to take the bait. But generous subsidies are costly.

A proposal put together hastily by Senate Republican Leader Bob Dole and endorsed by 39 other Senate Republicans would give subsidies to Americans with incomes up to 150% of the federal poverty line without raising taxes. But the still-sketchy proposal is difficult to evaluate because it doesn't specify how generous a benefit plan would be offered.

Some of the Democratic universal-coverage bills also may come up short. An employer mandate reduces the need for large government expenditures. To fund subsidies to small, low-wage companies and low-income people, most of the bills rely on higher tobacco taxes, Medicare and Medicaid savings and a payroll tax on large companies.

Arthur S. Flemming and Elliot L. Richardson

Let the Employer Provide

THE WASHINGTON POST

B12 SUNDAY, JUNE 12, 1994

President Clinton has done our nation a great service by putting health care reform at the top of our national agenda. His approach is thoughtful and conservative, building on the existing system to guarantee coverage to every American. And as the legislative debate moves forward, the centerpiece of his approach—a guarantee that all employers will provide health insurance to their employees—must be discussed in its proper historical context.

The link between health benefits and employment goes back 50 years. During World War II, when wage and price freezes were in effect, many employers found that offering benefits was a good way to reward and attract workers—a particularly attractive option because of the tax-exempt status of health insurance. By the middle of the 1950s, health coverage through the workplace was widespread.

The growth in employer-provided health insurance continued through the late 1970s. But since then, the percentage of employed Americans who lack health insurance has begun to increase. This reflects in part the changing job market—as manufacturing jobs with generous benefits have given way to service jobs with few or no benefits during the 1980s. Recently, researchers at the Harvard School of Public Health predicted that 30 percent of small businesses would drop coverage for their employees in the coming years because of rising costs.

Extending our current system of employer-provided insurance builds on what we have. Today, the vast majority of Americans with private insurance get it through their employers, yet eight out of 10 Americans who have no insurance are in working families. By extending the employer-based system, we can cover most Americans. The government can help by protecting small businesses and the unemployed. This approach is the easiest, simplest and fairest way to get to universal coverage.

In 1971, President Nixon first proposed comprehensive health reform—with an approach very similar to President Clinton's. Nixon proposed that all employers provide a standard benefits package to their employees and pay 75 percent of the costs, with the government helping to cover the unemployed. President Clinton's proposal calls for the same, except employers would pay 80 percent.

The Nixon proposal—the National Health Insurance Standards Act—was drafted at the Department of Health, Education and Welfare when we were colleagues there. It called for "employers to provide basic health insurance coverage for their employees." President Nixon saw this as part of a tradition of government guaranteeing basic worker protections. "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 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," he argued in his message to Congress.

Today, the vast majority of businesses provide insurance, and most of the rest say they would if they could afford it. Businesses that provide insurance today will undoubtedly gain from both cost-containment efforts and universal coverage, which will eliminate cost-shifting. And though firms that do not now provide insurance would no longer get a free ride, President Clinton's approach protects small businesses by providing them very generous discounts on insurance.

The Congressional Budget Office analysis of the Clinton plan—praised by Democrats and Republicans alike—is valuable in evaluating the impact on business. Even when new spending from those businesses that do not now provide insurance is included, the CBO concluded that American businesses as a whole would save $90 billion by the year 2004. The CBO also concludes that the president's approach will have a negligible net effect on employment—defusing a main charge by critics.

Further, the experience of Hawaii—the on state that has already asked all employers t provide insurance to their employees—bode well for small business. Since Hawaii passe reform in 1974, the unemployment rate ha dropped to one of the lowest in the nation; sma business creation rates have remained high; an the rate of business failures has been less tha half the national rate. In addition, Hawaii's "rain day" fund, set up to help small businesses provid insurance, has only been used five times over 1 years.

Despite the "sky-is-falling" rhetoric of som lobbyists (rhetoric that is familiar from pas debates), some kind of employer-based approac should be adopted. Proposed by presidents Nixo and Clinton, it is sensible and conservative building on the existing system that covers mo Americans. And it is necessary to achieve un versal coverage.

As former secretaries of health, education an welfare in Republican administrations, we hav seen past health reform efforts start and fail. Bu we believe that the dedication of the presiden and the First Lady, the public demand for actio and the commitment of veteran lawmakers w make universal coverage a reality this time. Wi the cooperation of moderate Republicans, th can be a bipartisan effort that shows the Amer can people what happens when Congress wor together to get things done.

We want the president to succeed—not Democrats or Republicans—but as Americ citizens. This year's Congress should be proud leave comprehensive health care reform as i legacy.

Arthur S. Flemming, secretary of health, education and welfare under President Eisenhower, is chairman of a coalition of groups concerned with Social Security and health care. Elliot L. Richardson, secretary of health, education and welfare under Presider Nixon, is a Washington lawyer.

New York Finds Fewer People Have Health Insurance a Year After Reform

By Leslie Scism
Staff Reporter of The Wall Street Journal

Almost one year after New York State adopted stiff insurance reforms, fewer people have health-care coverage than under the old system.

The surprising decline provides ammunition to supporters of nationwide mandatory insurance, and could prove troublesome for advocates pushing for incremental insurance reforms.

Under New York's system, insurers are required to offer one-size-fits-all pricing, a method that sharply decreased rates for older, sicker people but increased them for others. The law also forces insurers to take all comers, and, as a result, some insurers contend that disproportionate numbers of young, healthy people are dropping coverage on the assumption they can buy it later if needed.

With increasingly fewer healthy people counterbalancing the sick, the result, according to the insurers, is the start of an upward spiral in rates for those still in the pool. If the trend continues, insurers contend, the very people that the program was intended to help could again be priced out of the market.

Crumbling Barriers

"There should have been a substantial gain in people insured [in New York] because a number of barriers for people to be insured came down," says Robert Laszewski, a partner with Health Policy & Strategy Associates, a Washington consulting firm. But the abrupt increase in rates for young, healthy people has "affected the ability of New York to achieve a lower-cost pool. Now we may have a pool in New York skewed toward the sick, and in the long run that doesn't help the consumer."

Ronald Pollack, executive director of Washington-based Families USA Foundation, a consumer group that backs President Clinton's plan of mandated coverage, adds: "New York's experience gives very little comfort to those who just want incremental insurance reforms." Mr. Pollack insists that reforms, in isolation, "can't keep insurance affordable and available for families."

New York's effort is one of the nation's most sweeping attempts at reform and is closely watched by national policy makers. New York Insurance Department figures show that, overall, 1.2% fewer people – or 25,477 fewer people – were insured individually or in small-employer groups as of Jan. 1, nine months after the law, which covered those categories, took effect. The decline was particularly pronounced among individual policyholders – 12.4%, or 43,666 people. The figures respresents people insured by conventional insurance companies, health-maintenance organizations as well as Blue Cross/Blue Shield.

Insurance-department officials downplay the slight drop in overall enrollment, citing a "disruptive phase-in period." As for the steeper drop in individual coverage, they suggest some people previously covered individually are now in small groups, perhaps because their employers were prompted to add coverage.

'Unqualified Success'

New York Insurance Superintendent Salvatore Curiale calls the state's effort an "unqualified success" because it opened the system to those needing insurance the most. "The reason for all the effort to portray this as a failure is because the health-insurance industry is deathly afraid it will be taken up as a national policy," Mr. Curiale says. "What they're afraid of is that their profits will decrease" if they can't make money "on the backs of young, healthy people."

Many insurance companies that strongly opposed the New York law say their individual and small-group businesses have always had thin profit margins. Although they are allowed under the law to raise rates anytime they wish, the insurers contend that forcing them to take on a disproportionate number of less-healthy policyholders makes it even tougher to turn a profit, making rate increases necessary.

The insurance industry's practice of rejecting sick people, or charging them exorbitant rates, has long been one of Hillary Clinton's biggest complaints. But her calls for change have generally been in the context of sweeping reform that would bring all Americans into the health-care system, mostly by forcing employers to pay for premiums. The debate over insurance-underwriting practices has revved up recently as some leading legislators have suggested that Congress enact moderate reforms now and revisit the issue of a massive system overhaul later.

'Bailing Out'

In New York's case, the state adopted a "community rating" system, so-named because insurers must charge all people within given communities the same price regardless of such factors as age and medical condition. While considered a revolutionary effort, the state still allows insurers to refuse to cover prior medical conditions during an individual's first 12 months of coverage. The idea is that the exclusion will induce healthy people into the system before they get sick.

But Cecil Bykerk, chief actuary for Mutual of Omaha, which along with HMOs and Blue Cross/Blue Shield provides individual coverage in New York, says young, healthy people are nonetheless "bailing out." The average age of the company's New York policyholders has gone up 3.5 years under the new law, to 45 years, he says. The average New York claim more than doubled, to $7,900, while the company's claims nationally rose just $400 to $3,800.

The result at Mutual of Omaha: average 35% rate increases in New York this year, which come on top of increases for some young, healthy people of as much as 79% when the law took effect in April 1993. Before the reform, a 25-year-old male in Albany paid Mutual of Omaha $64.45 a month for coverage, and a 55-year-old paid $141.79; in the law's first year, each paid $107.33, and, with the newest rate increase, the bill is $145.10.

At New York Life Insurance Co., a small-group insurer, the average age of insured New York employees is up three years. Chubb LifeAmerica, a unit of Chubb Corp. that also sells small-group insurance, says people over 50 years old now represent 26% of New York enrollment, up from 20%.

"There's no question we have an adverse-selection cycle setting in," says Seymour Sternberg, a New York Life executive vice president, calling the situation "very unstable."

John Swope, president of Chubb LifeAmerica, meanwhile, speculates that some small employers with mostly young workers ended coverage because of the rate increases imposed when the law took effect, while employers with older workers "grabbed it because it was such a bargain."

At Chubb and New York Life, rates are jumping more than 20% this year. But Mr. Curiale says some small-group insurers with double-digit increases underpriced their policies last year and are playing catch-up. He says more representative increases are in the single-digit range.

For now, the state has no plans to reconsider the law, saying the problems are overdramatized. "The figures still don't show the system isn't working," Mr. Curiale says. "There's no doubt that there are younger, healthier people who decided not to pay the premium increases. But you can extrapolate that these are people who can get back into the system if they want to."

Wi h Do e's mainstream GOP proposal, the debate is joined

By Richard A. Knox
GLOBE STAFF

In the eight months since President Clinton introduced his health reform plan, mainstream Republicans have been saying what they don't want in the way of reform. Last week they finally said what they are for. And now they will have to defend it.

It isn't universal health insurance. Senate Republican leader Bob Dole, who supported health coverage for all Americans before he began to consider running for the GOP presidential nomination in 1996, introduced a proposal that makes no pretense of aiming for that goal.

Instead, Dole's 27-page plan offers modest federal subsidies and other inducements for people to buy health coverage, financed by more than $100 billion in cuts from Medicare and Medicaid and no new taxes.

Dole's quintessentially Republican proposal is not just the umpteenth plan in the hopper. It claims the backing of 39 other Republican senators. Thus, it clarifies the health care debate in a way that has been lacking in the morass of permutations on Clinton's blueprint and other schemes.

In other words, the debate is finally joined. "It is now our plan versus theirs," exulted conservative GOP strategist William Kristol of the Project for the Republican Future.

The Dole plan, Kristol said, "must be treated as a final and authoritative Republican position," not as an opener in the next round of horse-trading. Republicans must proudly sell it, he advises, as "straightforward reforms that make insurance more stable, accessible and affordable."

It is a program that "brings more people into the system and provides more security and flexibility for those already in it," he adds.

A senior White House health adviser greeted the Dole plan with similar relish. At last, he said, the public will begin to understand what the debate is all about – and when people understand, they will press for real reform.

In fact, a number of health policy analysts from all parts of the ideological spectrum last week began to raise doubts about the Dole plan. Their early but remarkably congruent verdict: It's not likely to do much to expand access to health insurance. And it might make things worse for many who are now insured.

Mark Pauley, a conservative economist at the University of Pennsylvania who is no supporter of the Clinton plan or its cousins, labels Dole's federal insurance subsidies for the poor "stingy."

Dole's plan would offer subsidies to Americans earning less than 1½ times the federal poverty level – $22,200 this year for a family of four. The average 1994 premium for such a family is nearly $6,800, or more than 30 percent of the family's gross income.

"My guess is that Congress will want subsidies that reach somewhat higher," Pauley said. "They don't want to be that beastly – even the conservative ones."

How far would Dole's subsidies take the nation in reducing the number of uninsured people, now estimated at 39 million?

Pauley notes that the Congressional Budget Office this spring concluded that a proposal by Rep. Jim Cooper, Democrat of Tennessee, and Sen. John Breaux, Democrat of Louisiana, would cover about 40 percent of the uninsured with a more generous subsidy scheme that reached people earning up to twice the poverty level.

"Given the relative stinginess of Dole's subsidies, I would say the Dole plan could pick up between one-third and one-half of the uninsured," Pauley said in an interview.

This would leave between 19.5 million and 26 million uninsured Americans, at 1994 levels, who would have to be brought into the system through other means. For many of them, Dole proposes insurance market reforms, such as rules designed to even out the wide disparities in health insurance premiums that now exist between the young and old, the sick and healthy.

The Dole plan would also eliminate insurers' ability to refuse coverage for preexisting medical conditions, a practice that currently makes an estimated 1 million Americans "uninsurable."

But Pauley predicts such measures "probably do almost nothing, or maybe even make things worse" in the effort to reduce the remaining millions of people who would lack health coverage but could not qualify for subsidies.

"To the extent you force insurers to take all comers or in other ways not charge what they cost, the insurer has to raise what they charge other people," Pauley explains. "You exchange some insured healthy people for some uninsured unhealthy people. The net effect of that is probably somewhat of a loss."

Other analysts concur, and they point out that such outcomes are not merely hypothetical. "At least 37 states have enacted insurance reforms essentially identical to the reforms proposed in Congress," said Patricia Butler, an independent health consultant from Boulder, Colo., who often works with state governments.

"I think any insurance commissioner would say these reforms are a necessary but not sufficient way to decrease the number of uninsured," Butler said. "To say they're going to improve access is a little bit misguided."

New York state is often cited these days as one real-world example of the unintended consequences of health insurance market reforms in the absence of any requirement that either employers or individuals purchase insurance. (Dole and almost all other Republicans have rejected such "mandates.")

New York passed a law requiring insurers to average premiums across an entire community rather than pricing coverage according to their estimate of whether a subscriber was likely to get sick. Nine months after the law took effect, the number of New Yorkers insured individually or through small employer groups dropped by 25,477, or 1.2 percent.

Analysts also point out that the seemingly sensible idea of offering federal subsidies to help the poor and near-poor to buy health insurance contains some hidden pitfalls.

The problem has to do with the fact that subsidies provide a perverse incentive for people not to work or increase their earnings, if they would no longer qualify for subsidies.

"Take a family of four just above the poverty line ... earning about $19,000 a year," explains David A. Super of the nonpartisan Center on Budget and Policy Priorities, a Washington-based organization that studies how government spending affects low-income Americans.

For each additional dollar such a family earns, Super says, they now lose about 72 cents by having to pay more federal and state income tax, FICA tax and through reduced earned income credit and decreased food stamps. They keep 28 cents.

Adding a health insurance subsidy for low-income families adds to the amount they risk losing if they exceed the income limits. Under the subsidy scheme approved yesterday by the Senate Finance Committee, Super estimates, the $19,000-a-year family "would lose an additional 18 cents on the dollar" once they exceed the income limit. So they could keep not 28 cents of every additional dollar earned, but only 10 cents, giving them even less incentive to earn more.

If such a family happened to live in an area with relatively high health care costs, Super said, they could easily reach the point where they are earning more but taking home even less.

If Dole and his colleagues want to minimize this problem, there are ways to do it, analysts say. But the solutions may not be congenial to conservatives or their constituents.

For example, government subsidies can be structured to reach into higher income levels, such as up to 2½ to 3 times the poverty level, so that the phase-out of subsidies can be made more gradual. But this swells federal spending on subsidies, especially when there is no requirement that employers share the burden.

Benefits also could be reduced to make insurance less costly. But even a stripped-down benefit package, with no mental health coverage or prescription drugs and only 15 hospital days per year, would reduce the work disincentive by only a few cents on the dollar.

"It's one thing to ask people to work hard and get only 28 cents on the dollar," Super said. "It's another when you make working irrational."

An Unpleasant Choice if Employers Won't Pay for Health Care

By ROBERT PEAR
Special to The New York Times

WASHINGTON, July 7 — President Clinton's goal of health insurance for all Americans is often described as a moral imperative or a political objective, but it is also a pocketbook issue.

In one sense, there is no mystery about how to reduce the number of uninsured: it just takes money. The question is who should pay.

In trying to achieve universal health insurance coverage, Mr. Clinton and Congress will confront an unpleasant choice in the next few weeks. If employers do not pay most of the cost, as Mr. Clinton has proposed, then the Government and consumers must pay more.

Many people describe Mr. Clinton's proposal for an "employer mandate" as an alternative to taxes. Still, the public would ultimately pay. Economists say that employers would pass on the costs to their workers by reducing the amount of money available for wages or future pay raises.

Guarantees, but Not for All

Members of Congress are skittish about requiring everyone to obtain insurance, and many flatly oppose Mr. Clinton's proposal to make employers pay most of the cost. Many lawmakers now suggest that the Government should initially try to guarantee coverage for some fraction of the population, perhaps 95 percent, as the Senate Finance Committee has proposed.

What difference does it make whether 95 percent or 100 percent of the people have insurance? And who is most likely to remain uninsured? Those questions are at the heart of the current debate over how to redesign the nation's health care system.

Currently, the Government estimates that 39 million Americans, accounting for 15 percent of the population, have no health insurance. But such numbers imply far more precision than is possible with any measuring tools now available. People's insurance status is continually changing as they change jobs, marry and divorce, move from one state to another and go on and off the rolls of programs like Medicaid and Medicare.

Virtually all the major health care proposals now in Congress would make health insurance more available, prohibit insurers from denying coverage to people with a history of illness or disability and prevent insurers from charging extremely high premiums to people with high medical risks.

But such changes, by themselves, would not solve the problem, and experts warn that half measures could have unintended adverse effects. Alice F. Rosenblatt, an actuary at Coopers & Lybrand, the accounting firm, said that "a small proportion of the uninsured, probably less than 5 percent, have been denied coverage because of pre-existing conditions like cancer and cardiovascular problems."

Moreover, unless there is some mechanism for enrolling all people in health plans, millions of Americans are likely to remain uninsured because they do not want to be bothered, see no need for coverage or cannot afford their share of the cost.

"Many people may rationally choose not to purchase health insurance coverage, either because they have low income or because they believe they have a low risk of needing health care services," said William S. Custer, research director of the Employee Benefit Research Institute, a nonpartisan organization whose members include businesses and labor unions.

The Young May Go Without

If there is no requirement for people to have insurance, many who are young and healthy will probably go without it because they see no immediate need, given the cost. If significant numbers of healthy people go without insurance, the average risk of the policyholders rises, and their premiums increase as a result.

At least 11.6 million people 18 to 29 years old have no health insurance. They account for 30 percent of the uninsured. It is desirable to have these people in the insurance pool because their medical costs are generally lower than those of older people, actuaries say.

Under most of the proposals in Congress, poor people would pay little or nothing for health insurance. The Government would pay the premiums for people with incomes below the official poverty level, now $14,764 for a family of four. Lawmakers assume that affluent people can buy private health insurance, costing $4,000 to $6,000 a year for a family, if they do not receive coverage through employers.

So, health policy experts say, if employers are not required to provide insurance to their employees, the people most likely to be uninsured are people in the middle-income range, particularly those who work for small companies.

"All the major proposals would give full coverage to people below the poverty line," said Mr. Custer of the Employee Benefit Research Institute. "That's the first group that would pick up coverage. Uninsured people at the poor end of the middle class are least likely to pick up coverage as a result of these reforms."

Eleven million people without insurance, or 28 percent of the uninsured, have incomes below the poverty level. They could get coverage at little or no charge under most of the proposals pending in Congress.

If the Government provided coverage similar to what the average employer now offers, it would cost $2,000 a year for each uninsured person. For every million people who received fully subsidized coverage, the Government would have to pay at least $2 billion a year.

Nearly one-third of the uninsured — 12.5 million of the 39 million people without coverage — have incomes between the official poverty level and twice that amount. Under the major proposals, these people would get some financial assistance from the Government to help them buy insurance.

Whether such subsidies would be adequate depends on many questions: the amount of the assistance,

the cost of the insurance and the portion, if any, paid by employers.

Mr. Custer sounds a cautionary note. "It is extremely unlikely that simply lowering the costs of insurance will achieve universal coverage," he said.

Clinton Administration officials say that universal coverage is not only good health policy but also good politics. Health care is a pocketbook issue, they say, because people can be impoverished by medical bills.

"People who work should not be left behind when we reform the health care system," said Gregory E. Lawler, a lawyer coordinating the health care campaign at the White House. "They should have guaranteed private insurance."

More than half of the uninsured are working adults. Eighty-four percent of the uninsured live in families headed by workers. But in recent years, there has been a decline in coverage provided by companies with fewer than 25 employees. Such companies say they are often unable to obtain affordable health insurance for their workers because insurers charge them higher premiums, reflecting the risks and the administrative costs associated with small groups.

Concern for Children

Congress has for years shown special concern for the medical needs of children, and that impulse is clear in many proposals to overhaul the health care system. The Finance Committee, for example, accepted a proposal by Senator Donald W. Riegle Jr., Democrat of Michigan, to provide extra subsidies to help pay insurance premiums for children in families with incomes up to 2.4 times the poverty level.

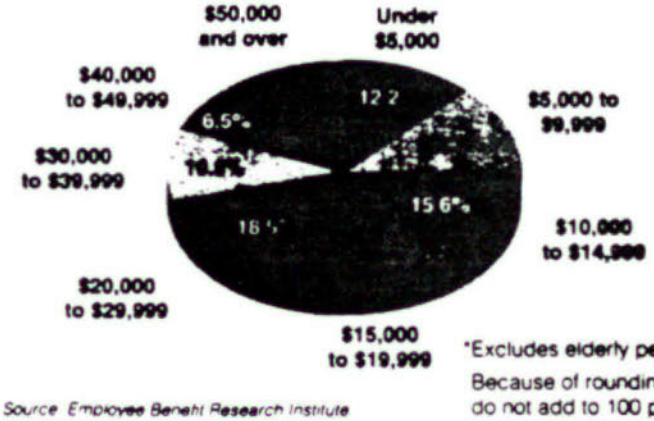
Nearly 10 million children under 18 years old have no health insurance coverage, and most of them could obtain it under the bills now pending in Congress.

About one-third of the uninsured children are in poor families. Another third live in families with incomes between the poverty level and twice that amount. The remainder have family incomes exceeding twice the poverty level.

DEMOGRAPHICS

The Uninsured, by Income

The percentage of uninsured Americans in each family income category, 1992 figures *



*Excludes elderly people.

Because of rounding, figures do not add to 100 percent.

Source: Employee Benefit Research Institute

The New York Times

Peril Seen in Reform Limited to Insurance

■ Health care: Analysts warn that Congress would be shortsighted to focus only on coverage discrimination.

By EDWIN CHEN
TIMES STAFF WRITER

WASHINGTON—It sounds so simple: Ban insurers from jacking up rates on sick people and force them to accept all applicants, offering the same rates regardless of age or health status.

No single health reform proposal enjoys broader support among the public or members of Congress. And no wonder.

Ending discriminatory insurance practices would instantly allay deep-seated fears of middle-class Americans that they might lose coverage when they change jobs or be priced out of the market when they become seriously ill. In poll after poll, 80% to 90% or more of respondents favor such reforms.

But there's a big hitch.

Unless accompanied by a requirement that everyone be insured, insurance reforms would mean higher premiums for the insured and actually *increase* the ranks of the uninsured.

That's because such reforms would enable the sick and the vulnerable to buy insurance, often for the first time. Their high health costs would force insurers to increase premiums across the board.

What's more, the young and the healthy—confronted by rising rates—might drop coverage, secure in the knowledge that they could buy insurance when they needed it. That in turn would increase premiums for everyone else.

Thus would begin a vicious cycle that, experts say, would hasten the deterioration of the nation's health care financing system.

The prospect is growing that Congress will abandon comprehensive health care reform this year and instead do little more than try to remedy the apparent shortcomings of today's insurance system.

That approach could do more harm than good. Dire warnings of the unintended consequences of insurance reform are being sounded by such disparate analysts and advocates as conservative hospital lobbyist Michael Bromberg and First Lady Hillary Rodham Clinton, architect of President Clinton's agenda for change.

"Insurance reforms will solve [illegible] the problems that the market [illegible] a threat about. But I think the two [illegible]—the two biggest challenges we face," said Drew Altman, president of the Kaiser Family Foundation, a health care philanthropy based in Menlo Park, Calif.

"You buy some time, but costs will continue to escalate," added Edward F. Howard, executive vice president of the Alliance for Health Reform, a nonpartisan educational group here. "So you lay the groundwork for a bigger explosion in a few years."

Yet, as Congress prepares to begin floor debate on health reform, the appeal of insurance reforms may prove all but irresistible.

Almost every health reform bill introduced in recent years contains such measures—including all four bills reported out recently by two committees in each chamber.

Insurance reforms "solve real problems for real people. And it can happen without turning the system on its head," said Gail Wilensky, a health expert in former President George Bush's White House who now advises congressional Republicans.

Wilensky, former head of the Health Care Financing Administration, said that "it's important for Congress to say to the American people: 'We can do something, and here's one piece, signed, sealed and delivered.'"

She and other advocates of incrementalism acknowledge that insurance reforms alone will do little for the estimated 38 million uninsured Americans. But they say that such measures are a good and realistic beginning.

Opponents argue that insurance reforms alone are doomed to fail unless they are accompanied by a requirement leading to universal coverage, such as Clinton's controversial proposal to require all employers to pay at least 80% of workers' insurance premiums, with individuals picking up the rest.

Insurance reforms alone "just won't work," said Marvin B. Hall, president of the Hawaii Medical Service Assn., the largest insurance company in that state. "You'd push costs even higher."

"Insurance reforms by themselves will increase premiums substantially because you'd be allowing back into the group people who have been excluded primarily because of costs," said John Rother, legislative director of the Amer[illegible]

[illegible] market reforms [illegible] short term, would be small businesses. Most such reforms being contemplated by Congress would give them a choice of health plans by pooling them into large, voluntary purchasing groups, thus affording them lower rates enjoyed by large groups.

The biggest losers would be younger people, whose rates would rise sharply. "You'll see a bunch that's going to drop out," said Richard L. Smith, an analyst at the Assn. of Private Pension and Welfare Plans. "And what problems are we solving if we end up just producing more uninsured?"

Willis D. Gradison Jr., [illegible] of the Health Insurance Assn. of America, agreed, saying that insurance reforms "could [illegible] have just the opposite [illegible] of what is intended." He cited the experience of New York state as a prime example.

There, a law took effect in April of 1993 that barred insurers from setting premiums based on age, sex or health status and required them to guarantee coverage to all.

After just nine months, 40% of policyholders at Mutual of Omaha, the largest underwriter of individual policies in New York, saw their premiums drop, according to Medicine & Health, a weekly newsletter. But 60% experienced increases of as much as 60%.

Meanwhile, the number of uninsured grew by more than 25,000.

Hoping to pave the way for national insurance market reforms as a first step toward broader reforms, Reps. J. Roy Rowland (D-Ga.) and Michael Bilirakis (R-Fla.) have introduced just such a bill, saying that it is "designed to re-establish the health reform debate on a foundation of agreement rather than one of divisiveness."

"Some members have made clear that that's as far as they are willing to go," said Martin Corry, AARP's director of federal affairs. "But we think that's pretty shortsighted."

Wilensky, the Republican consultant, worries that insurance reforms could sap the will of Congress to press on with more comprehensive reforms, such as expanding coverage to the uninsured.

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For Release on Monday,
July 18, 1994 at 12:15 p.m.

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STATE MEDICAID COSTS WOULD SKYROCKET UNDER DOLE HEALTH CARE BILL

Boston – A study released today at a news conference in Boston finds that Senator Robert Dole's (R-KS) incremental health care reform proposal would put each and every state in a "fiscal straitjacket" by shifting the burden of covering the poor and uninsured from Washington to the states.

The study, conducted by the American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO, analyzed how each state would be affected by the Dole plan, which calls for capping the amount of federal money spent on the joint state-federal Medicaid program. The study was released today by AFSCME President Gerald W. McEntee.

"There's a very basic reason why America needs universal coverage," said McEntee, "and the Dole plan makes it crystal clear. Unless every American has health insurance, the rest of us will be stuck with their bills. The Dole bill is nothing more than a shell game."

According to the AFSCME study, under the Dole bill, State Medicaid spending would have to increase by $115 billion in the first eight years because the bill would forbid the states from cutting Medicaid eligibility and offset the federal spending cap.

Costs of the Medicaid program doubled between 1981 and 1988, and then again between 1988 and 1992. The nation's governors have been looking to President Clinton and Congress for comprehensive national health care reform to contain those costs. States now spend more on Medicaid than they do on higher education, according to the National Association of State Budget officers.

The AFSCME study shows that the Dole plan would only shift costs from Washington to the states.

Over eight years, California will face $13.1 billion in additional costs, Texas will face $ 8.4 billion, and New York will face $13.4 billion in new costs.

The Dole plan would limit the growth in federal Medicaid spending to six percent per recipient per year from 1996 to the year 2000, and five percent each year thereafter. The AFSCME study stressed the fiscal straitjacket this will put on states, since there is no universal coverage under the Dole plan and no system-wide cost containment to keep the costs of covering the uninsured and underinsured from falling on state governments. In fact, the study points out that the Dole plan (Section III, p. 22) specifically prohibits states from offsetting new costs by eliminating health coverage for anyone now covered by Medicaid.

In addition, the Dole plan would make an across-the-board 25 percent cut in the Medicaid "disproportionate share" program, which gives states additional funds for hospitals and other providers that treat a large number of low-income patients. Disproportionate share payments are particularly important to New York, California, Texas, and Florida, which have a high number of undocumented immigrants.

--MORE--

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AFSCME in the public service

The Dole cuts in disproportionate share will translate into new costs to the states of $41 billion over the first eight years of implementation, with $3 billion in new costs in the first year alone. The report found this cut to be "particularly ironic, given that the states most likely face an increase in costs for uncompensated care resulting from the Dole plan's lack of employer mandate, insufficient subsidies, and incentives for small business to drop coverage for low-wage workers."

The Dole changes in the Medicaid program would force the states to spend more and more of their own money to cover the costs of the Medicaid program, according to the AFSCME study. Instead of spending 20 percent of their general fund budget for Medicaid in the year 2000 under current projections, the Dole plan states would force states to increase that percentage to 23 percent in the year 2000.

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The following individuals are available for comment on the study:

- **Diane Rowland, Director, Kaiser Foundation Commission on Medicaid (202-347-5270)**
- **Jim Verdier, Assistant Secretary for the Office of Medicaid Policy/Planning for Inidana Family and Social Administration (317-233-4455)**

SQUEEZING THE STATES:

The Impact of Senator Dole's Health Reform Plan On State Budgets

July 15, 1994

A joint study prepared by:
American Federation of State, County and Municipal Employees
and
Citizen Action

Introduction

Senator Bob Dole has presented an alternative national health reform proposal which takes a more "incremental" approach to solving the crisis in health care costs and rising rates of uninsured Americans. The Dole plan would impose strict cost controls on the federal share of the federal-state Medicaid program, which provides health care to over 30 million low income and elderly Americans. Specifically, the Dole proposal would cap the growth in the federal share of acute care Medicaid to 6% per recipient per year from 1996 to 2000, and 5% each year thereafter. In addition, it would impose a 25% across-the-board cut in the "disproportionate share" (DSH) program of Medicaid, which provides additional money to states to help them compensate hospitals that have significant amounts of uncompensated care.

This study assesses the impact these federal "cost containment" measures will have on state budgets, since states are partners with the federal government in the Medicaid program. The major findings are summarized below:

- Absent universal coverage and system-wide cost containment, the Dole plan would simply pass additional costs down to state and local governments. In total, state governments would have to spend $5 billion more from their own funds to cover Medicaid costs in the first year of implementation than they would without reform. Costs over the 8 year period 1997-2003 would total an astounding $115 billion.

- Some states would be particularly hard hit. Increased costs to state governments would range from a low of $1.4 million in the first year for Wyoming to $606 million in the first year for California. Over 8 years, California will face $7.5 billion in additional costs, Texas will face $4.8 billion, and New York will face $12.7 billion more in total Medicaid costs.

- The plans' proposed cut in the "disproportionate share hospital" (DSH) program alone would mean states must find an additional $41 billion over 8 years to keep the program funded. This would have a direct negative effect on the hospitals that act as safety nets for uninsured and low-income patients. The plan also presents the option of phasing out DSH altogether, which would represent a loss to the states of $15 billion in 1997 alone.

- States would have to spend more of their own tax dollars to compensate for the loss in federal assistance. Whereas states are projected to spend 20% of their general fund budgets for Medicaid in the year 2000 without comprehensive reform, they would be forced to increase that to 23% if the Dole plan were to become law. This will squeeze other programs states must fund, such as education and anti-crime measures.

Ironically, many state leaders have been looking to national health reform as means of providing some fiscal relief from the constantly rising Medicaid costs, but the Dole plan would only exacerbate the stress on state and local governments.

Summary of the Dole Plan

Senator Dole's alternative health plan is not detailed enough to assess all of its implications on state budgets. However, its provisions which cap the federal share of Medicaid and cut disproportionate share hospital payments (DSH) would result in clear and measurable new costs to the states.

The Dole proposal would subject federal Medicaid spending for acute care services, less DSH spending, to an annual payment cap for each state. This cap would be determined by multiplying the per-capita amount times the number of Medicaid recipients in the state. The cap would allow this per-capita federal spending amount to increase only 6% a year from FY 1996 through FY 2000, and then only 5% each year beyond FY 2000. The proposal also reduces Medicaid payments for disproportionate share by 25%, starting in 1996, to help pay for subsidies for low-income individuals and families without health insurance.

New Costs To States Will Be Unavoidable

The Dole plan specifically precludes states from taking such actions as limiting Medicaid coverage as a means to help off set these new mandated Medicaid costs. In addition, the plan does not guarantee universal health care coverage nor require that employers cover their employees. As a result, there will still be large numbers of uninsured and underinsured populations for which state and local governments will continue to be health care providers of last resort. Hospitals will still have to absorb uncompensated care costs, especially public and teaching institutions, without the same amount of offsetting assistance from the federal government.

In fact, the Dole plan could induce small employers to drop coverage for low-wage workers, increasing the burden on the public sector. The combination of subsidies for low-wage workers and no required employer contribution towards insurance may encourage employers to let federal taxpayers shoulder the burden of insuring the working poor. The Dole plan even anticipates this effect by saying, "An employer that finances health care coverage for any employee would not be allowed to discriminate against any employee based on his/her eligibility for a low-income subsidy. Employers who violate this rule would be assessed a penalty. . ."[1] How such a system would be enforceable is very unclear.

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[1]see Section C. 3., p. 7.

Even the Dole plan's provisions for cost containment from "managed competition" are weak. Purchasing cooperatives would be voluntary. The insurance reforms in the small group sector could actually lead to higher premiums for that market, further discouraging small employers from contributing towards health insurance for their employees.

Like other versions of health reform currently under debate in Congress, the Dole plan does not assist states in providing care for undocumented immigrants. Moreover, it takes disproportionate share funds currently used by states to defray these costs, and allocates them instead for low-income subsidies. Furthermore, the Dole plan makes cuts in Medicare that will adversely impact public hospitals and teaching institutions which also rely on state financial support for both operations and capital investment.

All of these aspects of the Dole plan imply significant cost-shifting from the federal government to state governments, and from the private to the public sector. Since there is no framework for overall cost containment in the Dole plan, states will be unlikely to find savings within their own programs to offset the new federal costs.

The Additional Financial Burden on the States

The total additional costs to state governments from having to absorb Senator Dole's proposed cap on federal acute care Medicaid spending and cuts to disproportionate share total $115 billion over the first 8 years of implementation.

YEAR	TOTAL NEW COST TO STATES
1996	$ 3.5 billion
1997	$ 4.7 billion
1998	$ 7.1 billion
1999	$ 9.4 billion
2000	$13.3 billion
2001	$19.6 billion
2002	$25.2 billion
2003	$31.8 billion
Total Over 8 Years	**$115.0 billion**

TABLE 1

While the cost to state government of the federal cap compounds over time, all states will see additional burdens immediately. The following chart shows the implications of the Medicaid cap on a yearly basis for each state:

COST OF DOLE CAP (Dole Plan vs. No Reform)

State	FY97 Additional Cost to State if Dole cap	FY98 Additional Cost to State if Dole cap	FY99 Additional Cost to State if Dole cap	FY2000 Additional Cost to State if Dole cap	FY2001 Additional Cost to State if Dole cap	FY2006 Additional Cost to State if Dole cap	FY2005 Additional Cost to State if Dole cap	TOTAL ADDED COST TO STATE w/CAP
TOTAL	905,366,097	2,707,478,775	4,792,842,982	7,965,963,343	13,666,121,227	18,718,077,856	24,671,408,482	73,366,378,744
AL	11,573,981	34,610,988	60,500,456	101,832,696	174,943,408	259,262,084	315,366,339	936,132,954
AK	2,136,238	6,366,244	11,162,044	18,758,718	32,274,618	44,144,207	58,184,580	173,072,444
AZ	17,037,220	50,946,331	89,062,784	149,900,541	257,521,831	352,229,841	464,257,408	1,380,967,834
AR	10,060,833	30,056,146	52,541,140	88,431,404	151,920,668	207,792,307	273,881,181	814,673,668
CA	85,162,882	278,853,552	487,114,208	819,856,456	1,408,471,848	1,926,453,442	2,539,179,866	7,552,921,864
CO	9,860,056	28,657,656	50,446,081	84,906,200	146,662,830	199,508,586	262,980,144	782,166,531
CT	8,815,545	20,361,298	35,626,642	59,966,000	105,018,648	140,906,526	186,720,873	562,436,330
DE	1,925,458	4,860,731	8,497,042	14,301,277	24,568,868	33,604,526	44,292,828	131,780,407
DC	4,071,756	12,179,236	21,285,274	35,826,006	61,545,648	84,180,056	110,953,733	330,037,808
FL	41,765,448	124,869,978	218,320,141	367,482,186	631,264,228	863,425,333	1,138,037,943	3,386,180,660
GA	22,618,481	67,636,561	118,234,956	199,006,627	341,863,287	467,617,208	616,344,008	1,833,347,088
HI	2,564,034	7,046,516	12,318,266	20,729,367	35,612,008	48,706,874	64,200,983	190,969,141
ID	2,812,548	7,812,008	13,656,161	22,984,532	39,486,281	54,008,086	71,166,482	211,744,834
IL	30,516,466	91,256,867	159,526,090	268,496,578	461,260,508	630,901,700	831,561,536	2,473,522,734
IN	22,267,658	66,580,106	116,406,148	195,921,861	336,563,861	460,356,808	606,790,236	1,804,928,893
IA	7,217,365	21,582,964	37,729,174	63,501,561	109,092,448	149,213,218	196,670,840	585,007,571
KS	7,093,326	21,211,974	37,080,947	62,410,081	107,217,263	146,648,383	193,290,261	574,951,894
KY	16,474,453	86,246,252	96,575,960	162,546,917	279,246,946	381,943,401	503,421,457	1,497,453,087
LA	30,799,391	92,102,916	161,006,063	270,966,662	465,539,967	636,760,893	839,271,078	2,496,436,188
ME	4,834,077	13,827,909	24,172,564	40,684,668	69,884,008	95,596,818	126,004,264	374,806,182
MD	14,411,447	43,096,184	75,336,426	126,797,869	217,832,363	297,944,347	392,708,148	1,168,194,713
MA	21,266,109	63,600,440	111,179,814	187,125,669	321,472,413	439,599,643	579,547,466	1,723,893,847
MI	31,264,158	93,562,472	163,561,496	275,309,015	473,018,471	646,979,789	852,753,273	2,536,564,865
MN	12,043,029	36,013,638	62,956,431	105,959,561	182,033,188	248,979,264	328,187,728	976,181,861
MS	11,586,811	34,656,337	60,580,867	101,983,160	175,167,578	239,588,894	315,790,406	939,356,081
MO	12,357,589	36,955,260	64,077,061	107,847,367	185,279,309	253,416,101	334,014,396	993,943,073
MT	3,662,717	10,953,059	19,147,004	32,228,108	55,362,831	75,723,628	99,807,575	296,882,787
NE	4,231,861	12,655,013	22,122,228	37,233,670	63,966,556	87,480,076	115,316,509	343,014,913
NV	2,216,415	6,627,998	11,586,402	19,500,844	33,501,654	46,822,479	60,396,431	179,852,306
NH	2,242,136	6,704,813	11,720,536	19,727,243	33,890,408	46,354,226	61,097,300	181,737,074
NJ	26,341,293	75,780,942	132,472,847	222,983,228	383,039,536	523,909,398	690,540,070	2,054,047,104
NM	6,452,056	19,294,316	33,726,266	56,767,674	97,534,330	133,390,707	175,816,948	522,973,821
NY	92,036,183	275,223,248	481,117,894	809,783,806	1,391,135,170	1,902,748,142	2,507,921,858	7,459,945,101
NC	21,111,610	63,132,144	110,381,248	185,747,843	319,105,379	436,462,388	575,280,191	1,711,200,841
ND	3,240,126	9,689,313	16,937,886	28,507,963	48,975,238	66,966,758	88,282,102	262,628,417
OH	33,453,487	100,059,758	174,878,478	294,337,668	505,657,229	691,922,054	911,884,119	2,711,883,792
OK	8,837,280	26,819,450	50,378,274	84,792,783	145,669,718	199,242,456	262,612,007	781,152,878
OR	8,614,338	25,780,432	45,031,804	75,792,528	130,207,717	178,094,016	234,757,264	698,258,087
PA	40,561,265	121,265,060	211,863,404	356,796,884	612,841,798	838,362,481	1,105,006,736	3,286,896,843
RI	4,466,275	13,353,017	23,342,408	39,287,343	67,495,863	92,318,707	121,678,944	361,834,366
SC	11,809,952	35,318,840	61,737,010	103,906,870	178,510,172	244,180,581	321,818,487	957,256,708
SD	2,348,722	6,724,810	11,756,288	19,786,184	33,989,891	46,490,398	61,276,783	182,270,866
TN	21,290,457	63,667,271	111,286,740	187,322,287	321,810,211	440,161,873	580,156,437	1,725,705,287
TX	51,348,464	153,553,138	268,436,309	451,788,138	776,143,986	1,061,566,374	1,399,226,076	4,162,067,289
UT	5,336,447	15,955,192	27,891,267	46,943,480	80,648,518	110,305,788	145,386,780	432,468,495
VT	1,878,487	5,618,485	10,347,880	17,416,361	29,920,408	40,934,186	53,940,232	160,448,007
VA	11,453,278	34,250,037	59,872,481	100,770,706	173,116,867	236,786,868	312,087,236	928,349,348
WA	14,928,871	44,643,487	78,041,266	131,360,414	225,653,352	308,641,580	406,806,752	1,210,084,780
WV	13,302,762	39,780,756	69,540,735	117,049,228	201,074,336	275,025,143	362,494,928	1,078,268,888
WI	14,956,287	44,725,513	78,184,956	131,591,722	226,067,808	309,206,586	407,563,106	1,212,287,770
WY	1,372,663	4,104,891	7,175,759	12,077,439	20,748,428	28,379,046	37,406,071	111,265,316

TABLE 2

The cut in the disproportionate share program alone represents a significant loss to many state governments. For example, as the following chart shows, California, New York, Texas and Louisiana would suffer the greatest losses in federal aid from the Dole plan, and would have to turn to their own state resources to compensate hospitals.

TOTAL LOSS IN DISPROPORTIONATE SHARE

State	FY96 DSH reduced by 25%	FY97 DSH reduced by 25%	FY98 DSH reduced by 25%	FY99 DSH reduced by 25%	FY2000 DSH reduced by 25%	FY2001 DSH reduced by 25%	FY2002 DSH reduced by 25%	FY2003 DSH reduced by 25%	TOTAL DSH reduced FY96-2003
TOTAL	3,844,508,834	3,836,744,203	4,430,322,346	4,738,824,738	5,316,852,631	6,807,221,660	6,487,944,036	7,086,807,146	41,350,747,564
AL	111,442,731	130,755,811	136,287,844	148,544,436	167,157,481	166,738,846	204,301,847	202,872,846	1,300,106,838
AK	10,282,483	11,130,014	12,842,194	13,708,436	16,423,116	17,136,823	18,880,886	20,843,776	119,946,838
AZ	22,340,188	24,201,106	27,853,226	29,786,714	33,906,239	37,281,771	40,854,848	44,877,752	280,930,821
AR	708,994	762,686	879,863	936,871	1,066,869	1,179,806	1,290,822	1,407,861	8,213,464
CA	472,066,866	518,474,875	561,286,472	630,734,860	708,576,740	766,416,716	867,351,766	946,084,876	5,514,801,002
CO	20,437,966	28,940,941	33,048,116	36,948,216	39,956,371	44,081,086	46,467,181	52,572,866	306,439,000
CT	76,216,067	82,847,033	86,286,842	101,832,074	114,322,963	127,023,822	136,728,204	152,427,316	886,170,840
DE	886,402	1,048,803	1,207,817	1,384,486	1,448,846	1,816,880	1,771,848	1,886,882	11,374,166
DC	8,574,827	9,284,804	10,717,837	11,432,387	12,841,447	14,280,862	16,716,366	17,146,861	100,203,844
FL	48,048,012	53,173,784	61,261,825	68,444,286	73,894,809	81,804,803	88,884,736	96,164,346	572,826,818
GA	71,463,276	77,487,817	89,247,822	95,307,006	107,220,377	116,132,561	131,046,817	142,867,842	833,821,864
HI	8,173,186	8,554,813	10,216,780	10,867,181	12,264,286	13,631,208	14,863,430	16,346,427	96,346,370
ID	286,442	281,264	334,280	348,916	389,146	452,369	476,821	516,866	3,086,883
IL	44,676,838	48,364,066	56,337,087	59,941,481	67,006,810	74,481,844	81,886,146	88,340,826	521,166,706
IN	7,844,842	8,806,431	9,530,100	10,861,437	11,816,486	13,240,414	14,864,466	16,844,346	93,886,334
IA	863,806	1,009,864	1,166,176	1,241,867	1,366,847	1,863,393	1,706,862	1,864,286	10,076,300
KS	36,927,436	43,253,366	46,806,767	53,234,462	56,666,791	66,242,486	73,186,860	79,866,264	466,736,342
KY	36,646,676	39,860,146	43,676,116	46,726,807	54,616,846	60,806,776	66,867,462	76,067,821	426,346,421
LA	266,194,861	291,342,836	336,361,866	364,816,864	403,870,676	446,816,767	480,276,677	536,217,866	3,126,646,763
ME	36,066,344	42,316,467	46,836,726	52,066,066	56,366,866	66,106,862	71,816,260	76,126,167	466,741,816
MD	14,476,376	16,646,802	18,267,852	19,306,264	21,716,167	24,161,866	26,644,186	28,867,066	166,816,416
MA	90,146,177	97,864,271	112,676,467	120,166,830	136,216,432	160,234,862	166,267,676	180,276,824	1,061,946,836
MI	113,166,760	122,626,076	141,466,862	160,926,276	169,766,466	186,661,864	207,617,164	226,340,463	1,330,346,236
MN	6,564,266	7,143,867	8,342,271	8,766,936	9,861,264	10,966,866	12,066,821	13,167,804	76,916,266
MS	64,761,713	46,822,863	56,946,646	59,716,826	67,164,816	74,646,186	82,114,676	89,576,244	522,646,676
MO	167,864,476	170,767,836	187,266,862	210,210,866	236,467,376	262,761,116	286,067,261	316,316,716	1,836,336,467
MT	142,162	164,006	177,661	166,643	213,266	236,867	260,726	284,316	1,666,466
NE	762,606	636,026	863,066	1,016,837	1,146,717	1,276,764	1,367,662	1,536,626	8,606,626
NV	16,616,264	16,616,804	16,616,726	26,626,822	26,486,206	26,026,616	26,626,066	31,226,361	182,176,661
NH	6,866,276	7,676,176	6,744,866	9,626,162	10,464,146	11,666,046	12,626,062	13,661,841	81,626,726
NJ	262,476,266	216,344,726	262,076,946	266,666,361	306,706,466	336,646,166	371,161,616	404,636,146	2,366,146,646
NM	2,416,666	2,616,666	3,616,616	3,216,671	3,616,606	4,061,266	4,466,466	4,626,616	26,146,266
NY	606,616,676	646,126,767	666,667,467	676,666,461	766,646,767	844,614,616	666,266,676	1,016,766,666	6,616,726,164
NC	66,766,666	61,626,616	106,646,626	116,616,266	126,146,666	141,266,626	166,266,616	166,616,666	666,676,666
ND	6,666	6,616	6,706	6,866	6,446	6,861	6,426	6,666	64,667
OH	166,676,626	166,266,966	126,626,776	136,266,464	161,606,776	167,761,462	164,666,646	201,226,664	1,176,676,646
OK	6,066,676	6,646,606	7,606,646	6,116,606	6,126,166	10,146,261	11,166,606	12,176,626	76,666,266
OR	4,766,626	6,161,661	6,676,661	6,676,676	7,176,161	7,671,166	6,766,266	6,666,266	66,766,266
PA	167,466,466	161,416,446	206,616,266	226,276,626	261,166,606	276,066,666	306,606,666	336,616,606	1,866,666,176
RI	16,366,126	21,606,676	26,246,866	26,667,626	26,066,066	62,661,664	66,266,166	66,766,606	266,266,616
SC	116,606,662	126,661,611	146,116,266	166,666,466	176,267,666	196,626,671	216,211,626	236,766,467	1,366,666,126
SD	6,666	6,626	6,766	6,666	6,466	6,626	6,426	6,616	66,661
TN	106,166,466	116,166,266	126,226,062	146,246,266	162,276,266	160,266,666	166,226,426	216,666,476	1,262,066,616
TX	362,626,666	366,066,167	466,466,676	666,767,666	666,216,776	606,676,146	666,146,666	726,606,761	4,226,766,676
UT	1,266,662	1,361,661	1,666,766	1,666,777	1,671,766	2,676,766	2,666,676	2,466,626	14,666,676
VT	6,142,666	6,466,666	6,176,216	6,626,666	6,216,646	6,606,426	7,266,676	6,266,646	46,666,226
VA	26,626,166	26,266,716	26,466,226	26,466,661	26,466,211	46,646,466	66,661,146	66,666,266	266,626,606
WA	62,666,616	66,616,266	66,766,761	76,166,616	76,666,666	66,766,616	66,466,676	106,266,666	616,666,616
WV	26,666,666	26,666,466	66,676,626	66,666,676	66,666,626	66,626,676	66,611,676	66,766,676	666,666,466
WI	1,766,666	1,666,766	6,166,266	6,676,776	6,666,466	6,646,166	6,161,666	6,416,666	66,666,266
WY	66,161	66,666	66,616	66,646	66,666	66,666	46,466	46,266	266,666

TABLE 3

Total Shortfall Due to Dole Medicaid Cuts

State	TOTAL SHORTFALL ACUTE & DSH FY96-2003
TOTAL	114,737,126,429
AL	2,236,239,893
AK	293,029,370
AZ	1,641,581,265
AR	822,886,112
CA	13,071,822,666
CO	1,090,617,561
CT	1,441,807,270
DE	143,024,591
DC	430,070,552
FL	3,957,783,375
GA	2,667,278,942
HI	286,318,710
ID	214,771,527
IL	2,994,682,500
IN	1,697,512,230
IA	595,882,771
KS	1,040,751,113
KY	1,923,802,498
LA	5,606,100,901
ME	830,548,060
MD	1,337,043,132
MA	2,775,540,456
MI	3,857,128,581
MN	1,053,081,719
MS	1,461,881,624
MO	2,832,879,569
MT	298,541,283
NE	351,910,442
NV	361,831,786
NH	263,357,795
NJ	4,416,187,944
NM	561,122,841
NY	13,373,673,255
NC	2,700,080,141
ND	262,664,004
OH	3,886,059,134
OK	852,149,280
OR	754,036,356
PA	5,240,584,812
RI	588,189,167
SC	2,321,066,825
SD	182,305,487
TN	2,987,801,204
TX	8,394,834,231
UT	447,024,435
VT	208,779,240
VA	1,212,176,153
WA	1,824,034,237
WV	1,427,064,348
WI	1,232,218,185
WY	111,533,168

METHODOLOGY

1. The 6% Per Recipient Cap on Federal Medicaid Acute Spending

Medicaid expenditures for medical assistance are based on Health Care Financing Administration (HCFA) form 64. From this total, skilled nursing facilities, ICF/MR, and DSH expenses were subtracted.

Recipient data taken from HCFA form 2082. Skilled nursing facility and ICF/MR recipients were subtracted to give acute care recipients. Projections for the number of Medicaid recipients are based on HCFA's national estimates. Projections for federal cost per capita are based on Congressional Budget Office (CBO) estimates.

Federal cost per capita = Acute care expenditures/FY 93 acute recipients.

The difference in the cost per capita under Dole is the uncapped projections less the Dole capped projections for each year. This difference is then multiplied by total recipients and added to each state's share of total Medicaid costs.

2. Disproportionate Share Cut of 25%

HCFA projections for disproportionate share for 1996 through 2003 were reduced 25%, and these cuts were distributed across all 50 states according to their 1993 shares of total disproportionate share spending.

3. State Budget Projections

All state general fund FY 1993 figures come from the National Association of State Budget Officers (NASBO), as reported in Fiscal Survey of the States, 4/94. State Medicaid expenditures are derived from HCFA cost reports for FY 1993. These were compared with total state Medicaid spending as reported by NASBO, and in most cases agree (see notes at bottom of tables).

Budget data was projected based on the following assumptions:

a. State general fund budgets will increase on average by 7% annually (this is the nominal average from FY 1979-94, according to NASBO).

b. Total state Medicaid spending will increase 9% annually without system-wide health care reform (i.e. the Dole Plan). This is lower than recent experience, and is taken from 1994 CBO projections and HCFA preliminary estimates.

c. The "Dole effect" of capping federal Medicaid expenditures per recipient is then added to the state share in each year beginning in FY 1997.

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CHA

For Release: Immediate
Monday, July 18, 1994

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STUDY CONCLUDES THAT INCREMENTAL REFORMS WOULD FORCE MIDDLE INCOME FAMILIES TO PAY MORE FOR THEIR HEALTH CARE

Insurance Reform Proposals, Without Universal Coverage, Found to Drive Up Health Care Spending for Insured Families Making Between $20,000 -$75,000

Senator Jay Rockefeller (D-West Virginia) and Senator Patty Murray (D-Washington) today released the findings of a new Lewin-VHI Study that was commissioned by the Catholic Health Association to measure the impact of several health reform plans on household spending for health care at various income levels. A central finding of the study is that a "managed competition" approach, or insurance reforms linked to subsidies, but without universal health coverage, significantly increases household health costs for families making between $20,000 and $75,000 per year.

"What this study shows is that an incremental approach to health care reform, and failure to enact universal coverage, will have a substantial impact on virtually all but the wealthiest families in America. Any Senator who advocates a non-universal approach will now have to explain why he or she is backing a plan that forces middle class families to pay more for health care without giving them any additional health security," Senator Rockefeller said.

"Incremental reform will force families making between $20,000 and $75,000 per year -- and that's almost 60% of the families in America -- to spend more on health care. In contrast, a universal coverage approach, linked to cost controls and employer contributions, would lower spending on health care for every insured family making less than $100,000. What this information tells us is that the "go slow idea" on health care reform is the equivalent of putting a 10 m.p.h. speed limit on ambulances -- it's costly and it's dangerous," Senator Murray said.

"Insurance reforms, without universal coverage, causes higher premiums because coverage would be extended to older adults and people with pre-existing

conditions -- people who typically consume more health care -- without the offsetting factor of extending coverage to all of the presently uninsured, many of whom are young and healthy. Higher premium costs would in turn cause many small businesses and young people to drop their insurance coverage. Year after year, the result would be a vicious cycle of upwardly spiraling health insurance premium costs. The failure of incremental reform can already be seen in New York State, which enacted insurance reforms without universal coverage, and insurance premiums shot up 18% in the first year," said William Cox, vice-president of the Catholic Health Association, who commissioned the study.

"First the opponents of comprehensive health care reform said no to cost constraints. Then they said no to requiring employers and employees share costs. Now they are saying no to universal coverage. Every time the incrementalists and obstructionists say no to real reform, what they are really saying is yes to higher health care spending for every insured middle income family in America. The time has come to say no to the incrementalists, and reject their phony reform ideas, before they ever get the chance to give the rich a break and put billions more on the backs of the middle class," Senator Rockefeller said.

The Catholic Health Association of the United States, a member of the Management Committee of the Health Care Reform Project, represents more than 1,200 Catholic-sponsored facilities and organizations. The members, located across the country, make up the nation's largest group of not-for-profit health care facilities under a single form of sponsorship.

-30-

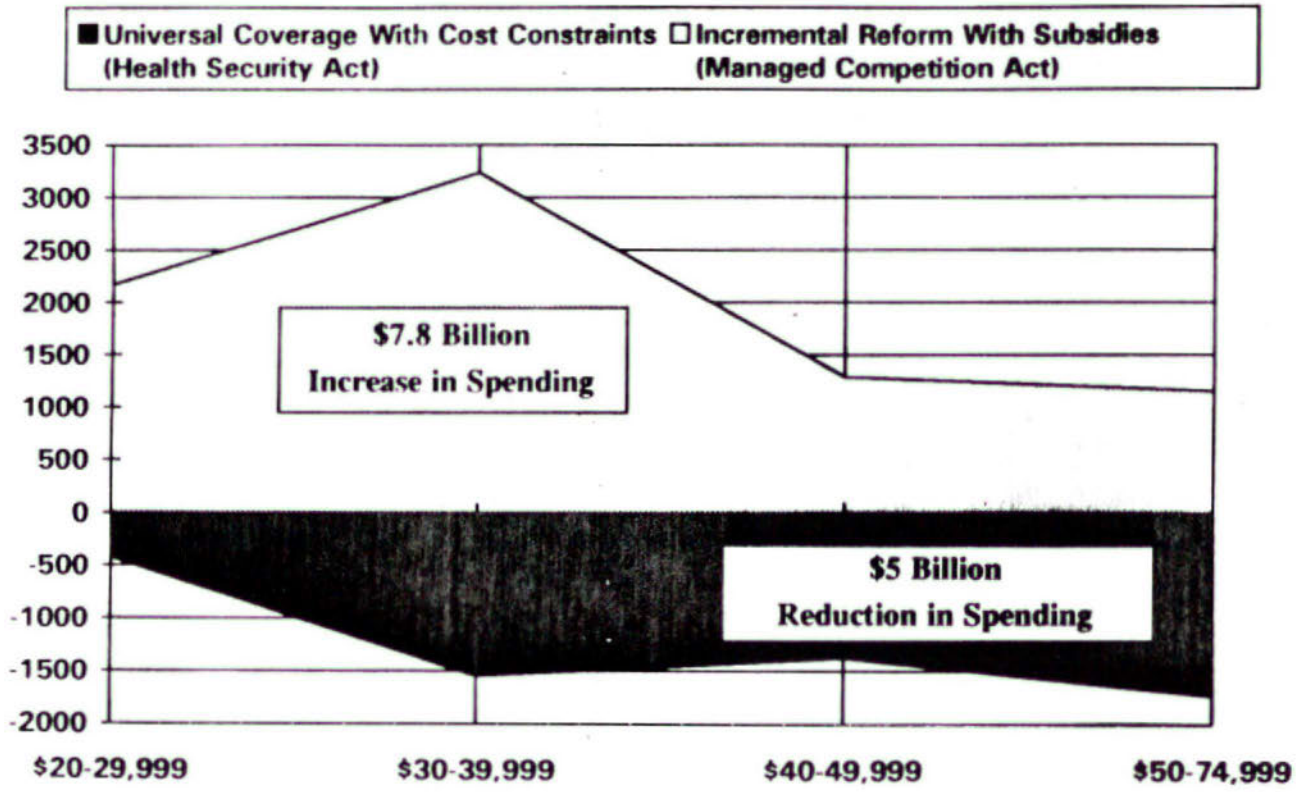
Household Spending Implications of Health Reform

"Our analysis shows that premiums are lower under universal coverage than under insurance market reform linked to subsidies. Further, we estimate that middle income families that currently have insurance will pay more in general for health care under partial reform than under reform that includes universal coverage. In addition, for currently insured households earning less than $100,000 annually, health spending will decline under universal coverage with an employer mandate and cost constraints."

- Lewin-VHI
July 18, 1994

Impact of Health Care Reform on Insured, Middle Income Households

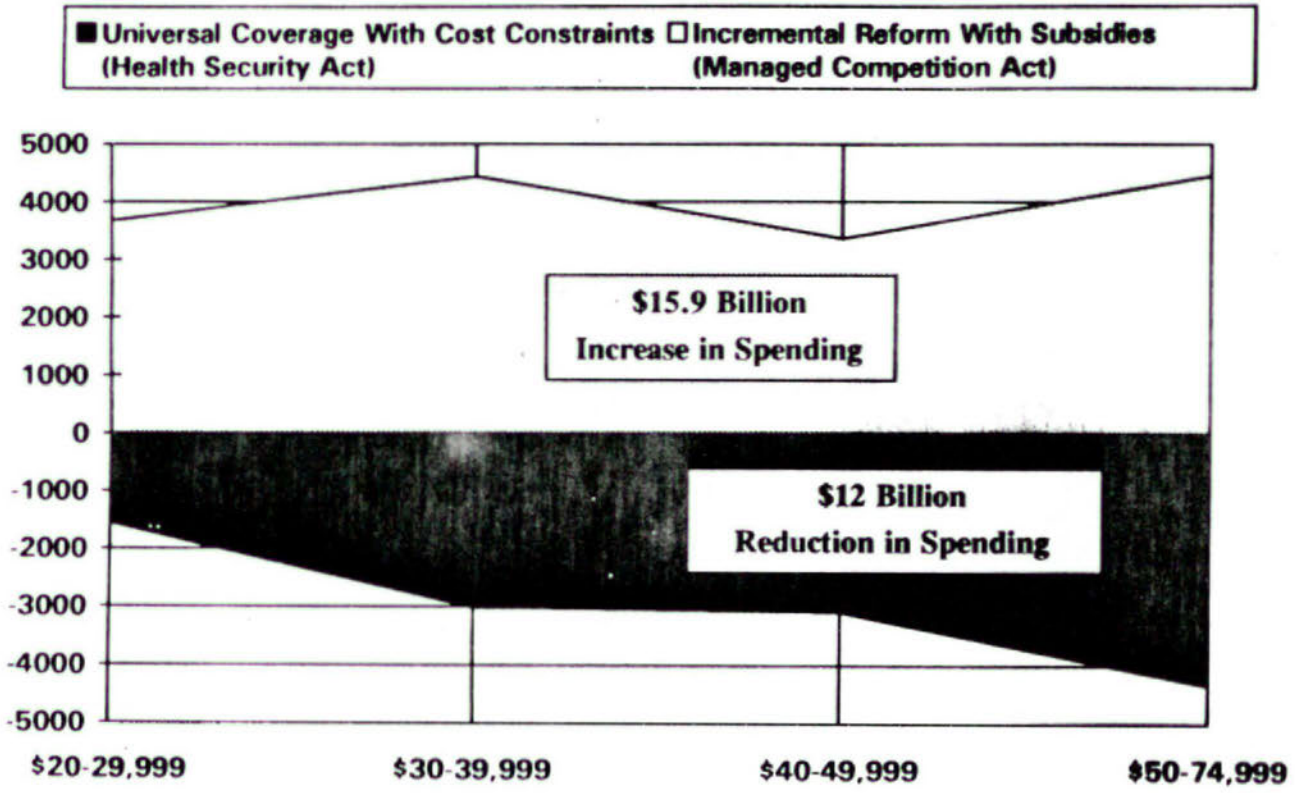
(with wage effects)



Source: Catholic Health Association based on Lewin-VHI Study:
Coverage, Premium and Household Spending Implications of Health Reform, July 1994

Impact of Health Care Reform On Insured, Middle Income Households

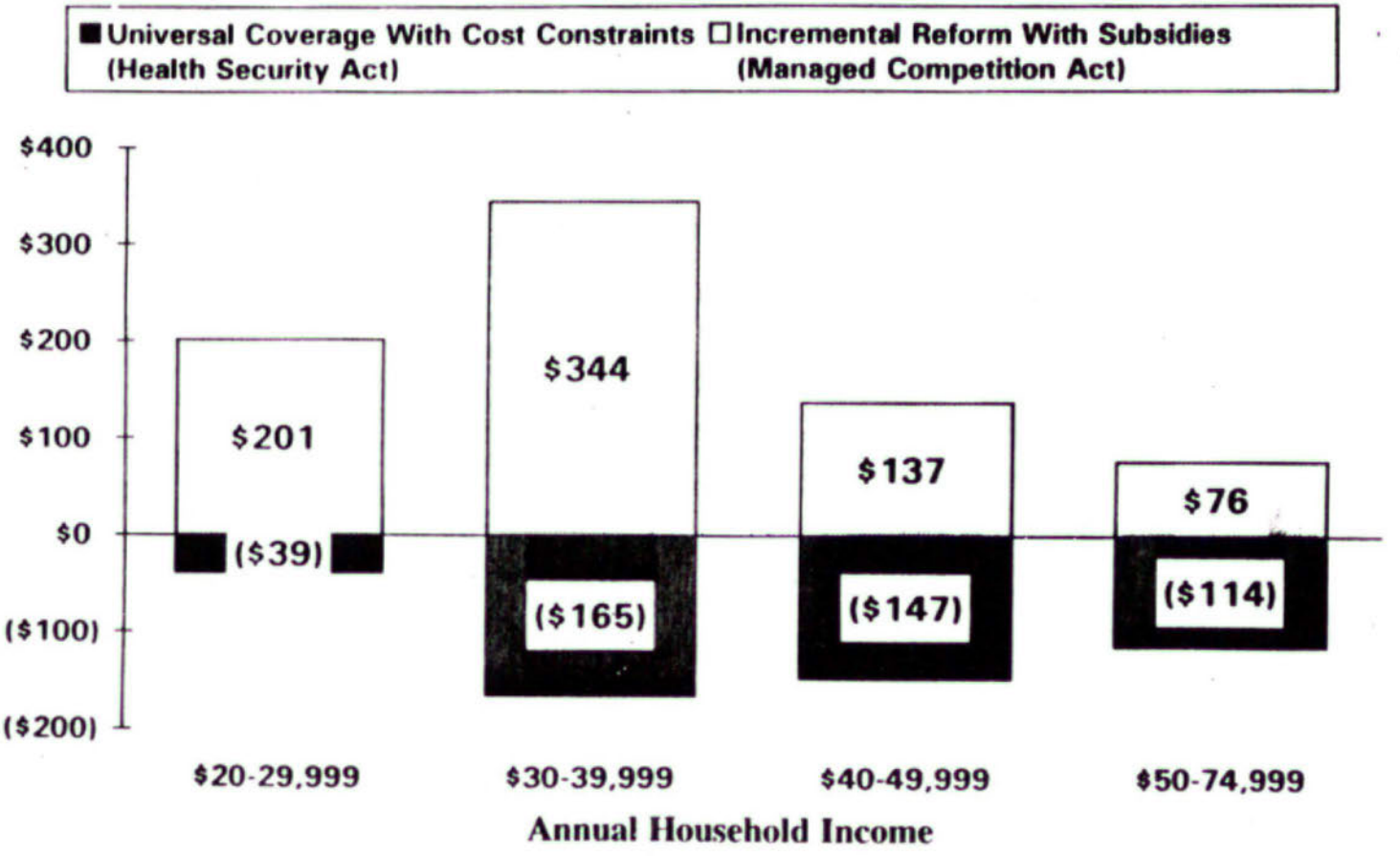
(without wage effects)



Source: Catholic Health Association based on Lewin-VHI Study:
Coverage, Premium and Household Spending Implications of Health Reform, July 1994

Impact of Health Care Reform Proposals on Insured Household Spending

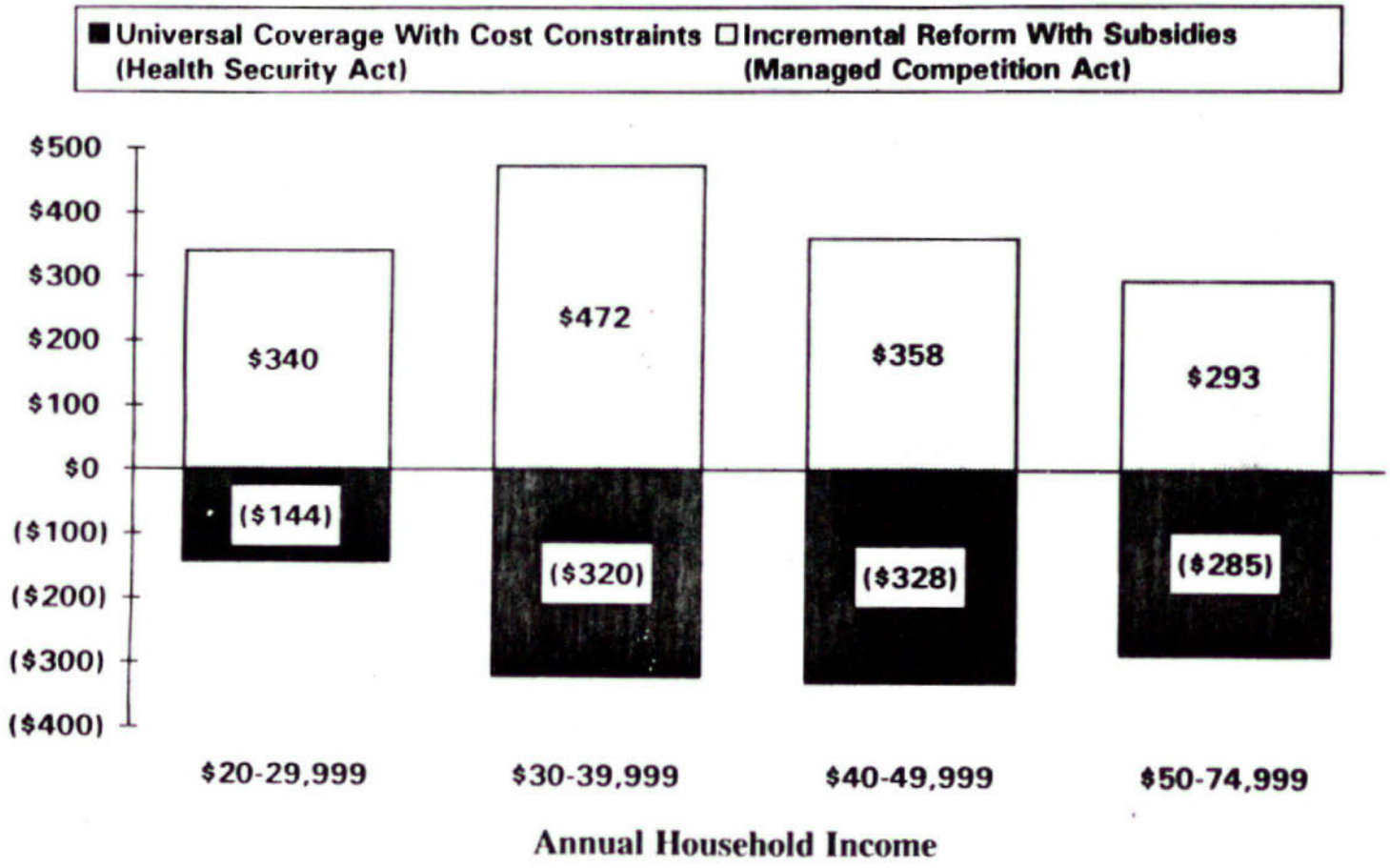
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Source: Catholic Health Association based on Lewin-VHI Study:
Coverage, Premium and Household Spending Implications of Health Reform, July 1994

Impact of Health Care Reform Proposals on Insured Household Spending

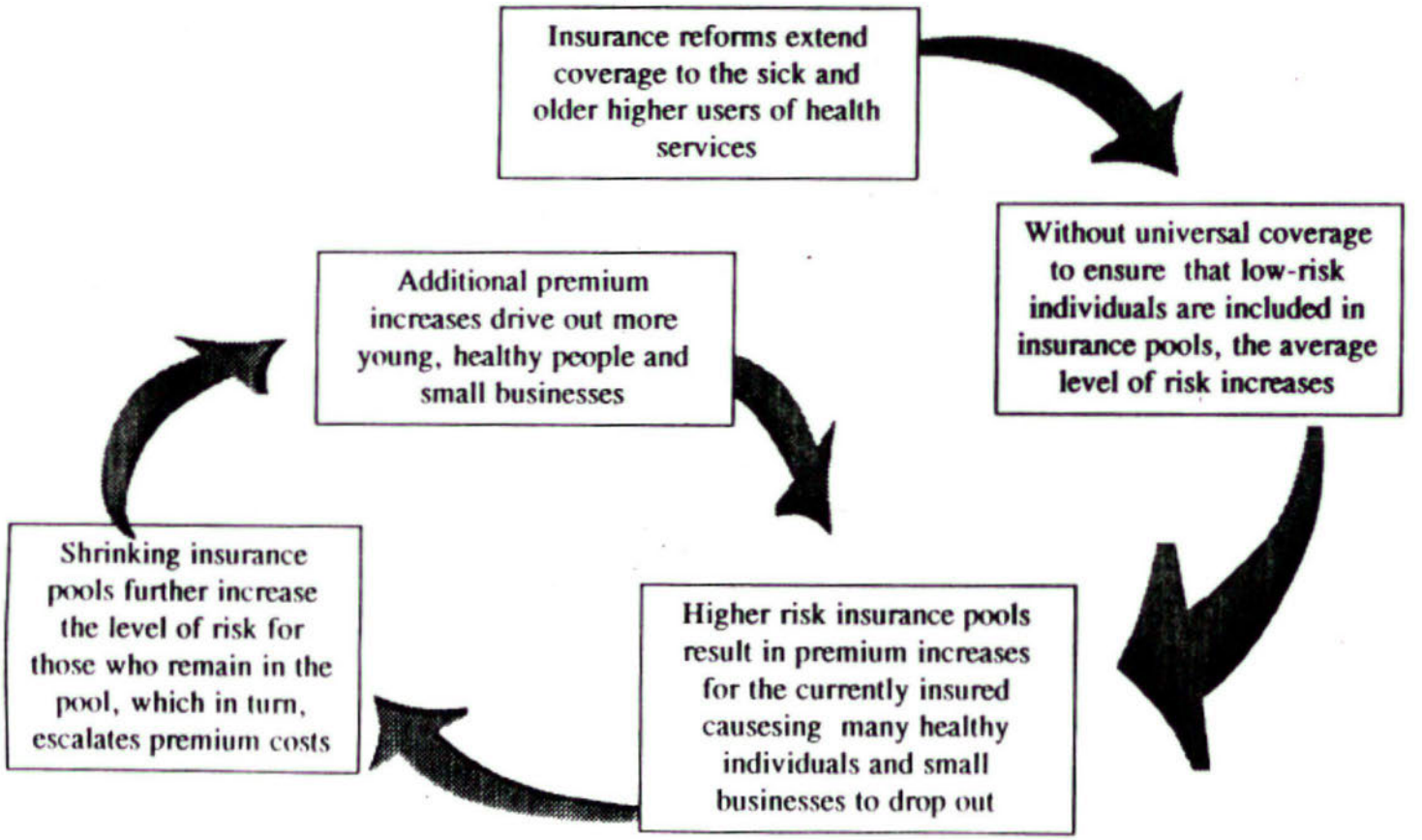
(without wage effects)



Source: Catholic Health Association based on Lewin-VHI Study:
Coverage, Premium and Household Spending Implications of Health Reform, July 1994

The Vicious, Upward Spiral

The Impact of Incremental Reform on Insurance Premiums



COVERAGE, PREMIUM, AND HOUSEHOLD SPENDING IMPLICATIONS OF HEALTH REFORM

PREPARED FOR:

THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES
DIVISION OF GOVERNMENT SERVICES
WASHINGTON, D.C.

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JULY 18, 1994

94FM0180

EXECUTIVE SUMMARY

The ongoing debate on national healthcare reform has recently focused on President Clinton's insistence that the final bill include universal coverage. Three congressional committees have reported-out bills with universal coverage while the Senate Finance Committee recently completed work on a bill which achieves partial coverage. This paper estimates the number of persons covered under selected partial approaches to health reform and then quantifies the differences among partial and universal approaches with regard to: health spending for persons who remain uninsured; insurance premiums for those who are currently insured; and household spending on health care. We compare:

- Insurance market reforms alone;
- Insurance market reforms combined with premium subsidies as in the Managed Competition Act (whose lead sponsors are Representative Jim Cooper (D, TN) in the House and Senator John Breaux (D, LA) in the Senate);
- Universal coverage as applied to the Managed Competition Act (individual mandate)[ES-1] ; and
- Universal coverage under the President's Health Security Act (employer mandate).

The bills recently reported-out by the Senate Labor and Human Resources Committee and the House Education and Labor Committee include universal coverage and are similar to the Health Security Act. The bill reported-out by the Senate Finance Committee and legislation recently introduced by Senator Bob Dole include insurance market reform and subsidies, but not universal coverage.

Our analysis shows that premiums are lower under universal coverage than under insurance market reform or insurance market reform linked to subsidies. Further, we estimate that middle income families that currently have insurance will pay more in general for health care under partial reform than under reform that includes universal coverage. In addition for currently insured households earning less than $100,000 annually, health spending will decline under universal coverage with an employer mandate and cost constraints.

ES-1 The Managed Competition Act as written does not include universal coverage. For illustrative purposes only, this analysis assumes an expansion of the Act to include all persons.

Insurance Coverage

We estimate that insurance market reforms alone will cover about 1.1 million persons, or about three percent of all persons projected to be uninsured in 1998 ***(Table ES-1)***. When these reforms are linked with subsidies as specified in the Managed Competition Act, about 40 percent of the uninsured would be covered. This would leave about 22.3 million uninsured persons in 1998.

Table ES-1

Number of Persons Remaining Uninsured Under Selected Approaches in 1998

Reform Scenario	Number of Persons That:		Percent Reduction
	Become Insured (millions)	Remain Uninsured (millions)	
Current System	--	37.2	--
Insurance Market Reform Only[a]	1.1	36.0	3.0%
Insurance Market Reform with Subsidies[b]	14.9	22.3	40.0%

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

Expenditures For The Remaining Uninsured

Under current policy, the uninsured would consume about $45.4 billion in health services in 1998.[ES-2] Persons who remain uninsured under the Managed Competition Act would continue to consume about 55 percent of this amount, or $24.8 billion. This amount includes out-of-pocket spending, free care provided by physicians, hospital uncompensated care, and care provided in public hospitals and clinics. Overall, about 97 percent of national health spending would be covered through insurance under the Managed Competition Act.

Much of the remaining care for the uninsured would continue to be financed through cost shifting to the privately insured. As markets become increasingly competitive, physicians and hospitals will be put under increasing pressure to either avoid the uninsured or lose financially. In this way partial reform could perpetuate the destabilizing effects of the cost shift.

ES-2 Assuming a benefits package comparable to that of the President's Health Security Act.

Changes In Insurance Premiums For The Currently Insured

In general, we find that average premiums would increase if coverage were expanded through insurance market reforms and premium subsidies *(See Table ES-2)*. This is because those who would obtain coverage under these policies would tend to be individuals in relatively poor health who are above average users of health services.

Table ES-2
Number of Persons and National Average Premiums for Persons Under Alternative Reform Scenarios in 1998

Reform Scenario	National Average		Increase In Average Annual Premium for an Insured Family[d]
	Size of Pool (in millions)	Monthly Per-Capita Premium	
Currently Insured	185.6	$172	---
Insurance Market Reform Only[a]	186.8	$176	$104
Insurance Market Reform with Subsidies[b]	200.5	$182	$260
Universal Coverage[c]	222.8	$175	$78

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act. 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

c For consistent analysis, universal coverage is based on the Managed Competition Act expanded to include an individual mandate. An employer mandate could be used to attain universal coverage as in the Health Security Act. The premium changes shown in this analysis would be the same under either mandate because we focus only on premium amounts regardless of payer.

d Change in average premium compared to premium without reform. All premiums have been standardized to the Health Security Act benefits package.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

This increase in average premiums is largely averted under a program of universal coverage because such a plan would require all individuals to participate in the insurance pool including healthier individuals who receive little health care. Specifically:

- Without reform, the overall average monthly premium for currently insured persons would be $172 per person in 1998.[ES-3]

ES-3 This premium amount for 1998 is standardized to reflect the standard benefits package in the Health Security Act. The benefit package is used throughout this analysis because the Managed Competition Act does not specify a standard benefit package.

- Subsidies linked to insurance market reforms (as in the Managed Competition Act) would increase average monthly premiums from $172 to $182 for persons who already have coverage. This amount translates into an annual increase of $260 for currently insured families.

- Going beyond the Managed Competition Act to provide for universal coverage would lower the average monthly premium to $175 per person as healthier persons are brought into the insurance pool, less than 2 percent higher than the average premium paid by the currently insured. This translates into an annual increase of about $78 for a currently insured family in 1998.

It is important to note that a universal coverage program would require a net increase in federal premium subsidies. For example, we estimate that an expansion of the Managed Competition Act to include universal coverage would increase federal subsidy costs by $17 billion and reduce tax revenues by $11 billion in 1998. However, federal subsidy costs would vary by specific proposal.

Universal coverage also reduces consumer exit and entry into health insurance markets because if people can move freely in and out of the system, the healthy will tend to avoid insurance coverage until they become ill. The Managed Competition Act addresses this by permitting six month pre-existing condition exclusions which encourages people to maintain insurance coverage. To the extent that this issue is not addressed in a reform proposal, premiums are driven up, encouraging more people to become uninsured.

Changes in Household Health Spending

In addition to the effects on premiums, we examine the impact of insurance reform linked to premium subsidies and universal coverage on net household health care spending. This analysis accounts for household premium payments, subsidy policies, tax deduction revisions, and wage effects resulting from changes in employer costs under health reform. Specifically, we compare changes in household health spending for the under 65 population across: the Managed Competition Act as written; the Managed Competition Act coupled with universal coverage; the President's Health Security Act as written; and the Health Security Act without premium growth constraints.

On average, all reform scenarios reduce spending of households earning less than $10,000. The Health Security Act also reduces spending for families earning less than $100,000, assuming that employers absorb the 80 percent share of the premium they are required to pay under the Act. Generally accepted economic theory suggests that most of these employer costs are shifted to employees in the form of wage reductions. When this "wage effect" is considered, all of the reform scenarios result in some additional costs for families earning $20,000 to $75,000, although the amounts are generally higher for the Managed Competition Act with universal coverage than for the Health Security Act.

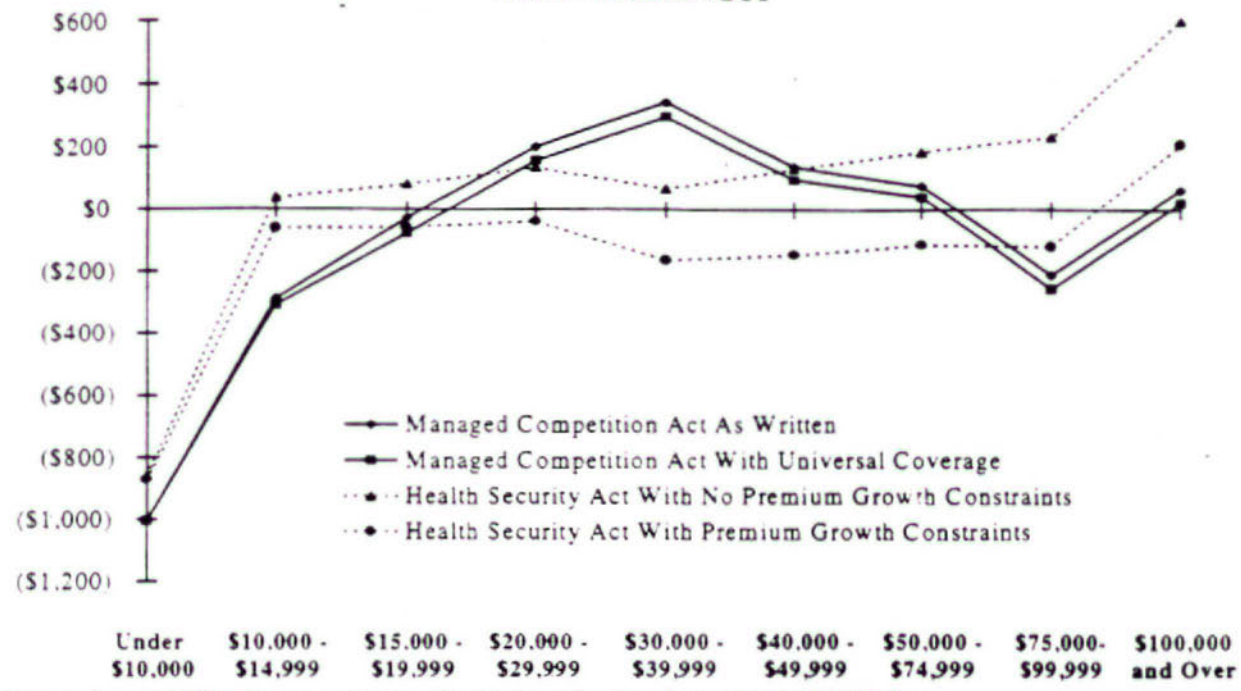
For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects.[ES-4] ***Figure ES-1*** shows the net changes in household health spending for the currently insured population in 1998 by family income accounting for wage effects. ***Figure ES-2*** shows the same effects but does not include the wage effect.

Currently insured families earning less than $10,000 a year see a net decrease in health spending under all four approaches, but middle income families that already have insurance generally see an increase in spending under the Managed Competition Act with or without universal coverage. These middle income families also spend slightly less under the Managed Competition Act if it includes universal coverage because average premiums are lower when all persons are brought into the pool.

Of the three universal coverage approaches, the Health Security Act as written is the only one that reduces household spending for currently insured middle income families, with or without wage effects.

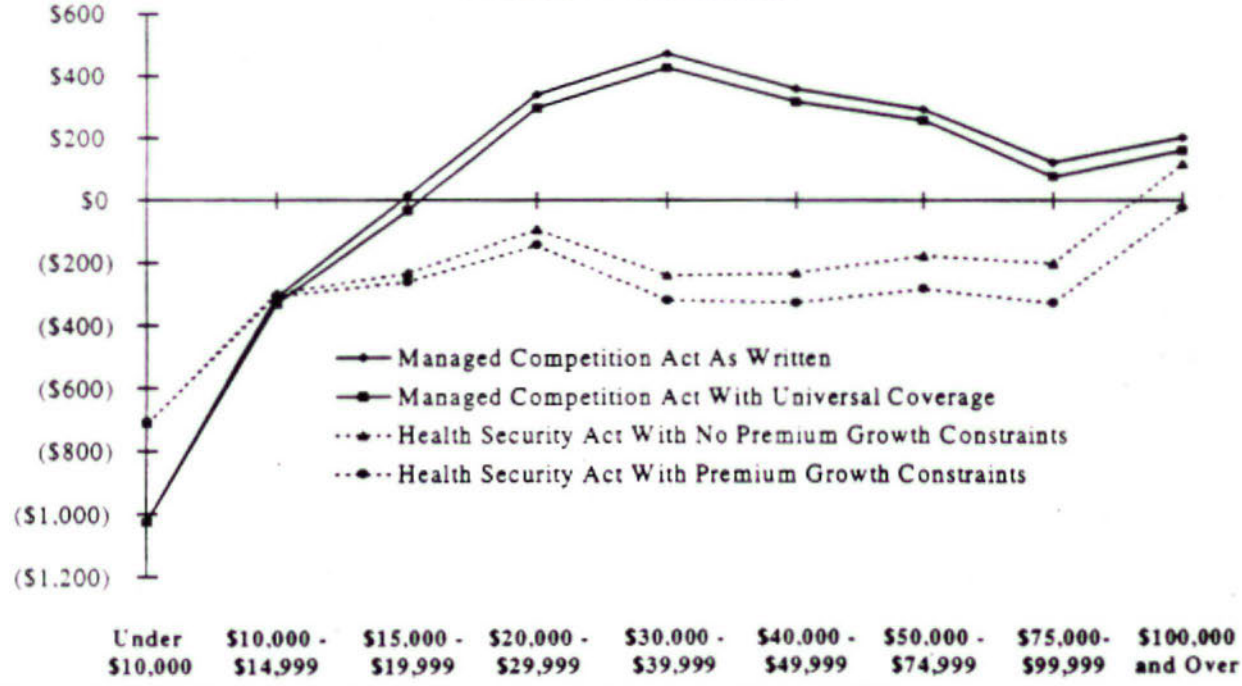
ES-4 To estimate the wage effect, we assume that 88 percent of new employer costs (based on econometric studies) are eventually passed on to employees in the form of wage reductions, ***and*** that 88 percent of new employer savings are generally passed on to employees in the form of wage increases.

FIGURE ES-1
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED POPULATION UNDER AGE 65 BY INCOME WITH WAGE EFFECT



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

FIGURE ES-2
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED POPULATION UNDER AGE 65 BY INCOME WITHOUT WAGE EFFECT



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

COVERAGE, PREMIUM, AND HOUSEHOLD SPENDING IMPLICATIONS OF HEALTH REFORM

The ongoing debate over national health care reform has recently focused on President Clinton's continued insistence that any bill he signs must provide health insurance coverage for all Americans. The President's Health Security Act requires that all employers provide health insurance coverage to their workers while non-workers would be eligible for subsidized coverage through regional alliances. In contrast, a number of bills which attempt to expand insurance coverage without a mandate have received significant attention on Capital Hill including the one passed recently by the Senate Finance Committee. These bills range from incremental reform based on restructuring the small group insurance market to the Managed Competition Act (MCA).

In recent weeks, considerable attention has been given to the Managed Competition Act for its potential to cover 91 percent of all Americans while accounting for about 97 percent of potential national health spending.[1] Relatively little attention has been paid, however, to some of the important financial implications of expanding insurance coverage without universal coverage, especially the impact on health care financing for the remaining uninsured and insurance premium levels for families who are currently insured.

In this study we compare four reform approaches:

- Insurance market reforms alone;
- Insurance market reforms combined with subsidies as in the Managed Competition Act;
- Universal coverage as applied to the Managed Competition Act (individual mandate)[2]; and
- Universal coverage under the Health Security Act (employer mandate).

The purpose of the analysis is first to determine how many people remain uninsured under the various reform options and then to determine the consequences of leaving portions of the population uninsured in terms of:

- Health spending for persons who remain uninsured;

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[1] See "Expanding Insurance Coverage Without a Mandate" prepared for the Health Care Leadership Council by Lewin-VHI, May 18, 1994. The estimate of covered national health spending assumes those insured have the standard benefits package specified in the Health Security Act.

[2] The Managed Competition Act as written does not include universal coverage. For illustrative purposes only, this analysis assumes an expansion of the Act to include all persons.

- Per-capita health insurance premiums for persons currently insured: and
- Average household health spending.

The report addresses each of these issues in turn.

I. COVERAGE UNDER THE REFORM ALTERNATIVES

We estimate that there will be about 37.2 million uninsured persons at any given point in time during 1998.[3] This estimate is based upon detailed insurance coverage data reported in the 1987 National Medical Expenditures Survey (NMES) data projected to future years based upon insurance coverage trends reported in the Current Population Survey (CPS) data for 1987 through 1993.[4]

A. Insurance Market Reform

Insurance market reforms are intended to regulate medical underwriting and other barriers to coverage. Medical underwriting is a process by which insurers review the health status of individuals (or firms) who apply for insurance to determine whether they are an acceptable risk. Insurers often decline to cover individuals and/or groups due to their health status and are allowed to vary premiums with the health status of the individual making coverage more expensive for some populations. These insurer practices leave many individuals uninsured, either because they (or their firm) are denied coverage or cannot afford the higher-than-average premiums.

The most common insurance market reform proposals attempt to address these problems by assuring that all individuals can obtain insurance at a group rate regardless of their health status. For this analysis, we also assumed that pre-existing condition exclusions would be limited, insurers would be required to renew policies upon request, and that premiums would be community rated for individuals and small groups (under 100) markets. We estimate that these insurance market reforms would reduce the uninsured population by about 1.1 million persons ***(Table 1)***.

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3 This and the other estimates of the uninsured in this paper are described in more detail, including data sources and methodologies in: Lewin-VHI, "Expanding Insurance Coverage Without a Mandate," prepared for the Health Care Leadership Council, May 18, 1994.

4 The NMES data is used because it provides a detailed account of insurance coverage by calendar quarter. NMES reports about 15 percent fewer uninsured persons that the CPS for any given year. It is for this reason that the total number of uninsured used in this study may differ from the total used in other studies.

TABLE 1

NUMBER OF PERSONS REMAINING UNINSURED UNDER SELECTED APPROACHES IN 1998

Reform Scenario	Number of Persons That:		Percent Reduction
	Become Insured (millions)	Remain Uninsured (millions)	
Current System	--	37.2	--
Insurance Market reform Only[a]	1.1	36.1	3.0%
Insurance Market Reform with Subsidies[b]	14.9	22.3	40.0%

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

B. Insurance Market Reform Combined with Subsidies

The Managed Competition Act (MCA) includes the above insurance reforms, but it further encourages increased insurance coverage through premium subsidies for low-income individuals and tax deduction changes for individuals' premium payments. Under the subsidy schedule in the Act, individuals with incomes up to 100 percent of the poverty level would be eligible for full premium and cost sharing subsidies while subsidies would be phased down as income increases from 100 percent to 200 percent of poverty. Premium subsidies also would be available for Medicare recipients with incomes below 120 percent of poverty.

The Act also allows individuals to deduct premium payments for non-group insurance coverage.

To facilitate businesses and individuals purchasing coverage, states would be required to establish one or more Health Plan Purchasing Cooperatives (HPPC). Any individual or small business with fewer than 100 employees would obtain coverage through a HPPC which offers participants more market power in negotiating coverage with health plans.

Overall, about 61 percent of all uninsured persons would be eligible for premium subsidies under the program. Given past experience with Medicaid, however, we assume that many individuals will not obtain coverage even if they are eligible for full subsidies. For example, about 25 percent of those who are now eligible for Medicaid do not enroll. In addition, many persons eligible for partial subsidies are unlikely to obtain coverage, in part because the subsidized premiums will still be high compared to their income.

We estimated the number of uninsured persons who would participate in the subsidized insurance program based upon an analysis of participation rates in the Medicaid program for individuals with various demographic and health status characteristics using the 1987 National Medical Care Expenditure Study (NMES) data. These Medicaid enrollment rates were adjusted to account for individuals who are eligible for only partial subsidies (i.e., incomes between poverty and 200 percent of poverty).

Based on these calculations, we estimate that the MCA would increase the number of insured persons by about 14.9 million, leaving about 22.3 million individuals uninsured. This estimate includes the impact of insurance market reforms, subsidies, and increased tax deductibility of insurance policies.

The uninsured persons who would become covered under the program would tend to be older individuals who are higher users of care. For example, under the Act, about 46 percent of currently uninsured persons age 55 to 64 would become insured compared with only about 31 percent of those between the ages of 18 and 24.

II. HEALTH SPENDING FOR PERSONS WHO REMAIN UNINSURED

Under current policy, the uninsured will consume about $45.4 billion in health services in 1998 *(**Table 2**)*. This estimate includes the value of all health services consumed by the uninsured which meet the definition of covered services under the benefits package proposed in the HSA. This includes: family out-of-pocket payments ($10.7 billion); the value of free care provided by physicians ($1.1 billion); the value of uncompensated care in hospitals ($15.4 billion); and the cost of free care provided in public hospitals and clinics ($18.2 billion).

As noted above, we estimate that about 14.9 million of the 37.2 million currently uninsured would become insured under the MCA. Those who remain uninsured will account for about $24.6 billion in health spending or about 55 percent of the $45.4 billion expended on behalf of the uninsured under current policy. This amount includes: out-of-pocket spending ($5.7 billion); free care provided by physicians ($0.5 billion); hospital uncompensated care ($8.1 billion); and care provided in public hospitals and clinics ($10.3 billion).

The remaining $8.1 billion of hospital uncompensated care and the $0.5 billion free physician care would ultimately be cross subsidized by private payers through higher patient charges and insurance premiums. Partial reform will perpetuate the destabilizing effects of this cost shift as much of the care provided to the uninsured would continue to be shifted to the privately insured.

TABLE 2

HEALTH EXPENDITURES FOR UNINSURED PERSONS POTENTIALLY COVERED UNDER THE HSA BENEFITS PACKAGE IN 1998[a]

	Uninsured Under Current Policy	Persons Who Remain Uninsured Under the MCA
Out-of-Pocket	$10.7	$5.7
Free from Physician	$1.1	$0.5
Hospital Uncompensated Care	$15.4	$8.1
Public Hospitals/Clinics	$18.2	$10.3
TOTAL	**$45.4**	**$24.6**

a. These estimates are based upon health expenditures data for the uninsured as reported in the National Medical Expenditures Survey (NMES) data. These data report utilization for insured and uninsured persons including care provided free by providers. The value of free care was estimated by the Agency for Health Care Policy Research (AHCPR) based upon charges for comparable services reported by insured persons. We calibrated the NMES data (for insured and uninsured persons) to reflect: 1) projections of health spending by source of payment and type of service in 1998 developed by the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO); and 2) projections of hospital uncompensated care based upon data provided by the American Hospital Association (AHA).

These figures exclude spending for services that are not covered under the Health Security Act benefits package such as adult dental care and eyeglasses for adults. These figures also exclude health spending for this group that is covered under the workers compensation program and/or auto insurance. (This should not be an issue since this care is in fact covered by these sources). These figures also do not include the increase in utilization that would occur among those who remain uninsured if they were provided with insurance.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

III. CHANGES IN PER CAPITA HEALTH INSURANCE PREMIUMS

In general, we find that average premiums are higher if coverage is expanded only through insurance market reforms and premium subsidies because those who would obtain coverage under these policies would tend to be individuals in relatively poor health who are above average users of health services. This increase in average premiums is largely averted under a program of universal coverage because such a plan would require all individuals to participate in the insurance pool including healthier individuals who receive little health care.

To estimate changes in health insurance premiums under three reform approaches, we assumed the standard benefits package proposed in the President's Health Security Act (HSA). The President's package is used to standardize comparisons across reform options because the MCA does not specify a standard package. The Congressional Budget Office also makes this assumption in its analysis of the MCA.

A. Insurance Market Reform

We estimate that the average monthly premium for all persons already insured in 1998 would be $172 per person under the HSA benefits package *(**Table 3**)*.[5] Under insurance market reforms only, all individuals may obtain insurance at a group rate regardless of their health status. Most of the 1.1 million persons that would obtain insurance under these reforms are persons in relatively poor health who are above average users of care, and this would increase the overall average monthly per person premium for the currently insured population from $172 to $176.

B. Insurance Market Reform Linked to Premium Subsidies

Under a program that links the insurance market reforms to subsidies, most of the 14.9 million persons who would obtain insurance would be above-average users of health care. This would increase the overall average monthly per-capita premium for the currently insured from $172 to $182. For a family already receiving insurance in 1998, this would translate into a average annual premium increase of $260.

C. Universal Coverage

Under a program of universal coverage, all individuals would be required to obtain insurance broadening the insurance pool to include healthier individuals who would otherwise decline to obtain insurance even if subsidies were available.[6] This broader insurance pool would lower the average premium to $175 per person per month, about two percent greater than the average premium cost for the currently insured population ($172 per person per month). Thus, a universal coverage program would raise average annual premiums for families already insured by about $78 compared to $260 per year under the MCA.

It is important to note, however, that a universal coverage program would require a net increase in federal premium subsidy payments because many of those who would become insured are lower income persons who would qualify for premium subsidies under the Act. We estimate that universal coverage under the MCA would entail an additional $17 billion in federal subsidy

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5 The premium estimate is based on fee-for-service cost sharing and includes coverage for these currently enrolled in Medicaid. The previously insured population excludes the over 65 Medicare beneficiaries.

6 As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

TABLE 3

NUMBER OF PERSONS, NATIONAL AVERAGE PREMIUMS AND CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER ALTERNATIVE REFORM SCENARIOS IN 1998

Reform Scenario	National Average		Increase In Average Annual Premium for an Insured Family[d]
	Size of Pool (in millions)	Monthly Per-Capita Premium	
Currently Insured	185.7	$172	---
Insurance Market Reform Only[a]	186.8	$176	$104
Insurance Market Reform with Subsidies[b]	200.5	$182	$260
Universal Coverage[c]	222.8	$175	$78

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

c For consistent analysis, universal coverage is based on the Managed Competition Act expanded to include an individual mandate. An employer mandate could be used to attain universal coverage as in the Health Security Act. The premium changes shown in this analysis would be the same under either mandate because we focus only on premium amounts regardless of payer.

d Change in average premium compared to premium without reform. All premiums have been standardized to the Health Security Act benefits package.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

payments and $11 billion in reduced tax revenue for a total federal cost of $28 billion. However, federal subsidy costs will vary by the approach to universal coverage.[7]

D. Community Rating Inside a HPPC

Another factor that will affect premium levels under healthcare reform is the degree to which community rating is applied broadly across all firms and persons. Under the President's proposal, for example, premiums are adjusted for family composition but otherwise are the same across all workers in firms of fewer than 5,000 employees, as well as all non-workers.

The MCA as drafted would place workers in small firms (less than 100 employees) and their dependents as well as various non-workers in HPPCs. Premiums both in and out of HPPCs are set on an age adjusted community rated basis which leads to a relatively high premium increase for employees in small firms.

Non-workers in the HPPCs will have significantly higher health care costs than workers in either large or small firms because a portion of non-workers are disabled persons currently covered under the Supplemental Security Income program (SSI). Disabled persons and other non-workers make the HPPC pool expensive to cover because their health costs are so high.

Table 4 indicates how community rating inside HPPCs would affect monthly per capita premiums under three reform strategies.[8] If no health reform were implemented other than community rating within HPPCs, the currently insured would pay, on average, $205 monthly premiums. Under insurance reform, the average premium in HPPCs would rise to $215 and under the MCA to $227.

In comparison, ***Table 4*** indicates that premiums in HPPCs will be about $50 to $75 higher than out of HPPCs. This difference in premiums in and out of HPPCs creates a major problem implementing the Act. The primary incentive for cost containment under the Act is an excise tax on employer premium contributions in excess of the lowest cost health plan in the HPPC. Given the inherently higher costs for HPPC enrollees, most non- HPPC health plans will have premiums below this level even if these plans are minimally effective in controlling costs. Thus, basing the tax cap limit on the lowest cost HPPC premiums will create little incentive for employers and health plans to control costs undermining the long term viability of the program.

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[7] See Lewin-VHI: "Expanding Insurance Coverage Without A Mandate," May, 1994.

[8] Note that Table 4 findings are due to the effects of pooling which are independent of the organizational structure (e.g., HPPC, health alliance, or other small group reforms) used to create the pools.

TABLE 4

NUMBER OF PERSONS AND PER-CAPITA MONTHLY PREMIUMS FOR PERSONS IN AND OUT OF THE HEALTH PLAN PURCHASING COOPERATIVES (HPPCs) UNDER ALTERNATIVE REFORM SCENARIOS IN 1998

Reform Scenario	Inside HPPC[a] (Individuals & Firms <100)		Out of HPPC[b] (Firms > 100)		National Average	
	Size of Pool (in millions)	Per-Capita Premium	Size of Pool (in millions)	Per-Capita Premium	Size of Pool (in millions)	Per-Capita Premium
Currently Insured	72.8	$205	112.9	$150	185.7	$172
Insurance Market Reform Only[c]	73.7	$215	113.3	$151	186.8	$176
Insurance Market Reform with Subsidies[d]	83.3	$227	117.2	$150	200.5	$182
Universal Coverage[e]	95.6	$213	127.2	$147	222.8	$175

a Persons in the HPPC include workers and dependents in firms with less than 100 workers, persons in the individual insurance market, Medicaid recipients and the non-working uninsured. The revised version of the Managed Competition Act would require that premiums within the HPPC be rated separately for (1) the disabled; (2) firms that provide coverage; and (3) all other persons.

b Persons outside the HPPC include workers (including public employees) and their dependents in firms with 100 or more employees.

c Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

d As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

e For consistent analysis, universal coverage is based on the Managed Competition Act with an individual mandate. An employer mandate could be used to attain universal coverage as in the Health Security Act. The premium changes shown in this analysis would be the same under either mandate because we focus only on premium amounts regardless of payer.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The authors of the Act have acknowledged these problems and have indicated to the Congressional Budget Office that they intend to separately rate non-workers in HPPCs. A potential solution would be to create three premium pools within HPPCs: workers and dependents in small firms providing insurance; persons without employer provided insurance; and aged and disabled cash recipients.

Using three premium pools within HPPCs, we estimate that the average premium within the HPPC would remain at $227 a month, but premiums for workers and their dependents would be much lower at $153 a month, comparable to premiums for workers and their dependents outside HPPCs allowing the tax cap incentive to trigger cost controls.

A secondary effect of this revision would be to make monthly premiums higher for persons without employer provided insurance ($279 per month) and for disabled persons ($710 per month). As a result, aggregate federal subsidy payments in HPPCs would be higher because a large portion of these individuals also are low-income.

Under universal coverage, ***Table 4*** indicates that average premiums in HPPCs would fall to $213 per month as younger and healthier populations are brought into the HPPC pool. Because enrollees in HPPCs could be divided into three premium pools under possible revisions to the Act, reduced costs from an infusion of healthier populations could be distributed across these pools. However, the disabled pool would see little change in monthly premiums since we assume that most of this population would participate in HPPCs without universal coverage provisions.[5]

The types of premium discrepancies discussed above are not unique to the HPPC arrangement contained in the MCA. They are likely to occur under other forms of community rating limited to voluntary enrollment of small firms and individuals.

IV. CHANGES IN AVERAGE HOUSEHOLD SPENDING

The financial implications of health reform extend beyond the impact on premium payments for individuals, families, and employers. This analysis also examines the effects on overall net changes in household (non-Medicare) health care spending by accounting for household premium payments, subsidies, tax deductions, changes in premium contributions, changes in out-of-pocket spending, and wage effects resulting from changes in employer costs. In addition, this analysis addresses changes in household health spending for the 185.6 million

[5] For a more detailed analysis of premium changes under various HPPC sizes and community rating schemes, see: Sheils, John F, "Permitting Voluntary Enrollment in Regional Alliances Under the Health Security Act," prepared for the Henry J. Kaiser Foundation by Lewin-VHI, March 1994.

persons that are currently insured (non-Medicare) and for the 5.7 million households in which all members are uninsured.

We also examine the effect of universal coverage on household health spending as compared to the MCA as written. Because there are a number of options for achieving universal coverage, this analysis compares the effects of universal coverage under the MCA and the President's HSA. We examine two versions of the HSA, one with premium growth restraints and one without.

Please note that the following discussion focuses on households headed by individuals under age 65. This population is consistent with the one addressed in the previous premium section. Detailed findings for the over 65 population are presented in Appendix A.

We present the financial impact on households in the following sections:

- Net Changes in Household Health Spending Without Wage Effects
- Net Changes in Household Health Spending With Wage Effects
- Net Change in Household Spending by Income

A. Net Changes in Household Health Spending Without Wage Effects

We estimate that under the MCA, the average household headed by a person under age 65 will see health care spending increase by $98 in 1998 as compared to health spending in the absence of reform (***Table 5***). This average applies to all households in the nation, regardless of whether they currently purchase health insurance or will purchase health insurance under reform and subsumes wide variations in health spending changes by income group as discussed below in Section C.

TABLE 5
NET CHANGES IN HOUSEHOLD HEALTH SPENDING FOR HOUSEHOLDS
HEADED BY AN INDIVIDUAL UNDER AGE 65
(WITHOUT WAGE EFFECTS)

	All Households (82.2 million households)	Currently Insured[a] (76.5 million households)	Currently Uninsured[b] (5.7 million households)
Managed Competition Act As Written	$98	$105	--[d]
Managed Competition Act With Universal Coverage[c]	$322	$69	$1,406
Health Security Act Without Premium Growth Constraints	($180)	($223)	$350
Health Security Act With Premium Growth Constraints	($254)	($300)	$310

a An insured household is defined as household with at least one person insured.
b An uninsured household is defined as a household in which no one is insured.
c Universal coverage under the Managed Competition Act would increase federal subsidy costs relative to the Act as written. Our estimates in this analysis assume the federal government absorbs the costs. To the extent that financing sources are sought through taxes, household spending would increase.
d We estimate the average currently uninsured household will spend an additional $2 under the Managed Competition Act as written. However, under the Managed Competition Act as written, many currently uninsured households still will not purchase coverage. For these households, health spending will not change. This $2 estimate reflects the average change in health spending for all currently uninsured households, including those that will experience no change.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The average change in household health spending reflects an increase in private premium payments partially offset by federal premium subsidies and "cashed-out" benefits. We assume that firms providing coverage above the standard benefits package will downgrade coverage to the minimum level and distribute the cash savings to employees which we then assume are used to purchase supplemental coverage.

Expanding the MCA to include universal coverage would increase average household health spending for those under age 65 by $322 in 1998. While the influx of healthier populations would reduce per capita premiums under universal coverage, in aggregate more households will be paying premiums and using more health care thus raising the average. In comparison, we estimate that the HSA will decrease average household health spending for those under age 65 by $180 in 1998 assuming no premium growth constraints and will decrease spending by $254 assuming constraints.

However, overall household health spending fails to highlight an important distinction: the currently insured population spends less or saves more under universal coverage. As shown in *Table 5*, the average currently insured household will spend an additional $105 on health care in 1998 under the MCA as written compared to $69 under the Act coupled with universal coverage.

More striking is the difference between all families and the currently insured under the Act with universal coverage. This difference indicates that the majority of increased health spending under this version of the Act will be borne by the currently uninsured population—an average increase of $1,406 in health spending in 1998.

An analogous effect is seen under the HSA with or without premium constraints. Under either assumption, the average family headed by a person under age 65 sees reduced health spending in 1998 ($180 in savings without premium growth constraints, $254 in savings with premium growth constraints). Compared to the total under 65 population, the currently insured save more under both scenarios ($223 in savings without premium constraints, $300 in savings with premium constraints). Once again, the uninsured see an increase in health spending although not as large as under the MCA with universal coverage. This is true because we assume that universal coverage under the MCA is achieved through an individual mandate while the HSA relies on an employer mandate.

B. Net Changes in Household Health Spending With Wage Effects

Generally accepted economic theory suggests that most employer savings and new costs eventually are passed on to workers in the form of increased or decreased wages. This "wage effect" further reduces or increases household health spending under health reform.[9] For example, we estimate that employer health care expenses will decrease under the MCA and that wages will rise as a result of three factors: (1) employer premium contributions will decrease due to the cap on tax deductibility; (2) some firms will discontinue providing health benefits altogether; and (3) firms continuing coverage will see savings resulting from managed care and reduced cost shifting[10].

Table 6 shows the changes in household health spending accounting for the wage effect. As noted above, the MCA reduces employer health care costs ultimately resulting in the reduced health care spending shown in the table for the currently insured population. In contrast, the HSA increases employer health care costs through an employer mandate which are passed on to employees through lower wages.

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[9] We estimate that about 88% of changes in costs are passed on to employees through wage effects. See, for example, Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in *Tax Policy and the Economy* (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, forthcoming; and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, v. 79, no. 2, May 1989.

[10] We estimate significant managed care savings under the Managed Competition Act that ultimately lower employer premium costs. For a detailed discussion of managed care savings see: Lewin-VHI, "Managed Care: Does it Work?" February 1993, and Lewin-VHI, "New Evidence on Savings from Network Models of Managed Care," May 1994.

TABLE 6

NET CHANGES IN HOUSEHOLD SPENDING FOR HOUSEHOLDS HEADED BY AN INDIVIDUAL UNDER AGE 65 IN 1998 (WITH WAGE EFFECTS)

	All Households (82.2 million households)	Currently Insured[a] (76.5 million households)	Currently Uninsured[b] (5.7 million households)
Managed Competition Act As Written	($38)	($41)	--[d]
Managed Competition Act With Universal Coverage[c]	$186	($77)	$1,406
Health Security Act Without Premium Growth Constraints	$191	$71	$1,478
Health Security Act With Premium Growth Constraints	$14	($161)	$1,343

a An insured household is defined as household with at least one person insured.
b An uninsured household is defined as a household in which no one is insured.
c Universal coverage under the Managed Competition Act would increase federal subsidy costs relative to the Act as written. Our estimates in this analysis assume the federal government absorbs the costs. To the extent that financing sources are sought through taxes, household spending would increase.
d We estimate the average currently uninsured household will spend an additional $2 under the Managed Competition Act as written. However, under the Managed Competition Act as written, many currently uninsured households still will not purchase coverage. For these households, health spending will not change. This $2 estimate reflects the average change in health spending for all currently uninsured households, including those that will experience no change.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

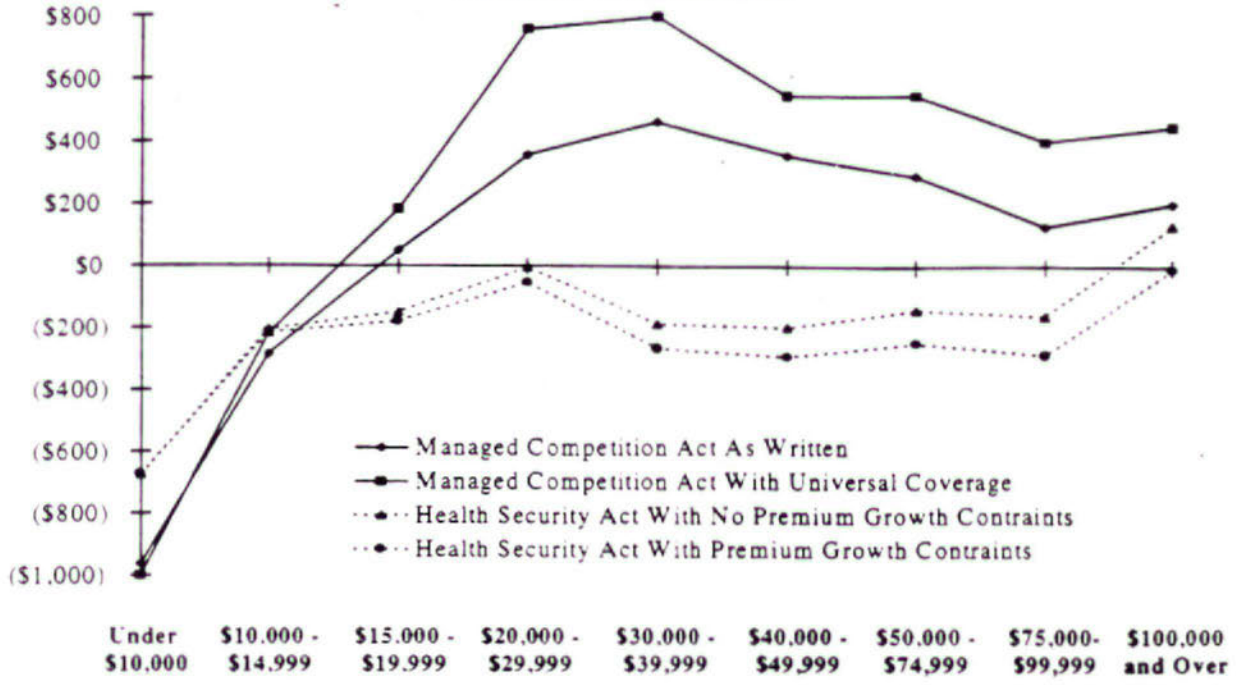
Employers who currently do not provide insurance will see a proportionally larger increase in employee health care costs under the HSA than employers who do provide insurance. Therefore, the currently uninsured will experience a greater wage effect than the currently insured as reflected in ***Table 6***.

While the wage effect tempers the increased health spending under the MCA, it is important to consider the sources of the wage effect enumerated above. The fact that some firms will reduce costs by discontinuing or reducing coverage certainly has policy implications for health reform.

C. Household Spending by Income

Finally, our analysis allows us to display changes in household health spending by income group (***Figure 1***). The changes in spending shown in Figure 1 are for households headed by persons under age 65 and do not include wage effects. Furthermore, these estimates include all households whether previously insured or not.

FIGURE 1
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998
FOR AGGREGATE UNDER AGE 65 POPULATION
WITHOUT WAGE EFFECT

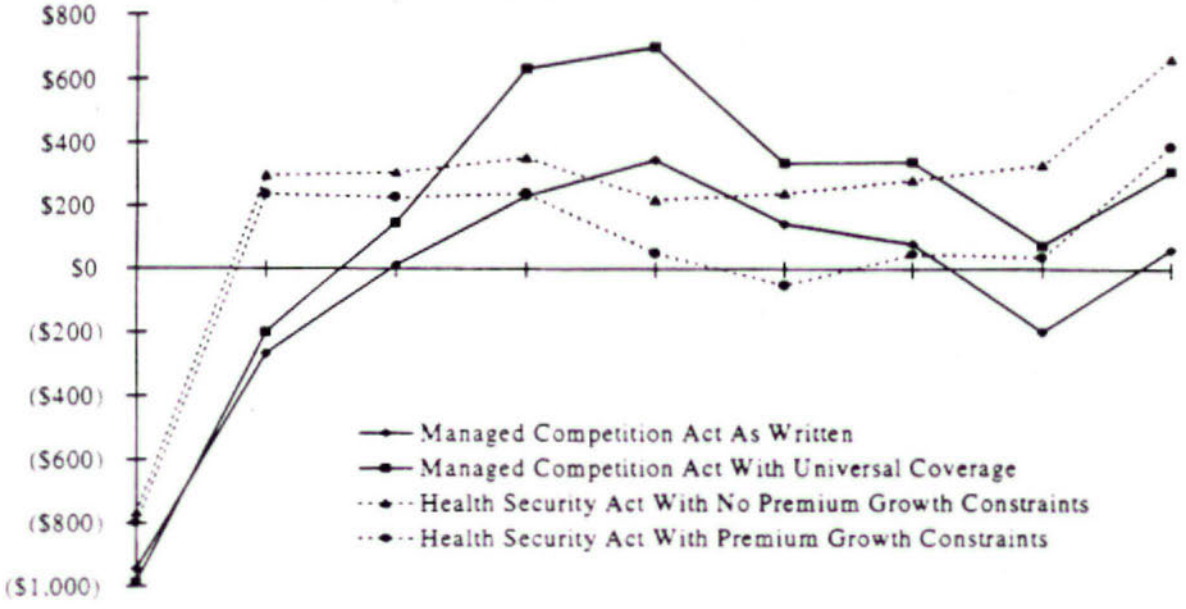


Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Our analysis shows that all four versions of health reform discussed in this paper reduce health spending for the lowest income groups while the MCA results in increased health spending for middle and higher income groups. The HSA with or without premium growth constraints lowers health spending for all but those households earning more than $100,000 per year. As noted above, a major reason for the observed differences between the MCA and the HSA are the Acts' approach to universal coverage. Without wage effects, the HSA's reliance on an employer mandate shifts a smaller portion of insurance costs onto households because employers are paying 80% of premiums.

Figure 2 takes into account the wage effect and shows that the HSA's employer mandate ultimately costs households through reduced wages. The MCA with universal coverage still shows the largest increases for middle income households, but both versions of the HSA also indicate health spending increases for these groups. Both versions of the HSA show increased health spending for households earning between $10,000 and $14,999 while the Managed Care Act with universal coverage decreases spending for this group. However, the HSA is consistently less costly than the universal coverage version of the Managed Care Act for middle income households earning between $20,000 and $49,999.

FIGURE 2
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998
FOR AGGREGATE UNDER AGE 65 POPULATION
WITH WAGE EFFECT

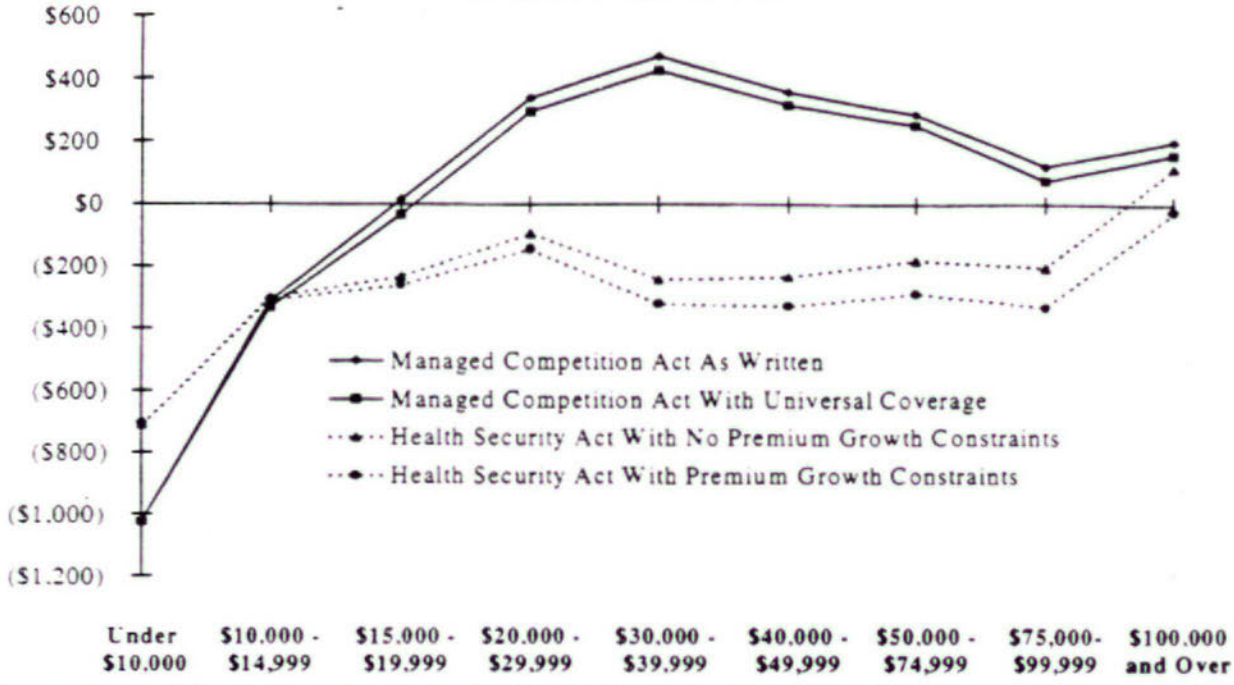


Under $10,000	$10,000 - $14,999	$15,000 - $19,999	$20,000 - $29,999	$30,000 - $39,999	$40,000 - $49,999	$50,000 - $74,999	$75,000- $99,999	$100,000 and Over

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

As in the earlier tables, our analysis also examines the changes in household health spending for the currently insured under 65 population (185.7 million people). For the currently insured, the MCA with universal coverage is consistently less costly than the Act as written across all income groups with or without wage effects. However, without wage effects, both versions result in increased health spending for households earning more than $20,000 a year (***Figure 3***).

FIGURE 3
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED POPULATION UNDER AGE 65 BY INCOME WITHOUT WAGE EFFECT



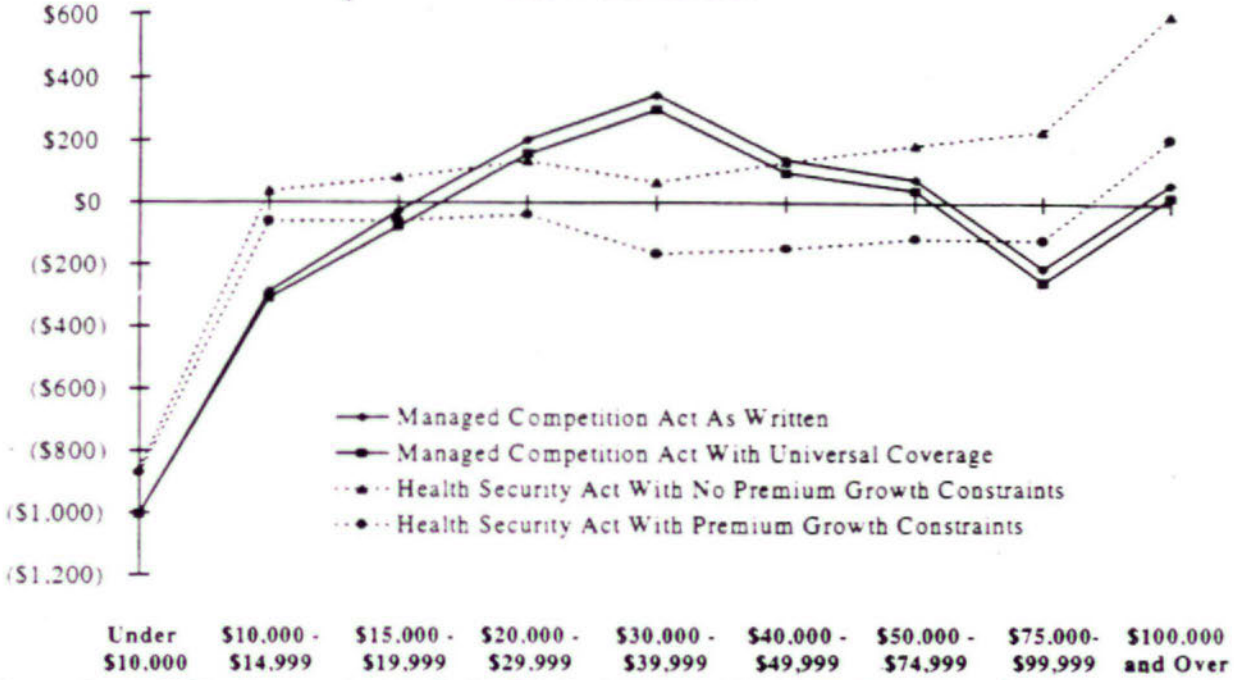
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

In comparison, both versions of the HSA reduce health care spending for the currently insured population across most income groups without wage effects.

Factoring in the wage effect creates a more complex picture. ***Figure 4*** shows that even with the wage effect, the HSA with premium constraints reduces health spending for the currently insured across all but the highest income groups. The MCA results in increased health spending for middle income currently insured earning between $20,000 and $49,999.

The HSA without premium constraints increases health spending for all the currently insured earning more than $10,000, accounting for wage effects. However, spending increases are less than the MCA with universal coverage for the currently insured earning between $20,000 and $39,999. Spending increases are greater than under the MCA for income groups earning more than $40,000 (***Figure 4***).

FIGURE 4
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED POPULATION UNDER AGE 65 BY INCOME WITH WAGE EFFECT



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Tables displaying detailed changes in household spending under the various reform scenarios and accounting for insurance status, wage effect, and income are available in Appendix A.

V. CONCLUSION

This analysis highlights some of the important trade-offs involved in achieving universal coverage as compared to more limited reforms. Insurance market reforms alone will have little impact on coverage, covering an estimated 3 percent of the currently uninsured. When combined with subsidies as in the MCA, however, about 40 percent of the uninsured would be covered, accounting for about 45 percent of all current health spending on the uninsured. As a previous Lewin-VHI study showed, 97 percent of health spending is covered by the MCA because persons who become covered voluntarily will tend to be more expensive than average.[11]

One of the trade-offs in pursuing a voluntary strategy, however, is the impact on premiums for persons who are already insured. Because persons who obtain coverage under the MCA will tend to be less healthy and more costly than persons who do not obtain coverage, average premiums will rise more for those already insured than they would under universal

[11] Lewin-VHI, Expanding Insurance Coverage Without a Mandate, prepared for the Health Care Leadership Council, May 18, 1994.

coverage. Accordingly, the average 1998 family premium amount would increase by $260 per year under the MCA compared to an increase of about $78 under universal coverage.

Changes in household health spending vary significantly by family income level and current health insurance status. Largely because of premium subsidies, all of the reform approaches result in a net decrease in spending for families earning less than $10,000. Middle income families that currently have insurance, however, generally experience a larger increase in health spending without universal coverage. Their change in health spending is also influenced by the structure of the reform proposal itself, such as whether or not the proposal utilizes an employer mandate and includes premium growth constraints like those in the HSA. Of the universal coverage approaches examined, only the HSA with premium caps reduces household health spending for currently insured middle income families with or without wage effects.

Universal coverage would entail higher federal subsidies for the additional low income persons who become insured. It would also require a mandate for insurance coverage. These costs will have to be weighed against the problems of higher average premiums and household spending for the currently insured, cost shifting, and constrained access for the remaining uninsured under more limited reforms.

APPENDIX A

TABLE A-1

CHANGE IN HOUSEHOLD HEALTH SPENDING BY INCOME IN 1998 UNDER THE MANAGED COMPETITION ACT AND UNDER THE ACT WITH UNIVERSAL COVERAGE

	With Wage Effects			Without Wage Effects		
Household Income (in thousands)	**Under 65**	**65 and Over**	**Total**	**Under 65**	**65 and Over**	**Total**
AS WRITTEN						
Under $10,000	($946)	($2,603)	($1,459)	($963)	($2,601)	($1,470)
$10,000 - $14,999	($266)	($1,498)	($757)	($285)	($1,481)	($762)
$15,000 - $19,999	$13	($537)	($161)	$49	($544)	($138)
$20,000 - $29,999	$231	$551	$304	$358	$519	$395
$30,000 - $39,999	$344	$757	$421	$464	$742	$517
$40,000 - $49,999	$143	$833	$220	$358	$833	$411
$50,000 - $74,999	$80	$763	$142	$293	$848	$343
$75,000 - $99,999	($197)	($88)	($187)	$127	$25	$118
$100,000 and Over	$62	$212	$73	$201	$162	$198
TOTAL	**($38)**	**($629)**	**($156)**	**$98**	**($624)**	**($46)**
UNIVERSAL COVERAGE						
Under $10,000	($988)	($2,623)	($1,494)	($1,006)	($2,620)	($1,506)
$10,000 - $14,999	($200)	($1,481)	($711)	($219)	($1,463)	($715)
$15,000 - $19,999	$147	($549)	($72)	$183	($556)	($49)
$20,000 - $29,999	$633	$782	$667	$760	$751	$758
$30,000 - $39,999	$696	$994	$752	$817	$979	$848
$40,000 - $49,999	$335	$1,101	$421	$551	$1,101	$612
$50,000 - $74,999	$339	$1,006	$399	$552	$1,091	$601
$75,000 - $99,999	$74	($106)	$57	$399	$7	$362
$100,000 and Over	$309	$534	$325	$447	$483	$449
TOTAL	**$186**	**($523)**	**$45**	**$322**	**($518)**	**$155**

SOURCE: LEWIN-VHI ESTIMATES USING THE HEALTH BENEFITS SIMULATION MODEL (HBSM)

TABLE A-2

CHANGE IN HOUSEHOLD HEALTH SECURITY BY INCOME IN 1998 UNDER THE HEALTH SECURITY ACT WITH AND WITHOUT PREMIUM GROWTH CONSTRAINTS

Household Income (in thousands)	With Wage Effects			Without Wage Effects		
	Under 65	65 and Over	Total	Under 65	65 and Over	Total
WITH PREMIUM CONSTRAINTS						
Under $10,000	($801)	($478)	($701)	($671)	($456)	($605)
$10,000 - $14,999	$236	($569)	($85)	($216)	($561)	($353)
$15,000 - $19,999	$226	($638)	($76)	($179)	($648)	($327)
$20,000 - $29,999	$239	($322)	$111	($53)	($436)	($140)
$30,000 - $39,999	$50	($483)	($51)	($266)	($404)	($292)
$40,000 - $49,999	($51)	($495)	($101)	($293)	($546)	($231)
$50,000 - $74,999	$47	($470)	$0	($248)	($285)	($251)
$75,000 - $99,999	$38	($683)	($30)	($287)	($425)	($300)
$100,000 and Over	$388	$3,361	$599	($8)	$3,484	$239
TOTAL	**$14**	**($383)**	**($65)**	**($254)**	**($365)**	**($276)**
WITHOUT PREMIUM CONSTRAINTS						
Under $10,000	($767)	($473)	($676)	($674)	($456)	($607)
$10,000 - $14,999	$295	($563)	($47)	($205)	($557)	($345)
$15,000 - $19,999	$306	($602)	$20	($150)	($637)	($303)
$20,000 - $29,999	$353	($263)	$213	($3)	($412)	($97)
$30,000 - $39,999	$218	($281)	$124	($187)	($367)	($221)
$40,000 - $49,999	$239	($310)	$178	($198)	($496)	($232)
$50,000 - $74,999	$282	($256)	$233	($140)	($222)	($147)
$75,000 - $99,999	$328	($361)	$262	($160)	($3,658)	($178)
$100,000 and Over	$663	$3,736	$883	$132	$3,568	$376
TOTAL	**$191**	**($294)**	**$95**	**($180)**	**($342)**	**($212)**

SOURCE: LEWIN-VHI ESTIMATES USING THE HEALTH BENEFITS SIMULATION MODEL (HBSM)

TABLE A-3

CHANGES IN HEATH SPENDING BY INCOME IN 1998 FOR THE CURRENTLY INSURED AND UNINSURED HOUSEHOLDS UNDER THE MANAGED COMPETITION ACT AND UNDER THE ACT WITH UNIVERSAL COVERAGE

		CURRENTLY INSURED				CURRENTLY UNINSURED			
		AS WRITTEN		UNIVERSAL COVERAGE		AS WRITTEN		UNIVERSAL COVERAGE	
HOUSEHOLD INCOME	NUMBER OF HOUSEHOLDS (IN MILLIONS)	WITHOUT WAGE EFFECTS	WITH WAGE EFFECTS	WITHOUT WAGE EFFECTS	WITH WAGE EFFECTS	WITHOUT WAGE EFFECTS	WITH WAGE EFFECTS	WITHOUT WAGE EFFECTS	WITH WAGE EFFECTS
Under $10,000	8.6	($1,025)	($1,004)	($1,025)	($1,005)	($627)	($627)	($793)	($793)
$10,000 - $14,999	4.6	($311)	($288)	($332)	($309)	($166)	($166)	$362	$362
$15,000 - $19,999	4.3	$15	($27)	($34)	($76)	$243	$243	$1,336	$1,336
$20,000 - $29,999	10.8	$340	$201	$296	$157	$545	$545	$3,291	$3,291
$30,000 - $39,999	9.4	$472	$344	$426	$298	$339	$339	$3,450	$3,450
$40,000 - $49,999	9.4	$358	$137	$317	$96	$363	$363	$2,757	$2,757
$50,000 - $74,999	15.2	$293	$76	$257	$40	$279	$229	$4,333	$4,333
$75,000 - $99,999	6.5	$120	($211)	$75	($256)	$505	$505	$3,750	$3,750
$100,000 and Over	7.8	$202	$63	$161	$22	$0	$0	$2,415	$2,415
TOTAL	**76.5**	**$105**	**($41)**	**$69**	**($77)**	**-- a**	**-- a**	**$1,406**	**$1,406**

a. We estimate the average currently uninsured household will spend an additional $2 under the Managed Competition Act as written. However, under the Managed Competition Act as written, many currently uninsured households still will not purchase coverage. For these households, health spending will not change. This $2 estimate reflects the average change in health spending for all currently uninsured households, including those that will experience no change.

SOURCE: LEWIN-VHI ESTIMATES USING THE HEALTH BENEFITS SIMULATION MODEL (HBSM)

TABLE A-4

CHANGE IN HOUSEHOLD HEALTH SPENDING BY INCOME IN 1998 FOR THE CURRENTLY INSURED AND UNINSURED HOUSEHOLDS UNDER THE HEALTH SECURITY ACT WITH AND WITHOUT PREMIUM GROWTH CONSTRAINTS

		With Premium Constraints		Without Premium Constraints	
Household Income (in thousands)	Number of Households (in millions)	With Wage Effects	Without Wage Effects	With Wage Effects	Without Wage Effects
Insured					
Under $10,000	8.6	($873)	($709)	($859)	($711)
$10,000 - $14,999	4.6	($62)	($308)	$35	($299)
$15,000 - $19,999	4.3	($58)	($263)	$81	($234)
$20,000 - $29,999	10.8	($39)	($144)	$134	($94)
$30,000 - $39,999	9.4	($165)	($320)	$65	($241)
$40,000 - $49,999	9.4	($147)	($328)	$131	($233)
$50,000 - $74,999	15.2	($114)	($285)	$187	($178)
$75,000 - $99,999	6.5	($120)	($330)	$232	($203)
$100,000 and Over	7.8	$210	($24)	$605	$117
Total	**76.6**	**($161)**	**($300)**	**$71**	**($223)**
Uninsured					
Under $10,000	1.6	($278)	($464)	($269)	($470)
$10,000 - $14,999	1.0	$1,298	$201	$1,420	$220
$15,000 - $19,999	0.8	$1,407	$302	$1,538	$329
$20,000 - $29,999	1.0	$2,274	$864	$2,461	$919
$30,000 - $39,999	0.5	$2,194	$578	$2,410	$669
$40,000 - $49,999	0.3	$2,642	$732	$2,952	$836
$50,000 - $74,999	0.3	$3,093	$1,397	$3,385	$1,522
$75,000 - $99,999	0.1	$3,063	$1,546	$3,352	$1,707
$100,000 and Over	0.1	$2,878	$1,159	$3,176	$1,274
Total	**5.7**	**$1,343**	**$310**	**$1,478**	**$350**

SOURCE: LEWIN-VHI ESTIMATES USING THE HEALTH BENEFITS SIMULATION MODEL (HBSM)

7/22/84

SEIU

The Dole Plan

It shifts billions to the states, cuts payments to health providers and still leaves more than 10% of Americans uninsured.

An Analysis of the Dole Health Reform Plan by Lewin-VHI

Prepared for the Service Employees International Union, AFL-CIO, CLC

SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO, CLC
1313 L STREET N.W. • WASHINGTON, D.C. 20005 • (202) 898-3200

JOHN J. SWEENEY
INTERNATIONAL PRESIDENT

RICHARD W. CORDTZ
INTERNATIONAL SECRETARY-TREASURER

July 18, 1994

Dear Member of Congress:

On June 30, 1994, Senator Bob Dole and 38 co-sponsors introduced their plan for reforming our nation's health care system. The Minority Leader characterized his plan as a significant move forward to universal coverage that would be paid for through cuts in the Medicare and Medicaid programs for the elderly and the poor. Premium subsidies would be available to low-income families and tax deductions would be phased in for individuals who purchase health coverage.

The Service Employees International Union commissioned a study by Lewin-VHI, a leading non-partisan health consulting firm, to examine the projected impact of Senator Dole's plan on the numbers of uninsured in each state and the state-by-state impact of his proposal for financing it through reductions in federal payments to states and health care providers.

The Lewin-VHI analysis, a conservative study, reveals that the Dole plan would accomplish only a modest decrease in the number of uninsured, while imposing heavy new costs on the states as well as on health care providers and private insurance plan members.

- **At full implementation and under the best of scenarios, the Dole plan would increase health coverage from 85.8 percent to 89.7 percent, reaching only 1 in 4 of those currently uninsured — even with the federal government paying over $106 billion in new subsidies and tax deductions by the year 2000.** According to Lewin-VHI, that would leave nearly 27 million Americans still without health insurance -- mostly middle class working families.

- **Medicaid cuts called for by the Dole plan will shift $35.8 billion (net) from the federal deficit to state budgets over five years.** By requiring that states maintain their Medicaid population while imposing a cap on federal Medicaid spending, the Dole proposal amounts to yet another large unfunded mandate.

- **Medicare cuts called for by the Dole plan will cut payments to health care providers -- hospitals and physicians — by $53 billion over the next five years.** Providers in five states will be especially hard hit -- those located in Florida, Illinois, Michigan, New York, and Pennsylvania account for half of the total reduction called for under the Dole proposal.

Providers are likely to shift the cost of Medicare underpayments to privately insured health care consumers, who already are paying higher premiums to cover the shifted cost of caring for the uninsured. Middle class Americans are once again the losers.

The massive costs shifted to states hold the potential to devastate state budgets, already struggling under multiplying Medicaid costs. These are costs the states have looked to health care reform to relieve, not exacerbate.

The Clinton Health Security Act also proposes spending limits for the Medicare and Medicaid programs, but the costs are not simply shifted from the federal government to states and providers: employer responsibility is used to achieve universal coverage and indigent care is eliminated. Lewin-VHI, for example, has estimated that states would save $67 billion in Medicaid costs under President Clinton's plan over the same five-year period analyzed in this study.

Despite its budget-roiling, the Dole plan leaves many states with even more people uninsured than the 10.3 percent national average. In Alabama, for instance, 11.9 percent will remain uninsured after full implementation of the Dole plan; in California, 13.4 percent; in Florida, 13.0 percent; in Louisiana, 13.5 percent; in Texas, 14.9 percent.

Our nation needs universal coverage based on sharing the benefits and costs of reform fairly, among governments, employers, providers and consumers. This analysis points up the financial shell-game that is triggered when any plan avoids requiring all employers to share responsibility for employee health coverage, thus building on the current system. Only by covering 100 percent of the population as the President has proposed can we end the health-care cost shifting game.

Sincerely,

John J. Sweeney

John J. Sweeney
International President

THE IMPACT OF SENATOR DOLE'S HEALTH REFORM PLAN ON STATES

PREPARED FOR:

SERVICE EMPLOYEES INTERNATIONAL UNION

PREPARED BY:

LEWIN-VHI, INC.

JULY 17, 1994

MC80179

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EXECUTIVE SUMMARY

Senator Dole has introduced a health reform proposal designed to expand insurance coverage through insurance market reforms and premium subsidies. Specifically, the proposal would require insurers to provide insurance to all individuals regardless of health status. It would also provide premium subsidies to low income persons and would phase-in tax deductions for insurance purchases by persons who do not have employer provided insurance. These tax deductions and premium subsidies would be financed with savings resulting from reduced funding for Medicaid and Medicare.

Eligibility for premium subsidies would be expanded as funding is reduced for Medicaid and Medicare. Beginning in 1996, premium subsidies would be available to families with incomes up to 90 percent of the poverty level. Eligibility eventually would be increased to 150 percent of poverty as Medicaid and Medicare savings increase to levels sufficient to pay for these subsidies.

In this analysis, we estimated the net federal cost of the program. We also estimated the program's impact on the number of persons without insurance by state. In addition, we estimated the impact of the program on state governments and the net impact on provider revenues by state.

NET FEDERAL COSTS

We estimate that the proposal would result in a net reduction in the federal deficit of $14.6 billion over the 1994 through 2000 period. The federal cost of premium subsidies and tax deductions over this period would be $106.3 billion. These new costs would be offset by about $120.9 billion in savings to Medicaid and Medicare.

As discussed above, eligibility for subsidies would be expanded to 150 percent of poverty only as funds become available through savings in other programs. Our analysis indicates that under these criteria, eligibility would remain at 90 percent of poverty through 1997. Eligibility would be increased to 100 percent of poverty in 1998 and 150 percent of poverty in 1999.

INSURANCE COVERAGE

The proposal would expand insurance coverage in three ways. First, the proposal would reform insurance markets so that individuals can obtain coverage regardless of their health status. Second, premium subsidies would be provided to lower-income persons to help them pay for the cost of insurance. Third, individuals who do not have employer-based insurance would be permitted to deduct the cost of individually purchased non-group coverage. (The deduction would be phased-in between 1994 and 1999.)

We estimate that in the first year of the program (i.e., 1996) about 6.2 million persons would obtain insurance coverage. This is about 17 percent of the 37.2 million persons who would be uninsured in 1996 under current policy. Overall, about 11.8 percent of all Americans would remain uninsured in 1996.

The number of persons who would obtain insurance under the proposal would gradually increase by 2000 as eligibility for premium subsidies is expanded to 150 percent of poverty and the tax deductibility of insurance is fully phased-in. We estimate that by 2000, about 10.3 million persons who would otherwise have been uninsured (i.e., 28 percent of the uninsured) would obtain coverage. Overall, about 10.3 percent of all Americans would continue to be without insurance by the end of the century..

Impact on State Governments

The proposal would finance these expansions in coverage in part through reduced federal payments to states under the Medicaid program of about $44.5 billion over the 1996 through 2000 period. The bill would cap the rate of growth in contributions to states for acute care services provided under the program and federal funding for disproportionate share hospital (DSH) payments would be reduced by about 25 percent.

These reductions in federal revenues for states would be offset by savings to existing state indigent care programs of about $8.6 billion over this five-year period as persons served by these programs obtain subsidized insurance coverage under the proposal. The net loss in funding to states would be $35.8 billion over the 1996 through 2000 period.

Impact on Providers

These coverage expansions are also financed through various reductions in Medicare spending. These include about $25.0 billion in reduced payments to hospitals and $28 billion in reduced payments to physicians over the 1996 through 2000 period.

These provider income reductions would be offset partially by reduced expenditures for free care provided to uninsured persons of about $38.5 billion over this five-year period. This includes reduced hospital uncompensated care and free care provided in public hospitals. Thus, the proposal would result in a net reduction in provider revenues of about $14.6 billion over the 1996 though 2000 period.

Closing

These estimates are based upon the most recent data and research available. However, they are very sensitive to assumptions concerning spending growth rates and individual behavior. In particular, these estimates are quite sensitive to differences in health expenditure growth rates across states. Therefore, these estimates should be treated as illustrative of potential program effects rather than point estimates of actual program outcomes.

INTRODUCTION

Senator Dole has introduced a health reform plan that is designed to expand health insurance coverage by requiring insurers to accept all applicants regardless of their health status. The proposal would also provide subsidies to enable lower-income persons to obtain coverage and permits a tax deduction for health insurance premium payments for persons without employer-based insurance. The proposal does not impose mandates to purchase health insurance on either employers or individuals.

Premium subsidies provided under the proposal would be financed with savings in existing federal programs. Specifically, the proposal would limit the rate of growth in federal Medicaid payments to states for acute care. It also specifies reductions in provider reimbursement under the Medicare program.

In this analysis, we estimated the net federal cost of the program. We also estimated the number of persons who would obtain insurance under the program by state. In addition, we estimate the net impact of the program on state governments and the net impact on provider revenues by state.

The analysis is presented in the following sections:

- Key Provisions of the Proposal
- Federal Expenditures under the Proposal
- Changes in the Number of Uninsured
- Impact on State Governments
- Impact on Providers

KEY PROVISIONS OF THE PROPOSAL

The proposal is designed to expand insurance coverage through insurance market reforms and premium subsidies. Specifically, insurers would be prohibited from denying coverage to individuals on the basis of health status and there would be limits on the extent to which insurers could vary premiums with individual characteristics. Pre-existing condition exclusions would be prohibited except in cases where individuals have failed to maintain their insurance coverage.

Initially, premium subsidies would be provided to persons with incomes below 90 percent of poverty and a tax deduction is phased-in for insurance purchases by persons who do not have employer-based insurance. These subsidies would be financed with reductions in provider reimbursement under the Medicare program and a cap on the rate of growth in federal funding for the Medicaid program. Eligibility for premium subsidies eventually would be expanded to 150 percent of poverty as Medicare and Medicaid program savings increase over time.

The eligibility levels for premium subsidies would be tied to federal health savings. When the proposal is enacted, premium subsidies would be available for families with incomes up to 90 percent of the poverty line. Eligibility for subsidies would be increased to 100 percent of poverty and then to 150 percent of poverty as federal savings in Medicaid and Medicare accumulate over time. (The subsidy would be phased-out for persons between poverty and 150 percent of poverty.) Premium subsidies would be provided for the full amount of the premium up to a maximum amount specified by the Secretary of Health and Human Services (HHS) for all persons below poverty.

Premium subsidies are applicable only to the purchase of a "FedMed" benefits package as defined by the Secretary of HHS. The FedMed package would include the minimum benefits provided under the Federal Employees Health Benefit program (FEHBP) plus improvements in coverage for mental health and prevention. The maximum subsidy amount available would be the amount that the federal government uses to calculate its maximum employee contribution under FEHBP.

The maximum contribution limitation in the proposal would effectively limit the amount of subsidies available to low-income persons. Our analysis indicates that on average, the premium for the population that is potentially eligible for subsidies would exceed the maximum contribution amount under the proposal by about 10 percent. This reflects the fact that the low-income uninsured population that is likely to obtain coverage under such a plan is in poor health and is therefore expected to have relatively above average health care costs. Consequently, the maximum subsidy available to any individual under the program at any income level would be equal to about 90 percent of the premium for eligible persons.

Subsides are not available to persons who are not U.S. citizens or permanent resident aliens, Medicaid eligibles, Medicare beneficiaries, or persons who receive employer financed coverage. The Medicaid program continues, although states would be permitted to enroll Medicaid recipients in private health plans. States also would be required to maintain current Medicaid eligibility levels.

As an added inducement to obtain insurance, self-employed individuals and other persons who do not receive coverage through an employer eventually would be allowed to deduct the full cost of their insurance premiums. The deductibility is phased-in at: 25 percent of premium payments in 1994 and 1995; 50 percent in 1996 and 1997; 75 percent in 1998 and 1999; and 100 percent in 2000 and thereafter.

In addition to the market reforms and subsidies discussed above, the proposal:

- Provides access to FEHBP health plans for individuals and small groups
- Allows people to establish tax exempt medical savings accounts
- Creates a "consumer value" program implemented by states to assure minimum quality standards for health plans and to make comparative information available
- Pre-empts state anti-managed care laws
- Builds primary care capacity in underserved areas
- Clarifies anti-trust treatment for providers
- Includes malpractice reforms such as a cap on non-economic damages

- Treats long-term care insurance premiums as medical expenses for purposes of potential income tax deductions

Federal Expenditures Under the Bill

We estimate that the bill would result in a net reduction in the federal deficit of $14.6 billion over the 1994 through 2000 period. This includes premium subsidies and tax deductions of $106.3 billion over this period offset by about $120.9 billion in savings to existing federal programs *(Table 1)*.

Table 1

Summary of the Net Impact of Senator Dole's Health Reform Proposal on Federal Spending: 1994-2000 (in billions)

	New Expenditures[a]	Program Savings	Net Increase (Decrease) in Federal Deficit
1994	$1.5	$0.0	$1.5
1995	$1.7	$2.9	($1.2)
1996	$14.1	$9.5	$4.6
1997	$15.3	$14.3	$1.0
1998	$19.0	$22.5	($3.5)
1999	$25.3	$31.8	($6.5)
2000	$29.4	$39.9	($10.5)
Total 1996-2000	**$106.3**	**$120.9**	**($14.6)**

a Based upon the provisions specified in the bill, we estimate that premium subsidies will be available to persons through: 90 percent of poverty in 1996 through 1997; 100 percent of poverty in 1998; and 150 percent of poverty in 1999 through 2000.

Source: Lewin-VHI estimates.

The $120.9 billion in savings under the program include:

- ***Medicare Savings*** - The bill would reduce Medicare spending by about $61.4 billion over the 1994 through 2000 period primarily through reductions in provider reimbursement *(Table 2)*.
- ***Medicare Savings*** - The bill would cap the rate of growth in Medicaid contributions to six percent per year beginning in 1996 (5 percent after 2000) resulting in savings of about $31.2 billion by 2000. Federal payments under the Medicaid disproportionate share hospital (DSH) program are also reduced by 25 percent resulting in additional savings of about $13.3 billion over this period.
- ***Postal Service Retirement*** - This proposal would require advance funding of the Postal Service Retirement Fund resulting in additional savings of $15 billion through 2000.

TABLE 2

DETAILED SUMMARY OF SOURCES AND USES OF FUNDS UNDER SENATOR DOLE'S HEALTH REFORM PROPOSAL (IN BILLIONS)

	1994	1995	1996	1997	1998	1999	2000	Total 1994-2000
PROGRAM SPENDING								
Premium Subsidies[a]	$0.0	$0.0	$10.7	$11.6	$13.0	$18.9	$20.2	$74.4
Tax Deductions[b]	$1.5	$1.7	$3.4	$3.7	$6.0	$6.4	$9.2	$31.9
TOTAL NEW PROGRAM SPENDING	**$1.5**	**$1.7**	**$14.1**	**$15.3**	**$19.0**	**$25.3**	**$29.4**	**$106.3**
PROGRAM SAVINGS								
Pre-Fund Postal Service Retirement[c]	$0.0	$2.0	$2.0	$2.0	$3.0	$3.0	$3.0	$15.0
Medicare Savings								
Reduces PPS Update Factor[d]	$0.0	$0.0	$0.0	$0.6	$2.0	$3.8	$5.6	$12.0
Reduce Capital payments for Inpatient Services[e]	$0.0	$0.0	$1.0	$1.1	$1.1	$1.3	$1.5	$6.0
Phase-Down DSH Payments[f]	$0.0	$0.0	$0.3	$0.5	$0.7	$1.0	$1.0	$3.5
Reduce Indirect Medical Education Adjustment[g]	$0.0	$0.0	$0.6	$0.6	$0.7	$0.7	$0.7	$3.3
Partially Extend Freeze on Updates to SNF Costs[h]	$0.0	$0.0	$0.2	$0.3	$0.3	$0.4	$0.4	$1.6
Partially Extend Freeze on Updates to Home Health[i]	$0.0	$0.0	$0.5	$0.5	$0.5	$0.6	$0.7	$2.8
Medicare Volume Performance Standard to GDP[j]	$0.0	$0.0	$0.0	$0.0	$1.0	$2.0	$2.0	$5.0
Cumulative Growth Targets for Physician Services[k]	$0.0	$0.7	$1.9	$3.0	$4.3	$5.3	$6.4	$21.6
Reduce Conversion Factor in 1995[l]	$0.0	$0.2	$0.4	$0.5	$0.5	$0.5	$0.5	$2.6
Extend Secondary Payer Provisions	$0.0	$0.0	$0.0	$0.0	$0.0	$1.2	$1.8	$3.0
TOTAL MEDICARE	**$0.0**	**$0.9**	**$4.9**	**$7.1**	**$11.1**	**$16.8**	**$20.6**	**$61.4**
Medicaid Savings								
Reduce DSH Payments	$0.0	$0.0	$2.0	$2.4	$2.6	$3.0	$3.3	$13.3
Medicaid Capitation	$0.0	$0.0	$0.6	$2.8	$5.8	$9.0	$13.0	$31.2
TOTAL MEDICAID	**$0.0**	**$0.0**	**$2.6**	**$5.2**	**$8.4**	**$12.0**	**$16.3**	**$44.5**
Total Program Savings	**$0.0**	**$2.9**	**$9.5**	**$14.3**	**$22.5**	**$31.8**	**$39.9**	**$120.9**
NET INCREASE (DECREASE) IN FEDERAL DEFICIT								
Net Increase (Decrease) in Federal Deficit	**$1.5**	**($1.2)**	**$4.6**	**$1.0**	**($3.5)**	**($6.5)**	**($10.5)**	**($14.6)**

TABLE 2

DETAILED SUMMARY OF SOURCES AND USES OF FUNDS UNDER SENATOR DOLE'S HEALTH REFORM PROPOSAL (IN BILLIONS)

(CONTINUED)

a Based upon the provisions specified in the proposal, we estimate that premium subsidies will be available to persons through: 90 percent of poverty in 1996 through 1997; 100 percent of poverty in 1998; and 150 percent of poverty in 1999 through 2000.

b Includes tax deductions for individual purchases of health insurance and self-employed tax deduction offset by reduced tax deductions for out of pocket spending. The tax deduction for premiums will be phased-in with: a 25 percent deduction permitted in 1994 and 1995; a 50 percent deduction permitted in 1996 and 1997; a 75 percent deduction permitted in 1998 and 1999; and a full deduction permitted in 2000 and thereafter.

c Based upon Congressional Budget Office estimates.

d The reductions in PPS update factors under OBRA 1993 are extended through 2000. Payments to non-PPS hospitals are similarly reduced.

e Assumed to begin in 1996. Federal capital payment rate reduced by 7.31 percent and hospital specific rate by 10.41 percent. Inpatient capital payment rates for non-PPS is reduced by 15 percent. We assume that total Part A capital payments are reduced by 10 percent in each year.

f We assume DSH payments are phased down by 10 percent in 1998, 15 percent in 1997, 20 percent in 1998, and 25 percent in 1999 and 2000.

g The IME adjustment is reduced by 13 percent assumed to begin in 1996.

h OBRA 93 established a two year freeze on the updates to SNF costs while allowing a catch-up in FY 1996. We assume the partial catch-up allowed by this proposal reduces payments to skilled nursing facilities by about 3 percent beginning in 1996.

i OBRA 93 established a two year freeze on the updates to SNF costs while allowing a catch-up in FY 1996. We assume the partial catch-up allowed by this proposal reduces payments to home health services by about three percent beginning in 1996.

j Same proposal in HSA. Based on CBO estimates in "An Analysis of the Administration's Health Proposal," February 1994.

k Same proposal in HSA. The proposal establishes a cumulative performance standard which slows the growth in physician spending to roughly GDP plus an allowance for increased enrollment.

l The update in the Medicare Fee Schedule Conversion Factor is reduced by 3 percent in 1995 except for primary care physicians. Based on CBO estimates.

Source: Lewin-VHI estimates.

As discussed above, eligibility for subsidies would be expanded to 150 percent of poverty as funding becomes available through savings in other programs. Our analysis indicates that under these criteria, eligibility could be increased to 100 percent of poverty in 1998 and 150 percent of poverty in 1999.

CHANGES IN THE NUMBER OF UNINSURED

The proposal would expand insurance coverage in three ways. First, the proposal would reform insurance markets so that individuals can obtain coverage regardless of their health status. Second, premium subsidies would be provided to lower-income persons to help them pay for the cost of insurance. Third, individuals would be permitted to deduct the cost of individually purchased non-group coverage. The impact of these provisions is discussed below.

1. Under the proposal's insurance market reforms, insurers would be required to accept applications for coverage regardless of health status. The proposal also limits the variation in premiums by health status. We estimate that these market reforms would reduce the uninsured population by about 1.1 million persons.

2. Initially, the proposal would provide subsidies to families with incomes up to 90 percent of poverty. As federal savings are achieved through Medicare spending reductions and a cap on federal Medicaid expenditures for acute care, subsidies would be expanded to those with incomes up to 100 percent of poverty and then up to 150 percent of poverty. For persons below poverty, the subsidy will be equal to the full amount of the premium up to the maximum allowed under the proposal (as discussed above, we estimate this to be equal to about 90 percent of the premium). Subsidies are phased-out on a sliding scale with income between the poverty line and 150 percent of poverty.

3. The proposal would phase-in a tax deduction for insurance premium payments by persons without employer-based insurance and would increase the deduction for self-employed persons to 100 percent of the premium cost. These deductions are phased-in with a 25 percent deduction in 1994 and 1995; a 50 percent deduction in 1996 and 1997; a 75 percent deduction in 1998 and 1999; and a full deduction in 2000. This effectively reduces the cost of insurance for families resulting in an increase in insurance coverage. These provision would tend to have their greatest impact on insurance coverage for middle and upper income groups where marginal tax rates are highest. We estimate that this provision ultimately would reduce the number of uninsured by 1.1 million persons once the deductions are fully phased-in.

As discussed above, we estimate that premium subsidies would be provided only through 90 percent of poverty in 1996 and 1997. In addition, only a 50 percent tax deduction for insurance purchases would be permitted in these years. Given these levels of subsidies, we estimate that in 1996 and 1997, about 16.9 percent of the 37 million persons who do not have insurance will obtain coverage ***(Table 3)***.

We estimate that by 1998, Medicare and Medicaid program savings would be sufficient to fund expanded eligibility for premium subsidies up to 100 percent of poverty. Tax deductions would

TABLE 3

PERCENT OF UNINSURED WHO BECOME COVERED AND PERCENT OF POPULATION REMAINING UNINSURED UNDER SENATOR DOLE'S HEALTH REFORM PROPOSAL.

		PERCENT OF UNINSURED WHO BECOME COVERED				PERCENT OF POPULATION UNINSURED				
							UNDER REFORM PROPOSAL			
	Number of Uninsured in 1998	1996-1997 Subsidies to 90% of Poverty (50% Deduction)	1998 Subsidies to 100% of Poverty (75% Deduction)	1999 Subsidies to 150% of Poverty (75% Deduction)	2000 Subsidies to 150% of Poverty (Full Deduction)	Current Law	1996-1997 Subsidies to 90% of Poverty (50% Deduction)	1998 Subsidies to 100% of Poverty (75% Deduction)	1999 Subsidies to 150% of Poverty (75% Deduction)	2000 Subsidies to 150% of Poverty (Full Deduction)
TOTAL	37.2	16.9%	19.4%	26.9%	27.7%	14.2%	11.8%	11.4%	10.4%	10.3%
INCOME										
< $10,000	5.9	39.0%	39.0%	40.7%	40.7%	21.7%	13.2%	13.2%	12.9%	12.9%
$10-15,000	4.6	21.7%	26.1%	43.5%	43.5%	24.2%	18.9%	17.9%	13.7%	13.7%
$15-20,000	4.1	12.2%	24.4%	43.9%	43.9%	24.4%	21.4%	18.4%	13.7%	13.7%
$20-30,000	6.5	10.8%	10.8%	24.6%	23.1%	19.2%	17.1%	17.1%	14.5%	14.8%
$30-40,000	4.6	10.9%	13.0%	17.4%	17.4%	15.0%	13.4%	13.1%	12.4%	12.4%
$40-50,000	3.4	11.8%	11.8%	11.8%	14.7%	11.1%	9.8%	9.8%	9.8%	9.5%
$50,000 +	8.1	11.1%	12.3%	12.3%	13.6%	7.8%	6.9%	6.8%	6.8%	6.7%
AGE										
<18	9.7	19.6%	21.6%	32.0%	33.0%	13.8%	11.1%	10.8%	9.4%	9.3%
18-21	2.8	25.0%	25.0%	32.1%	32.1%	29.8%	22.3%	22.3%	20.2%	20.2%
21-24	4.1	19.5%	19.5%	24.4%	24.4%	29.0%	23.3%	23.3%	21.9%	21.9%
25-34	7.8	19.2%	21.8%	28.2%	29.5%	19.5%	15.8%	15.3%	14.0%	13.8%
35-44	5.7	15.8%	19.3%	26.3%	28.1%	14.6%	12.3%	11.8%	10.8%	10.5%
45-54	4.3	4.7%	9.3%	14.0%	14.0%	12.3%	11.7%	11.1%	10.6%	10.6%
55-64	2.7	11.1%	14.8%	25.9%	25.9%	11.2%	9.9%	9.5%	8.3%	8.3%
65+	0.1	0.0%	0.0%	0.0%	0.0%	0.3%	0.3%	0.3%	0.3%	0.3%

Source: Lewin-VHI estimates.

also be increased to 75 percent of premium costs in that year. Due to this expanded eligibility for subsidies, about 19.4 percent of those who would otherwise have been uninsured in 1998 would obtain coverage *(Table 3)*. By 2000, subsidies would be available to all persons through 150 percent of poverty and the full amount of the premium would be tax deductible. Under these provisions, about 28 percent of those who would otherwise have been uninsured in 2000 would obtain coverage.

Table 4 shows the percent of uninsured who become covered and the percent of the population remaining uninsured under the proposal in each state.

Impact on State Governments

The proposal would finance expansions in coverage in-part through reduced federal payments to states under the Medicaid program of about $44.5 billion over the 1996 through 2000 period. The proposal would cap the rate of growth in contributions to states for acute care services provided under the program, and federal funding for disproportionate share hospital payments would be reduced by about 25 percent. These reductions in federal revenues for states would be offset by savings to existing state indigent care programs of about $8.6 billion as person served by these programs obtain subsidized insurance coverage under the proposal. The net loss in funding to states would be $35.8 billion over the 1996 through 2000 period.

As discussed above, the proposal would limit the rate of growth in federal Medicaid payments for acute care per eligible individual not to exceed six percent beginning in 1996 (five percent after 2000). The proposal also prohibits states from eliminating coverage for eligibility groups covered by the state as of 1994, thus, limiting the state's ability to absorb the revenue cuts through reductions in coverage. This per-capita capitation of federal contributions for acute care would result in a loss of revenues to states of about $31.2 billion over the 1996 through 2000 period. Thus, states either would have to raise the revenues required to fund benefits costs that otherwise would have been covered with federal funds or find some other way to reduce program costs.

The proposal also would reduce federal contributions for the disproportionate share hospital (DSH) program by $13.3 billion over the 1996 through 2000 period. The net impact these DSH payment reductions on state governments is difficult to assess. In some states, the DSH funds are passed-on to hospitals and/or locally funded public hospitals with no net fiscal impact on the state. In other cases states use the DSH funds to offset spending under other indigent care programs thus providing fiscal relief for the states. It was not possible to perform a detailed analysis of the ultimate impact of these DSH reductions on state and local governments due to data limitations.

These reductions in federal funding for states would be offset in-part by savings to other indigent care programs financed by states as low-income persons currently receiving care under these programs obtain subsidized insurance coverage under the proposal. In particular, states with "state only Medicaid" programs covering low-income persons who do not qualify for Medicaid are likely to see significant savings as some of these individuals obtain federally subsidized private insurance under the proposal. We estimate these savings to be about $8.6 billion over the 1996 through 2000 period.

TABLE 4

PERCENT OF UNINSURED WHO BECOME COVERED AND PERCENT OF POPULATION REMAINING UNINSURED UNDER THE SENATOR DOLE'S HEALTH REFORM PROPOSAL BY STATE[a]

		Percent of Uninsured Who Become Covered					Percent of Population Uninsured Under Reform Proposal			
	Number of Uninsured in 1998	1996-1997 Subsidies to 90% of Poverty (50% Deduction)	1998 Subsidies to 100% of Poverty (75% Deduction)	1999 Subsidies to 150% of Poverty (75% Deduction)	2000 Subsidies to 150% of Poverty (Full Deduction)	Current Law	1996-1997 Subsidies to 90% of Poverty (50% Deduction)	1998 Subsidies to 100% of Poverty (75% Deduction)	1999 Subsidies to 150% of Poverty (75% Deduction)	2000 Subsidies to 150% of Poverty (Full Deduction)
Total	37,202,343	16.9%	19.4%	26.9%	27.7%	14.2%	11.8%	11.4%	10.4%	10.3%
Alabama	769,929	24.5%	27.0%	34.7%	35.4%	17.5%	13.9%	13.5%	12.0%	11.9%
Alaska	79,561	21.6%	23.3%	28.6%	29.4%	14.4%	11.9%	11.6%	10.8%	10.7%
Arizona	630,229	23.9%	26.4%	33.5%	34.2%	16.7%	13.3%	12.9%	11.6%	11.5%
Arkansas	418,649	24.1%	26.7%	34.5%	35.2%	16.3%	13.0%	12.5%	11.2%	11.1%
California	6,168,586	23.6%	25.8%	32.6%	33.3%	18.9%	15.3%	14.9%	13.5%	13.4%
Colorado	378,539	23.9%	27.1%	35.8%	36.5%	10.9%	8.7%	8.3%	7.3%	7.2%
Connecticut	248,468	20.2%	22.0%	27.3%	28.1%	7.1%	5.9%	5.8%	5.4%	5.3%
Delaware	103,148	21.8%	23.9%	30.3%	31.1%	13.9%	11.4%	11.1%	10.1%	10.0%
DC	133,745	23.4%	25.9%	33.3%	34.0%	24.0%	19.3%	18.7%	16.8%	16.7%
Florida	2,638,648	23.2%	25.6%	33.3%	34.0%	18.7%	15.1%	14.6%	13.1%	13.0%
Georgia	1,019,704	24.4%	26.6%	32.8%	33.5%	15.5%	12.3%	11.9%	10.9%	10.8%
Hawaii	84,875	21.5%	23.0%	28.6%	29.4%	6.9%	5.7%	5.6%	5.2%	5.1%
Idaho	185,686	23.3%	25.7%	32.9%	33.6%	17.1%	13.8%	13.3%	12.0%	11.9%
Illinois	1,385,725	22.7%	24.7%	31.2%	31.9%	11.2%	9.1%	8.8%	8.1%	8.0%
Indiana	720,102	25.4%	27.6%	34.7%	35.5%	12.4%	9.7%	9.4%	8.5%	8.4%
Iowa	257,142	23.8%	26.3%	34.6%	35.3%	8.7%	6.9%	6.7%	6.0%	5.9%
Kansas	304,126	24.4%	27.0%	35.0%	35.7%	11.2%	8.9%	8.6%	7.7%	7.6%
Kentucky	487,679	25.2%	27.9%	36.6%	37.3%	12.8%	10.0%	9.7%	8.5%	8.4%
Louisiana	884,624	25.3%	27.8%	35.3%	36.0%	20.1%	15.8%	15.2%	13.6%	13.5%
Maine	143,172	24.0%	26.2%	33.7%	34.5%	11.2%	9.0%	8.7%	7.8%	7.7%
Maryland	654,354	21.2%	23.0%	28.6%	29.4%	13.1%	10.8%	10.6%	9.8%	9.7%
Massachusetts	618,839	22.3%	24.1%	29.4%	30.1%	10.2%	8.3%	8.1%	7.5%	7.4%
Michigan	867,655	22.8%	25.0%	31.8%	32.6%	8.9%	7.2%	7.0%	6.4%	6.3%
Minnesota	411,966	23.4%	25.9%	33.2%	33.9%	8.9%	7.2%	7.0%	6.3%	6.2%
Mississippi	529,592	25.3%	27.9%	35.8%	36.5%	18.8%	14.7%	14.2%	12.6%	12.5%
Missouri	625,422	24.4%	27.4%	35.4%	36.2%	11.9%	9.5%	9.1%	8.1%	8.0%
Montana	115,614	24.9%	27.8%	36.8%	37.5%	13.4%	10.6%	10.2%	8.9%	8.8%
Nebraska	147,751	24.4%	26.8%	34.5%	35.2%	8.5%	6.7%	6.5%	5.8%	5.8%
Nevada	234,842	22.9%	25.2%	31.7%	32.5%	18.1%	14.6%	14.2%	12.9%	12.8%
New Hampshire	112,867	22.2%	24.1%	30.3%	31.1%	9.7%	7.9%	7.7%	7.1%	7.0%
New Jersey	863,081	21.4%	23.2%	28.3%	29.1%	10.6%	8.8%	8.6%	8.0%	7.9%
New Mexico	340,299	23.4%	25.7%	33.4%	34.1%	20.8%	16.8%	16.3%	14.6%	14.4%
New York	2,321,180	22.4%	24.5%	30.7%	31.5%	12.3%	10.0%	9.8%	9.0%	8.9%
North Carolina	1,026,629	23.9%	26.5%	34.0%	34.7%	14.7%	11.8%	11.4%	10.2%	10.1%
North Dakota	47,062	24.6%	26.7%	34.2%	34.9%	7.1%	5.6%	5.4%	4.9%	4.8%
Ohio	1,168,185	23.6%	25.8%	32.6%	33.3%	10.0%	8.1%	7.8%	7.1%	7.0%
Oklahoma	601,362	24.6%	27.2%	35.4%	36.1%	18.0%	14.3%	13.8%	12.2%	12.1%
Oregon	433,260	24.4%	27.1%	35.5%	36.2%	13.9%	11.0%	10.6%	9.4%	9.3%
Pennsylvania	1,098,568	22.4%	24.6%	31.2%	32.0%	8.6%	7.0%	6.8%	6.2%	6.1%
Rhode Island	107,689	22.3%	23.9%	29.2%	30.0%	10.8%	8.8%	8.6%	8.0%	7.9%
South Carolina	546,478	24.9%	27.4%	34.8%	35.5%	14.7%	11.6%	11.2%	10.1%	10.0%
South Dakota	78,185	24.0%	26.4%	33.9%	34.6%	10.8%	8.6%	8.3%	7.5%	7.4%
Tennessee	699,537	23.8%	26.4%	34.3%	35.0%	13.9%	11.1%	10.7%	9.6%	9.5%
Texas	3,877,162	23.7%	26.2%	34.1%	34.8%	21.7%	17.4%	16.8%	15.0%	14.9%
Utah	225,761	22.6%	24.5%	31.5%	32.2%	12.5%	10.2%	9.9%	9.0%	8.9%
Vermont	67,768	23.2%	25.5%	33.2%	33.9%	11.1%	9.0%	8.7%	7.8%	7.7%
Virginia	1,050,171	22.5%	24.9%	31.5%	32.3%	16.3%	13.2%	12.8%	11.7%	11.6%
Washington	565,632	23.9%	25.9%	31.9%	32.7%	10.8%	8.6%	8.4%	7.7%	7.6%
West Virginia	281,012	24.3%	27.3%	36.2%	36.9%	14.6%	11.6%	11.2%	9.8%	9.7%
Wisconsin	384,275	23.0%	25.0%	31.6%	32.3%	7.4%	6.0%	5.8%	5.3%	5.2%
Wyoming	57,812	23.4%	26.1%	33.6%	34.3%	11.7%	9.4%	9.1%	8.1%	8.1%

a The bill phases-in subsidy eligibility at 90 percent of poverty in 1996 and 1997, 100 percent of poverty in 1998, and 150 percent of poverty in 1999 and 2000. Tax deductibility of non-group premium payments is also phased-in at: 50 percent of premium payments in 1996 and 1997; 75 percent in 1998 and 1999; and 100 percent in 2000.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

The net impact of the proposal on state government health spending over the 1996 through 2000 period is presented in ***Table 5*** for the 50 states and the District of Columbia. ***Table 6*** presents the net impact of the proposal on state governments in each individual year between 1996 and 2000.

IMPACT ON PROVIDERS

The proposal is in large part financed through various Medicare program reductions. Hospital revenues would be reduced by about $25 billion over the 1996 through 2000 period. Reductions in Medicare physician payments over this period would be about $28 billion. These provider income reductions would be partly offset by about $38.5 billion in savings for care provided free by hospitals and physicians as previously uninsured persons become covered through subsidized insurance. Thus, the proposal would result in a net reduction in provider revenues of $14.6 billion over the 1996 through 2000 period.

Table 7 shows the provider revenue effects by state for the 1996 through 2000 period. ***Table 8*** shows the annual net revenue effect by state for this period.

CLOSING

These estimates are based upon the most recent data and research available. However, they are very sensitive to assumptions concerning spending growth rates and individual behavior. In particular, these estimates are quite sensitive to differences in health expenditure growth rates across states. Therefore, these estimates should be treated as illustrative of potential program effects rather than point estimates of actual program outcomes.

TABLE 5

FEDERAL REVENUE REDUCTIONS NET OF STATE PROGRAM SAVINGS BY STATE: 1996 THROUGH 2000 (IN MILLIONS)

	Reductions in Federal Medicaid Funding				
	Per-Capita Payment Cap[a]	DSH Reductions[b]	Total Funding Loss	Savings to State Indigent Care Programs[c]	Revenue Reductions Net of Savings
Total	$31,200.0	$13,300.0	$44,500.0	($8,655.1)	$35,844.9
Alabama	$447.0	$332.9	$779.9	$0.0	$779.9
Alaska	$84.3	$12.6	$96.9	($21.3)	$75.6
Arizona	$614.6	$0.0	$614.6	($932.9)	$318.3
Arkansas	$382.0	$2.9	$384.9	$0.0	$384.9
California	$3,067.8	$1,289.8	$4,357.6	($137.0)	$4,220.6
Colorado	$233.9	$268.2	$502.1	($33.3)	$468.8
Connecticut	$300.8	$317.6	$618.3	($366.0)	$252.3
Delaware	$66.2	$3.9	$70.0	($12.8)	$57.3
Florida	$1,642.5	$154.3	$1,796.8	($61.9)	$1,734.9
Georgia	$979.0	$239.2	$1,218.2	$0.0	$1,218.2
Hawaii	$78.4	$30.7	$109.1	$0.0	$109.1
Idaho	$122.9	$0.9	$123.8	($61.9)	$61.9
Illinois	$1,214.0	$241.0	$1,455.0	($96.7)	$1,358.2
Indiana	$737.9	$113.4	$851.4	$0.0	$851.4
Iowa	$243.4	$3.7	$247.2	($51.9)	$195.3
Kansas	$152.6	$147.4	$300.1	($105.2)	$194.8
Kentucky	$728.0	$214.0	$942.0	$0.0	$942.0
Louisiana	$1,339.4	$823.4	$2,162.8	$0.0	$2,162.8
Maine	$246.9	$221.1	$468.0	$0.0	$468.0
Maryland	$587.0	$94.7	$681.7	$0.0	$681.7
Massachusetts	$750.5	$385.8	$1,136.4	($155.2)	$981.2
Michigan	$1,003.0	$438.1	$1,441.1	($128.9)	$1,312.2
Minnesota	$336.0	$13.9	$349.9	($319.2)	$30.7
Mississippi	$443.2	$124.9	$568.1	$0.0	$568.1
Missouri	$532.2	$563.6	$1,095.7	($71.6)	$1,024.2
Montana	$109.9	$0.8	$110.7	($24.0)	$86.7
Nebraska	$161.1	$2.0	$163.1	($25.2)	$137.9
Nevada	$89.3	$59.3	$148.6	($58.0)	$90.5
New Hampshire	$70.7	$315.3	$385.9	$0.0	$385.9
New Jersey	$842.4	$880.6	$1,722.9	($71.2)	$1,651.7
New Mexico	$234.9	$6.8	$241.8	$0.0	$241.8
New York	$3,890.3	$2,244.6	$6,134.9	($3,854.3)	$2,280.6
North Carolina	$835.8	$268.2	$1,103.9	$0.0	$1,103.9
North Dakota	$54.6	$0.8	$55.4	$0.0	$55.4
Ohio	$1,325.1	$364.2	$1,689.3	($869.8)	$819.5
Oklahoma	$325.3	$20.9	$346.2	$0.0	$346.2
Oregon	$236.9	$14.0	$250.8	($52.6)	$198.2
Pennsylvania	$987.7	$779.9	$1,767.6	($941.0)	$826.6
Rhode Island	$150.5	$32.5	$183.0	($48.0)	$135.0
South Carolina	$524.4	$340.7	$865.2	$0.0	$865.2
South Dakota	$78.0	$0.8	$78.9	$0.0	$78.9
Tennessee	$1,069.5	$355.5	$1,425.0	$0.0	$1,425.0
Texas	$1,725.9	$1,219.7	$2,945.5	$0.0	$2,945.5
Utah	$163.6	$6.0	$169.6	($22.8)	$146.7
Vermont	$72.0	$18.3	$90.3	$0.0	$90.3
Virginia	$484.2	$84.3	$568.5	($50.3)	$518.2
Washington	$465.4	$186.2	$651.6	$0.0	$651.6
West Virginia	$516.9	$53.5	$570.4	$0.0	$570.4
Wisconsin	$415.3	$6.5	$421.8	($77.8)	$344.0
Wyoming	$36.9	$0.8	$37.7	($4.3)	$33.4

a The growth in federal Medicaid acute care payments per recipient is capped not to exceed six percent per year beginning in 1996 (5 percent after 2000).

b Federal Medicaid DSH payments are reduced by 25 percent.

c Includes savings to state indigent care programs as persons now receiving care through these sources obtain subsidized coverage under the proposal.

Source: Lewin-VHI estimates.

TABLE 6

REDUCTIONS IN FEDERAL MEDICAID REVENUES OFFSET BY SAVINGS TO STATE INDIGENT CARE PROGRAMS UNDER THE DOLE BILL: 1996 THROUGH 2000 (IN MILLIONS)

	Federal Revenue Reductions Net of Savings to State Programs[a]					
	1996	1997	1998	1999	2000	1996 through 2000
Total	$1,122.3	$3,511.2	$6,711.2	$10,100.1	$14,400.1	$35,844.9
Alabama	$58.7	$100.2	$148.2	$204.0	$268.9	$779.9
Alaska	($0.1)	$5.7	$14.0	$22.5	$33.6	$75.6
Arizona	($147.5)	($126.9)	($67.8)	($27.5)	$51.3	($318.3)
Arkansas	$7.8	$34.8	$71.6	$110.8	$159.9	$384.9
California	$229.6	$481.3	$795.7	$1,145.8	$1,568.2	$4,220.6
Colorado	$39.2	$62.9	$89.4	$120.7	$156.7	$468.8
Connecticut	($9.0)	$12.9	$46.6	$78.0	$123.8	$252.3
Delaware	($0.3)	$4.1	$10.6	$17.2	$25.7	$57.3
Florida	$44.2	$163.2	$323.4	$495.0	$709.1	$1,734.9
Georgia	$54.8	$131.0	$228.7	$336.4	$467.3	$1,218.2
Hawaii	$6.1	$12.6	$20.6	$29.5	$40.3	$109.1
Idaho	($8.1)	($0.9)	$10.9	$22.1	$37.8	$61.9
Illinois	$43.1	$133.6	$253.9	$383.3	$544.4	$1,358.2
Indiana	$31.2	$86.7	$159.4	$238.4	$335.6	$851.4
Iowa	($3.6)	$12.4	$35.9	$59.7	$91.0	$195.3
Kansas	$7.1	$19.8	$36.7	$54.2	$77.1	$194.8
Kentucky	$46.2	$103.9	$177.2	$258.3	$356.4	$942.0
Louisiana	$149.6	$268.8	$409.9	$572.1	$762.4	$2,162.8
Maine	$38.0	$62.1	$89.1	$121.1	$157.7	$468.0
Maryland	$25.5	$69.8	$127.6	$190.7	$268.1	$681.7
Massachusetts	$46.0	$106.7	$184.7	$269.5	$374.4	$981.2
Michigan	$63.2	$143.9	$247.0	$359.9	$498.3	$1,312.2
Minnesota	($46.0)	($29.6)	$2.9	$30.0	$73.4	$30.7
Mississippi	$27.3	$62.3	$106.8	$156.0	$215.7	$568.1
Missouri	$82.8	$135.5	$195.1	$264.9	$345.9	$1,024.2
Montana	($1.9)	$5.3	$15.9	$26.6	$40.7	$86.7
Nebraska	($0.9)	$9.9	$25.4	$41.4	$62.1	$137.9
Nevada	$0.7	$7.4	$16.9	$26.4	$39.2	$90.5
New Hampshire	$48.8	$63.2	$74.8	$91.5	$107.7	$385.9
New Jersey	$136.5	$220.6	$314.8	$426.0	$553.8	$1,651.7
New Mexico	$5.5	$22.3	$45.0	$69.3	$99.6	$241.8
New York	($245.7)	$2.1	$409.9	$782.4	$1,331.8	$2,280.6
North Carolina	$56.4	$123.4	$207.8	$301.6	$414.8	$1,103.9
North Dakota	$1.2	$5.0	$10.3	$15.9	$23.0	$55.4
Ohio	($68.3)	$14.9	$147.8	$273.5	$451.6	$819.5
Oklahoma	$9.4	$33.0	$64.6	$98.5	$140.7	$346.2
Oregon	($2.3)	$13.5	$36.5	$59.9	$90.6	$198.2
Pennsylvania	($24.4)	$45.8	$152.5	$254.3	$398.5	$826.6
Rhode Island	($0.4)	$10.0	$25.0	$40.2	$60.2	$135.0
South Carolina	$61.3	$108.5	$164.1	$228.1	$303.1	$865.2
South Dakota	$1.6	$7.1	$14.7	$22.7	$32.7	$78.9
Tennessee	$74.0	$160.1	$268.3	$388.7	$533.8	$1,425.0
Texas	$216.6	$375.0	$559.3	$773.0	$1,021.7	$2,945.5
Utah	$0.2	$11.3	$27.1	$43.5	$64.6	$146.7
Vermont	$4.1	$9.8	$17.0	$24.9	$34.5	$90.3
Virginia	$13.4	$48.8	$96.7	$147.6	$211.6	$518.2
Washington	$36.9	$75.4	$122.9	$176.2	$240.1	$651.6
West Virginia	$18.0	$56.0	$106.5	$161.2	$228.6	$570.4
Wisconsin	($4.3)	$23.3	$63.3	$104.2	$157.6	$344.0
Wyoming	$0.1	$2.6	$6.2	$9.9	$14.6	$33.4

[a] Includes reduced federal Medicaid funding for acute care (capitation and DSH) offset by savings to existing state indigent care programs.

Source: Lewin-VHI estimates.

TABLE 7

CHANGE IN PROVIDER REVENUES UNDER THE DOLE BILL BY STATE: 1996 THROUGH 2000 (IN MILLION

	Reduced Physician Revenues[a]	Reduced Hospital Revenues[a]	Total Provider Revenue Reductions	Provider Revenue Increases[b]	Net Revenue Effect
TOTAL	$28,300.0	$24,787.8	$53,087.8	$38,535.2	($14,552.6)
Alabama	$490.5	$451.3	$941.7	$799.9	($141.8)
Alaska	$18.7	$13.7	$32.4	$53.2	$20.7
Arizona	$440.9	$313.0	$753.9	$203.7	($550.2)
Arkansas	$316.4	$200.4	$516.8	$196.4	($320.4)
California	$3,082.0	$2,832.2	$5,914.2	$4,969.0	($945.2)
Colorado	$219.4	$173.2	$392.6	$385.8	($6.9)
Connecticut	$431.1	$336.1	$767.2	$470.0	($297.2)
Delaware	$69.0	$52.7	$121.7	$69.3	($52.4)
DC	$77.7	$182.2	$259.9	$166.2	($93.8)
Florida	$2,739.7	$1,525.0	$4,264.7	$2,057.5	($2,207.2)
Georgia	$627.6	$631.6	$1,259.3	$1,801.4	$542.1
Hawaii	$68.1	$89.1	$157.2	$98.0	($59.2)
Idaho	$76.0	$33.3	$109.4	$82.9	($26.4)
Illinois	$1,226.0	$1,130.0	$2,356.0	$1,073.5	($1,282.5)
Indiana	$506.1	$437.2	$943.3	$829.3	($113.9)
Iowa	$268.2	$185.5	$453.7	$433.3	($20.4)
Kansas	$276.1	$169.5	$445.6	$309.7	($135.9)
Kentucky	$405.6	$375.6	$781.3	$372.5	($408.8)
Louisiana	$496.4	$523.5	$1,019.9	$650.9	($369.1)
Maine	$120.3	$90.5	$210.8	$93.7	($117.1)
Maryland	$555.2	$382.5	$937.6	$734.3	($203.4)
Massachusetts	$717.6	$820.6	$1,538.2	$1,191.0	($347.2)
Michigan	$1,181.3	$932.3	$2,113.6	$1,196.0	($917.6)
Minnesota	$255.2	$353.5	$608.7	$603.7	($5.0)
Mississippi	$256.5	$239.0	$495.6	$545.0	$49.5
Missouri	$568.5	$498.9	$1,067.3	$719.6	($347.8)
Montana	$70.0	$43.5	$113.6	$73.9	($39.6)
Nebraska	$145.6	$125.6	$271.2	$209.8	($61.4)
Nevada	$148.1	$88.4	$236.5	$212.7	($23.8)
New Hampshire	$85.4	$69.4	$154.8	$76.6	($78.2)
New Jersey	$1,033.2	$760.6	$1,793.7	$1,311.7	($482.1)
New Mexico	$112.6	$80.5	$193.0	$235.1	$42.0
New York	$2,466.2	$2,656.8	$5,123.0	$3,958.9	($1,164.1)
North Carolina	$591.9	$730.8	$1,322.7	$1,246.1	($76.7)
North Dakota	$62.0	$47.3	$109.3	$33.1	($76.2)
Ohio	$1,283.3	$1,102.2	$2,385.5	$1,387.6	($997.9)
Oklahoma	$335.6	$240.1	$575.7	$603.3	$27.6
Oregon	$226.7	$176.8	$403.5	$309.2	($94.4)
Pennsylvania	$1,873.4	$1,756.7	$3,630.1	$1,065.6	($2,564.5)
Rhode Island	$123.8	$95.2	$219.0	$114.3	($104.7)
South Carolina	$281.1	$358.1	$639.2	$836.3	$197.1
South Dakota	$59.8	$44.5	$104.3	$51.4	($52.9)
Tennessee	$524.0	$412.7	$936.7	$1,048.9	$112.2
Texas	$1,604.6	$1,550.1	$3,154.7	$3,080.4	($74.3)
Utah	$91.0	$79.4	$170.4	$143.0	($27.4)
Vermont	$40.8	$34.6	$75.4	$40.8	($34.6)
Virginia	$536.1	$483.9	$1,020.0	$1,068.3	$48.3
Washington	$440.5	$321.0	$761.5	$535.7	($225.7)
West Virginia	$208.9	$187.8	$396.7	$230.9	($165.8)
Wisconsin	$437.7	$351.2	$788.9	$459.6	($329.2)
Wyoming	$27.7	$18.0	$45.8	$96.3	$50.5

[a] Revenue reductions based on specific Medicare program reductions included in the Dole proposal (excludes payment reductions for long ter care and home health services).

[b] Increased insurance coverage under the Dole proposal results in increased revenue for providers as uncompensated care expenses decline.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM) and the Payments Simulation Model (PSM).

TABLE 8

NET ANNUAL PROVIDER REVENUE CHANGE BY STATE UNDER THE DOLE BILL[a]

	1996	1997	1998	1999	2000	1996-2000 Total
TOTAL	$2,276	$593	($2,833)	($6,023)	($8,566)	($14,553)
Alabama	$65	$34	($2[illegible])	($78)	($135)	($142)
Alaska	$6	$5	$4	$4	$1	$21
Arizona	$26	$54	$10[illegible]	($164)	($200)	($550)
Arkansas	($6)	($27)	($64)	($92)	($131)	($320)
California	$404	$215	($170)	($581)	($813)	($945)
Colorado	$33	$21	($3)	($19)	($40)	($7)
Connecticut	$16	($7)	($57)	($112)	($137)	($297)
Delaware	$1	($3)	($11)	($15)	($23)	($52)
DC	$7	$1	($16)	($39)	($48)	($94)
Florida	$14	$14[illegible]	$43[illegible]	$735)	($912)	($2,207)
Georgia	$211	$1[illegible]	$106	$58	($9)	$542
Hawaii	$4	($1)	($11)	($20)	($31)	($59)
Idaho	$6	$2	($6)	($9)	($19)	($26)
Illinois	($8)	($88)	($249)	($408)	($529)	($1,283)
Indiana	$66	$36	($21)	($75)	($120)	($114)
Iowa	$39	$24	($6)	($22)	($56)	($20)
Kansas	$16	$1	($29)	($44)	($80)	($136)
Kentucky	$2	($27)	($81)	($123)	($180)	($409)
Louisiana	$34	($1)	($68)	($137)	($197)	($369)
Maine	($1)	($9)	($24)	($33)	($50)	($117)
Maryland	$43	$15	($44)	($91)	($126)	($203)
Massachusetts	$69	$28	($66)	($164)	($214)	($347)
Michigan	$27	($39)	($179)	($316)	($410)	($918)
Minnesota	$54	$37	$0	($26)	($71)	($5)
Mississippi	$56	$40	$8	($8)	($47)	$49
Missouri	$32	($2)	($70)	($126)	($183)	($348)
Montana	$3	($1)	($9)	($10)	($22)	($40)
Nebraska	$14	$5	($13)	($23)	($45)	($61)
Nevada	$18	$10	($5)	($18)	($29)	($24)
New Hampshire	($1)	($6)	($16)	($24)	($32)	($78)
New Jersey	$70	$15	($97)	($205)	($265)	($482)
New Mexico	$25	$19	$7	$3	($11)	$42
New York	$263	$119	($202)	($578)	($766)	($1,164)
North Carolina	$109	$70	($14)	($85)	($156)	($77)
North Dakota	($3)	($8)	($16)	($20)	($30)	($76)
Ohio	$35	($40)	($194)	($351)	($449)	($998)
Oklahoma	$55	$37	$2	($16)	($51)	$28
Oregon	$22	$8	($19)	($39)	($65)	($94)
Pennsylvania	($124)	($248)	($497)	($765)	($931)	($2,564)
Rhode Island	$1	($6)	($20)	($36)	($44)	($105)
South Carolina	$93	$76	$40	$8	($20)	$197
South Dakota	($0)	($4)	($11)	($13)	($25)	($53)
Tennessee	$98	$70	$16	($3)	($68)	$112
Texas	$262	$170	($17)	($147)	($315)	($74)
Utah	$11	$6	($5)	($14)	($24)	($27)
Vermont	$0	($2)	($7)	($9)	($16)	($35)
Virginia	$94	$65	$6	($34)	($84)	$48
Washington	$32	$7	($44)	($92)	($129)	($226)
West Virginia	$6	($8)	($34)	($51)	($79)	($166)
Wisconsin	$14	($13)	($66)	($107)	($158)	($329)
Wyoming	$13	$12	$10	$8	$7	$51

a Revenue reductions based on specific Medicare program reductions included in the Dole Proposal (excludes payment reductions for long term care and home health services). Increased insurance coverage under the proposal results in increased revenue for providers as uncompensated care expenses decline.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM) and the Payments Simulation Model (PSM).

7/22/94

SENIORS ON DOLE

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Six Reasons the Dole Health Care Bill is Bad Medicine:

NO universal coverage: More than 22 million Americans would remain uncovered under the Dole health care bill.

NO home and community-based long-term care: Under the Dole bill, senior citizens needing assistance would continue to be forced into high-priced nursing homes rather than being allowed to stay at home with low-cost assistance.

NO prescription drug coverage: More than 31 million Americans under age 65, and over 18.5 million Americans over age 65 would be denied prescription drug coverage under the Dole bill.

NO private sector cost containment. Under the Dole bill, health care costs in the private marketplace would continue to spiral upward out of control. More and more Americans would find themselves unable to afford health insurance.

NO new benefits extended to senior citizens: The Dole bill would cut and cap Medicare, but would not invest any of the money saved into new benefits for older Americans.

- **NO end to insurance company discrimination:** Under the Dole bill insurance companies would be allowed to deny insurance coverage for preexisting conditions for up to one year, would be allowed to raise rates when people got sick, and would be allowed to discriminate against applicants on the basis of age.

For further information, contact Patrick Burns, Director of Communications, NCSC: (202) 624-9583

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island Second Vice President, George J. Kourpias, Washington, DC
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NEWS RELEASE
National Council of Senior Citizens
1331 F Street, NW • Washington, DC 20004-1171 • (202) 347-8800 • FAX (202) 624-9595

Remarks of Larry Smedley, Chair of the Leadership Council of Aging Organizations and Executive Director, National Council of Senior Citizens July 19, 1994 Press Conference on the Dole Health Care Bill

GOOD MORNING.

My name is Larry Smedley and I am Executive Director of the National Council of Senior Citizens and the current chair of the Leadership Council of Aging Organizations.

The LCAO is an umbrella coalition of 37 nonprofit membership groups and provider organizations working on behalf of America's 40 million senior citizens.

Joining me today on behalf of the LCAO are Lucretia Paschall of the American Association of Retired Persons, Dan Thursz of the National Council of Aging and a cochair of the LCAO, Samuel Simmons of the National Caucus and Center on Black Aged, and Dianna Porter of OWL, the Older Women's League.

Also joining us today are Senator David Pryor of Arkansas and Senator Bob Graham of Florida, who will give their own take on health care legislation now before the Senate.

The Leadership Council of Aging Organizations, which represents 40 million older Americans, is here today to serve notice that . . . **WE WILL NOT SUPPORT, AND MOST OF US WILL ACTIVELY OPPOSE, THE DOLE HEALTH CARE LEGISLATION.**

Mr. Dole offers the American people a bill that does not extend universal coverage to all Americans.

He offers us a bill that provides for no home and community-based long-term care for handicapped older and younger Americans.

He ignores the spiraling costs of prescription drugs, and fails to extend prescription drug coverage to the elderly and the young.

The Dole bill ignores the urgent need for cost containment and allows health care costs in the private marketplace to continue to rise unfettered.

Finally, the Dole bill would ***cut and cap Medicare, but give nothing back to senior citizens in return.***

This is a bill that takes, but does not give. A bill that would cut Medicare, but not reinvest in long-term care or prescription drug coverage.

In short, **this legislation is as hollow as a kettle drum and we are not buying it**.

We do not believe this is a serious attempt at reform. It is posturing at its worst — posturing when real lives are at stake and when real solutions are very near passage.

This is part of the great Washington end game of SAYING ANYTHING, AND DOING NOTHING and we are not playing.

We will not support Senator Dole's legislation which would leave more than twenty-two million of our children and grandchildren uncovered.

We will not support legislation that does not reinvest Medicare savings into long-term care and prescription drug coverage.

And we will not support legislation that does not provide for the kind of cost containment needed to assure that ALL Americans will be able to afford health care into the future.

The American people have extended far better health care coverage to Senator

Dole than he appears to be willing to extend to them.

Senator Dole's legislation would leave us with a **health care system** that is neither healthy, nor caring, nor a system.

It is not the best this great nation can do, and it is certainly not the best bill now before Congress.

Even the Senate Finance Committee bill -- ***a bill we in the aging community also find woefully inadequate*** -- is marginally better than the legislation Senator Dole has crafted.

And while we in the LCAO believe the Senate Finance Committee bill also takes too much and gives too little, we are at least hopeful that the Democratic leadership will craft a reconciliation bill that will set right what that Finance Committee has made wrong.

Senator Dole's bill, however, makes clear that we cannot expect compromise language from his end of the leadership aisle. Senator Dole continues to show far more enthusiasm for cutting existing health care benefits to older Americans than he does for extending universal coverage to ALL Americans.

In short, the Dole bill is a prescription for disaster, not a prescription for change. It would give older Americans less and cost them more. It would force millions of senior citizens deeper into poverty as they struggle to pay mounting out-of-pocket health care costs. It is **BAD MEDICINE**, plain and simple.

To steal a phrase, when asked to support or cosponsor Senator Dole's legislation, every Senator should "just say no" or risk being accused of being "soft on health" and of turning their back on the health care needs of the elderly.

With that, I'll close and turn the mike over to Senator David Pryor of Arkansas, Chairman of the Senate Aging Committee, followed by Senator Bob Graham of Florida. Senator Pryor . . . .

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AARP NEWS

For further inquiry, contact American Association of Retired Persons • 601 E Street, N.W. • Washington, D.C. 20049 • 202/434-2560

FOR IMMEDIATE RELEASE
July 19, 1994

CONTACT: Peter Ashkenaz
202/434-2560

AARP CALLS SENATOR DOLE'S HEALTH CARE REFORM PROPOSAL A HARMFUL PRESCRIPTION FOR OLDER AMERICANS

WASHINGTON, D.C. -- The health care reform proposal introduced by Sen. Robert Dole (R-KS) will harm the current health care system for seniors and would leave most of the 37 million uninsured Americans without health coverage, according to AARP.

"Senator Dole's plan will not help older Americans," said Lucretia Paschall, a member of AARP's National Legislative Council. "This plan would leave millions of American families without any health care coverage, does not address the high cost of prescription drugs and long-term care and shifts costs to the private sector.

"This proposal is a long way from providing health security to all Americans, nor does it control skyrocketing health care costs, leaving the young and old at the mercy of higher health care costs," continued Paschall. "And by simply cutting Medicare, employers and families will see their insurance premiums rise and Medicare beneficiaries could find it even harder to get into their doctor's offices.

"None of these savings will be re-invested into helping Americans pay for prescription drugs or long-term care, important elements for Americans of all ages," Paschall said.

-- more --

"AARP is committed to the enactment of comprehensive health care reform this year," Paschall said. "Congress needs to consider real solutions, not proposals that fall far short of the mark."

Real health care reform must:

- make sure that all Americans have health coverage;
- include important benefits like prescription drugs and long-term care for young and old;
- control skyrocketing health care costs; and
- be financed fairly - not primarily with Medicare cuts.

AARP is the nation's leading organization for people 50 and older. It serves their needs and interests through legislative advocacy, research, informative programs and community services provided by a network of local chapters and experienced volunteers throughout the country. The organization also offers members a wide range of special benefits, including Modern Maturity and the monthly Bulletin.

# # # #

news

The National Caucus and Center on Black Aged Inc.

NEWS RELEASE

FOR IMMEDIATE RELEASE

CONTACT: SAMUEL J. SIMMONS
(202) 637-8400

NCBA CONDEMNS SENATE FINANCE COMMITTEE AND DOLE PROPOSED HEALTH CARE REFORM PLANS

Washington, D.C. (July 19, 1994) -- The National Caucus and Center on Black Aged (NCBA), condemns the reported proposed Senate Finance Committee "breakthrough agreement" on Health Care Reform and the Dole proposal for Health Care Reform. Stated NCBA President Samuel J. Simmons, "We are very disturbed that these proposals will not bring about Health Care Reform but a mere patch job on a defective health care system. Neither responds to the needs of low and moderate income families in our nation."

NCBA's position is that any Health Care Reform plan must guarantee adequate comprehensive health care coverage by a date certain. Further, such a system will fail unless it is financed by mandated payments by the Federal Government or employers. The organization also strongly opposes any plan to finance Health Care Reform by drastically reducing the Medicaid program. NCBA applauds the House of Representatives Education and Labor and Ways and Means Committees, and the Senate Labor and Human Resources Committee for adopting Health Care Reform plans that provide for universal coverage and mandated employer payment of health insurance premiums.

Stated Simmons, "NCBA is urging the members of its thirty-six chapters and affiliated organizations to contact their Senators and Congresspersons to push for guaranteed universal coverage and mandated employer payment of premiums."

The National Caucus and Center on Black Aged is the only national organization that dedicates itself solely to improving life for the nation's 2.5 million African American elderly -- particularly those of low income.

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O·W·L

STATEMENT OF THE OLDER WOMEN'S LEAGUE
July 19, 1994

The Older Women's League is committed to working to ensure that the health care reform legislation passed in this Congress includes universal coverage and comprehensive benefits including long-term care and prescription drugs. The Dole proposal does not address any of these principles.

We call upon Congress to demonstrate genuine courage by guaranteeing all Americans that they will never again worry about how they will pay for the health care they need.

All Americans lose without universal coverage, even those who may now feel safe. Legislation without universal coverage is particularly detrimental to women who are traditionally marginalized in health care. Older women will lose because they will experience an erosion of benefits under Medicare. Poor women will lose because a patchwork system of health care that does not include universal coverage will continue to allow women just above the poverty level to slip through the cracks. And all women will lose because women represent a disproportionate number of those without health care coverage. Neither the Dole nor the Senate Finance Committee plans will provide universal coverage.

Health care legislation must mandate a full range of preventive, primary, reproductive health, mental health and long-term care services for women. Under the Dole proposal, insurance companies can still decide which benefits to cover and which to deny. The proposal also repeals existing state laws guaranteeing insurance for certain services, including mammograms.

The Dole proposal does not provide for a long-term care program--only tax deductions for those who can afford long-term care services on their own. Long-term care is not an issue for the older population only. Chronic and disabling illnesses affect people of all ages. It is a vital concern for women who both provide the majority of family caregiving and are most likely to require such care as they age.

Women outlive men by an average of seven years, and are the majority of the older population. Sixty percent of those age 65 and over are women. Sixty-eight percent of persons 80 years of age and older are women. Women are more likely to suffer from chronic illness, while being least able to pay for health care.

In addition, three out of every four caregivers to the elderly are women. The average caregiver is a 45-year-old married woman.

Thirty-five percent of caregivers to the elderly are over age 65. Many women assume eldercare responsibilities at a time of crisis and may continue to provide the quality care they feel their loved one deserves for years -- with no outside support.

Our nation's health care system can, and must, permit individuals to receive the supportive services they want to enable them to remain in their homes and to age with dignity. At the same time, responsibility for this care for long periods cannot be placed solely on the shoulders of family members. In-home and community services are needed that promote quality care and that protect the caregiver's own health.

The Older Women's League is the convenor of the Campaign for Women's Health. The CWH is a national coalition of 98 women's, labor and health care organizations representing over eight million Americans. Through these coalition efforts, OWL has ensured that preventive, primary, specialized, and reproductive services as well as long-term care are recognized as vital concerns of women.

The coverage of prescription drugs is also of crucial importance. Older women have an annual median income of only $8,189 and must frequently forego purchasing prescription drugs that would alleviate their chronic conditions. There is no provision for prescription drug coverage for Medicare beneficiaries under the Dole plan.

We call upon the members of Congress in the Senate and House of Representatives to meet their responsibility to the American people and to complete health care reform this year. We must all work together, not apart, to ensure a health care system in America that guarantees every person comprehensive health care.

Older Women's League
666 11th Street NW, Suite 700 · Washington DC 20001 · (202)783-6686 · (202)638-2356 FAX

NEWS The National Council on the Aging NCOA

409 Third Street SW, Washington, DC 20024 Phone: (202) 479-1200 FAX: (202) 479-0735 TDD: (202) 479-6674

FOR IMMEDIATE RELEASE

CONTACT: LOUISE CLEVELAND
202/479-6975

"TRUE" HEALTH CARE REFORM MUST INCLUDE LONG-TERM CARE AND UNIVERSAL COVERAGE, SAYS NCOA

WASHINGTON DC, JULY 19--Dr. Daniel Thursz, President of The National Council on the Aging, Inc. (NCOA), today expressed The Council's "long-standing, unequivocal position" toward health care reform:

> "The National Council on the Aging, representing millions of Americans of all ages, will not settle for any plan that does not include universal coverage; home and community-based long-term care; prescription drug coverage; and the maintenance of Medicare. Versions such as Senator Dole's and that of the Senate Finance Committee do not meet these objectives and would take unfair advantage of millions of older persons across America."

"Now is the time to respond to the health care crisis," added Thursz, co-chair of the Leadership Council of Aging Organizations. "We have enormous power to act, and cannot afford to wait one more minute."

Thursz said NCOA applauds the efforts of congressional leaders such as Senator Jay Rockefeller, who has worked diligently over the years on behalf of older Americans.

The National Council on the Aging, Inc., is a nonprofit organization that serves as resource for information, training, technical assistance, public policy advocacy, and publications on every aspect of aging. It has a national membership of thousands of individuals and organizations, professional and voluntary, who serve millions of older persons and their families.

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Press Conference on the Dole Health Care Bill July 19, 1994

Lawrence T. Smedley, Chair of the Leadership Council of Aging Organizations, and Executive Director of the National Council of Senior Citizens.

Senator David Pryor of Arkansas, Chairman of the Senate Committee on Aging

Senator Bob Graham of Florida

Lucretia Paschall, American Association of Retired Persons

- **Dan Thursz, President, National Council of the Aging**
- **Samuel J. Simmons, National Caucus and Center on Black Aged**
- **Dianna Porter, Older Women's League**

The Leadership Council of Aging Organizations is an umbrella coalition of 37 nonprofit membership groups and provider organizations working on behalf of America's senior citizens. The LCAO has a combined membership of approximately 40 million older Americans.

1331 F Street, NW, Suite 500, Washington, DC 20004-1171 (202) 347-8800 Fax: (202) 624-9595

ALZHEIMER'S ASSOCIATION
Someone to Stand By You.

STATEMENT OF THE ALZHEIMER'S ASSOCIATION
July 19, 1994

The Alzheimer's Association supports health reform that will provide universal coverage for all Americans, bring health costs under control, and address the central issues for families facing Alzheimer's disease -- long term care and funding for research. We cannot settle for anything less.

That is why we oppose the alternative health care plan that Senator Dole has offered. The Dole proposal is not real reform. It offers no way to achieve universal coverage or real cost containment. And it does nothing to address long term care. The 4 million Americans who have Alzheimer's disease and the 19 million people in the families that care for them will be left right where they are today -- paying everything out of their own pockets until they lose their life savings and qualify for welfare.

Tax incentives to help the healthy and wealthy pay for private long term care insurance are no answer for most American families. This is not the place to spend the next dollar on long term care. The President set out a reasonable and affordable proposal for home and community based long term care which has been incorporated, in one form or another, in the health care bills reported by every Committee with jurisdiction on this issue.

Alzheimer families understand that we cannot get adequate long term care, or full funding for research, until we bring health care costs under control -- a goal we can only achieve through comprehensive reform.

We call on Congress to seize this historic opportunity to provide real health security for all Americans. Don't dole out health care!

for further information contact:
Stephen McConnell
Senior Vice President, Public Policy
202/393-7737

UNITED STATES SENATE • SPECIAL COMMITTEE ON AGING

AGING NEWS

SENATOR DAVID PRYOR, CHAIRMAN

Statement of Senator David Pryor (D-Ark.)

Chairman

U.S. Senate Special Committee on Aging

July 19, 1994

Recently the distinguished Minority Leader unveiled his own health reform proposal. We are here today to express our concerns about how this plan will affect older Americans.

Under the Dole plan, not only will the ranks of the uninsured continue to grow, but also older Americans will see their coverage deteriorate. At first when I read the Dole proposal I thought a few pages were missing since the plan leaves out the key elements of health reform. In fact, this plan looks remarkably like what former President Bush proposed in the final months of his presidency – the plan that was designed to appease strong public sentiment for health care reform. This plan makes a mockery of true efforts to reform our health care system.

By relying almost entirely on Medicare and Medicaid cuts for financing, this plan places an unfair burden on the poor and the elderly. And after asking them to pay for his plan, Dole puts the Medicare program and its 34 million beneficiaries at risk. Instead of strengthening the Medicare program by adding benefits that seniors want and need, the Dole plan threatens the viability of the Medicare program. With Medicare cuts of this level coupled with the continuation of spiraling health care costs on the private side, seniors may see reduced access to the care they have now. Also, by capping Medicaid spending, the Dole plan would place the lowest income seniors at the highest risk by threatening that safety net program.

Although some claim this proposal improves Medicare managed care, it does

just the opposite. Benefits that have traditionally attracted beneficiaries to Medicare managed care -- like preventive care -- would be offered in the form of supplemental policies for additional premiums. Since many HMOs currently offer beneficiaries these kind of benefits without an additional premium, many people may be forced to pay more for benefits they currently receive as part of their coverage.

United States Senate Special Committee on Aging, G-31 Dirksen Building
Washington, D.C. 20510-6400
(202) 224-5364
Fax (202) 224-9926

This plan provides no real protection against the cost of prescription drugs and long-term care, which are the largest out-of-pocket costs for older Americans. Under Dole's plan, Medicare recipients will continue to go without coverage for prescription drugs. And disabled people of all ages will get no help with home and community-based long-term care.

The only long-term care provision is a tax deduction for individuals who purchase private long-term care insurance on their own. This may be of some help to higher income individuals who can afford to purchase long-term care insurance policies on the front end, but given the high price of those policies, that is a luxury most Americans can't afford.

Under the Dole plan, discriminatory practices by the insurance industry will continue. Insurance companies will be able to charge older people as much as four times more than younger people.

This plan fails to provide new benefits for seniors. At the same time, it puts their primary source of health care at risk. I urge the sponsors of this plan to reconsider their support.

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510-4802

Statement of Senator John D. Rockefeller IV

Press Conference on Dole Health Plan and Seniors
July 19, 1994

We are here to explain why we think the American people should reject Senator Dole's health care plan. It's possible that some of our colleagues are still taking a look at this so-called plan. Just dig into its contents, and the answer is easy.

This is poison for Americans who expect a cure.

Senator Dole's so-called plan is an inadequate, non-universal solution which takes more than $60 billion from the Medicare program to pay for health care reform, without providing a single improvement for seniors.

This is a proposal that says health reform should fall on the shoulders of America's senior citizens. Its name should be changed to the Bob Dole Grandparents Tax.

How about some truth-in-labelling: the Dole plan doesn't ask employers to help pay for health care coverage, but it makes seniors -- grandparents -- pay more. It hits seniors and the poor the hardest and asks little of anyone else. And what do senior citizens get for these Medicare cuts? No new benefits. No long term care. No prescription drug coverage. And a much shakier Medicare system. Plus no universal coverage.

That's the Dole health care plan: Ask nothing of employers, but dip straight into the wallets and pocketbooks and bank accounts of senior citizens and retirees.

If Congress swallows Bob Dole's prescription for health care reform, over $60 billion will be taken out of Medicare to pay for other health care expenses. This is where the alarm bells go off. A $60

billion cut, without a single step to strengthen the program, will throw up roadblocks for seniors who count on Medicare for accessible, good quality health care. The Dole plan says that the folks who depend on Medicare will just have to make do with less health care.

The Dole plan does nothing to extend prescription drug coverage to Medicare beneficiaries, meaning that his plan says sorry, no help for the millions of older Americans who are desperately hoping reform will mean relief from their greatest out-of-pocket expense. I bet a lot of our colleagues have told the senior citizens of their states that they'd try to do something about the plight of choosing between expensive medicines and vital needs like food and heat. The Dole plan will keep millions of senior citizens in this painful predicament.

Without even an attempt to expand long term care, Senator Dole's plan will continue to force millions into nursing homes when the care they really need could be given at home. Insurance companies would still run the show, allowed to deny coverage for up to a year, randomly raise rates, and even charge older Americans 400% more than younger people.

Universal coverage and shared responsibility are the foundation of meaningful, effective reform. That goes for the young and old -- grandparents and grandkids. So Bob Dole's non-universal plan, and the Grandparents Tax it's built on, should be sent packing. And Congress should put its remaining time and energy into health care reform that delivers what the American people, young and old, expect and deserve.

STATEMENT BY SENATOR BOB GRAHAM
JULY 19, 1994

THE DOLE BILL VERSUS THE ELDERLY

* The Dole Bill, recently introduced and co-sponsored by 39 Republicans, is a prescription for failure.

* Every generation or just about every 30 years, the Republican Party puts forth a position on health care or income security in direct opposition to the interests of the elderly of our nation.

  * In the 30's, the Republican Party opposed Social Security...

  * In the 60's, the GOP opposed Medicare...

  * and we have Senator Dole's bill this year, which continues that unfortunate tradition.

Long Term Care

* Upon the introduction of the Secure Choice Act with Senator Packwood in October 1993, Senator Dole made the following statement:

  "...over the next several months, Congress will likely make historic decisions regarding health care in the United States. However, these efforts will be incomplete unless the long-term care needs of America's seniors and individuals who become disabled are adequately addressed. This, perhaps will be the greatest challenge of health care reform."

* He added:

  "During the coming months, as we, in Congress, continue to debate health care reform, we must keep in mind that there is no true reform without long-term care reform."

* I fully agree with Senator Dole's comments in 1993. However, I was dismayed to read that Senator Dole has failed the challenge and instead taken the path of no true reform. The Dole bill contains no funding, no home- and community-based long term care program and only minor changes in the tax provisions for long term care insurance.

  This is a radical departure from his position just nine months ago, and it fails both the elderly and disabled citizens of this country.

Prescription Drug Coverage

* Senator Dole has also failed the elderly by not including Medicare prescription drug coverage. 13.8 million elderly Medicare patients would continue to bear the high cost of prescription drugs.

* As Stephen Long, senior economist for RAND said, "There is little question that prescription drugs are an essential part of current medical treatment technology, which is why nearly all private insurance plans, managed care organizations, and even state Medicaid programs cover their enrollees for prescription drugs. Medicare stands alone among the major insurers in not covering prescribed medicines." The Dole bill would continue this exclusive burden on the elderly.

* While I can understand a debate over how to pay for prescription drugs, I cannot understand Senator Dole's failure to even consider the possibility. According to recent estimates, 85% of the elderly use at least one prescription medicine during the year. They will be left at risk under the Dole plan.

No Cost Containment, Except for Medicare and Medicaid, and Rampant Cost Shifting to the Private Sector

* Senator Dole's bill takes an estimated $60 billion from Medicare over the next five years and, according to the National Governors' Association, $80 billion from Medicaid. In comparison to the private sector, public programs are already underfunded. Funding for public programs should only be reduced in conjunction with the private sector and not apart from it.

* According to the Prospective Payment Assessment Commission, "in 1992, hospitals faced losses totaling $26 billion from Medicare, Medicaid, other government programs, and uncompensated care. These losses were balanced by $29.5 billion in gains from private insurers."

* This gap would widen dramatically under the Dole plan and force providers to rapidly increase cost shifting, limit their Medicare and Medicaid patient load, or ration care substantially to the elderly, disabled and poor. In short, the Dole plan fails to increase health insurance coverage and jeopardizes the health care security of the elderly, disabled and poor.

Cost Shifting to State Taxpayers and the Elderly/Disabled Requiring Institutional Care

* The National Governors' Association recently release a bipartisan letter critical of the Dole plan's impact on its citizens. The July 13th letter says, "Governors could not be more united in their opposition to this proposal. A cap on the federal share of Medicaid spending would assure that states bear a disproportionate share of a program that was intended as a state and federal partnership. This action imposes a significant unfunded mandate on states and could result in state budget crises."

* Senator Dole seemed to agree with this point just a few months ago when, in March of this year, he said:

  "We pass mandates back to the states. We tell the State they have to do 'x'. That is a tax on the people in those states, because the states have to go out and raise money because we passed a law and we did not send the money."

* Where does Senator Dole and his Republican colleagues think that the states, which are mandated to comply with various federally-imposed eligibility criteria, benefits and financing, are supposed to come up with this money? Taxes and massive budget cuts are the only options to states.

* In 1990, according to the Kaiser Commission on the Future of Medicaid, 71% of all Medicaid expenditures were to the nonelderly disabled, long-term care elderly and Medigap elderly. When looking for $80 billion, states will undoubtedly tap this group and Medicaid long term care programs for much of the funding. Again, the elderly and vulnerable populations of this country will bear the risk of the Dole plan.

a.s.a.p.

GRASSROOTS ACTION FOR HEALTH AND LONG TERM CARE

Action Alert

TO: ***a.s.a.p.*** Participants
FROM: ***a.s.a.p.*** National Groups

July 8, 1994

WARNING TO SENIOR CITIZENS:
The U.S. Senate May Be Bad for Your Health!
Call Senator Boren TODAY!

The Senate will begin floor debate on health reform soon — probably before the end of the month. Many Senators are now searching anxiously for ways to avoid making the hard decisions needed to solve the crisis. Some have taken refuge by hiding behind two bad bills -- bills that are especially unfair to America's senior citizens. Your Senator has not decided whether he will support REAL REFORM or a cheap imitation that hurts seniors. **YOUR HELP IS NEEDED** TO TELL THE SENATE: **DON'T TREAD ON SENIOR CITIZENS!**

BACKGROUND: Two health care reform bills now before the U.S. Senate are inadequate responses to the health crisis — and both are unfair to senior citizens. One is the bill recently approved by the Finance Committee. The other is a proposal recently unveiled by Senate Minority Leader Bob Dole (R-KS), which has been endorsed by 40 of the 44 Republicans in the Senate. These bills do little for Americans who are too young for Medicare, but they are *downright harmful to senior citizens*. Senator Boren has not yet decided if he will support real reform or, instead, vote for either the Dole bill or the Finance Committee bill.

Both the Finance Committee-approved bill and Sen. Dole's alternative are seriously flawed. Neither of them will provide universal access to health care, and neither has meaningful provisions to bring spiralling health care costs under control. Both bills have **significant cuts in Medicare**. Unlike the President's proposal, which would have used Medicare savings to finance expanded benefits for seniors — chiefly long term care and prescription drugs — the Finance bill and the Dole bill have little or nothing that will benefit seniors.

THE DOLE BILL *has no prescription drug* coverage for seniors and ***no long term care***.

THE FINANCE BILL *does not provide prescription drug* coverage for seniors. Although this bill does include a ***long term care provision, the benefits are not adequately funded*** (despite the deep Medicare cuts) and further cuts in Medicare probably would be necessary to make it more than a paper program.

THE TIMING: Right now, Senators are working behind the scenes to make deals and develop details in anticipation of the floor debate. It is crucial that we send a message to undecided Senators, whose votes are up for grabs, that senior citizens will not stand by and take it on the chin.

WHAT YOU CAN DO: Call Senator Boren at (202) 224-4721 TODAY! Tell him you are outraged by the Dole bill and you don't like the Finance bill either (although you like the long

term care provision in it). Let him know you are dismayed that so much of the legislation is financed through deep cuts in the Medicare program. Urge him to support the REAL THING instead of cheap imitations. And tell him you'll stand up for him if he'll stand up to the special interests and give us all what he has — guaranteed health insurance that is paid for by his employer (YOU)!

Then call Senator Dole at (202) 224-6521 to register your disapproval of his bill!

And don't forget to tell at least five other people about this alert — in fact, tell everyone you know who is concerned about Medicare and about fairness to senior citizens!

1334 G STREET, NW · WASHINGTON, DC 20005-3169 · PHONE: (202) 737-6340 · FAX: (202) 347-2417

A PROJECT OF FAMILIES USA

President
Eugene Glover
Silver Spring, MD

National Council of Senior Citizens

Executive Director
Lawrence T. Smedley
Washington, DC

1331 F Street, N.W. • Washington, DC 20004-1171 • (202) 347-8800 • FAX (202) 624-9595

June 30, 1994

Dear Senator:

The National Council of Senior Citizens (NCSC), representing five million older Americans organized in five thousand grassroots clubs and Councils, has been fighting for a national health program for three decades. As parents and grandparents, we have worked to secure health care coverage for all citizens, young and old.

NCSC believes that the health bill proposed by Senator Bob Dole will drastically set back the cause of health reform and we urge all Senators to neither support nor co-sponsor his bill.

The Minority Leader's proposal fails to provide universal coverage, would punish older persons by permitting risk adjusted premiums based on age, allows insurance companies to deny coverage for preexisting conditions for up to a year, and cuts the growth in Medicare payments without providing for corresponding benefit improvements such as long-term care or prescription drugs.

Senator Dole's bill would continue to allow insurance companies to gouge small business, older persons, persons with chronic needs and self-employed persons. The ranks of the uninsured will continue to grow.

In short, Senator Dole's bill would simply codify and protect by statute some of the worst market practices of the health insurance and provider industry, and would carry the system distortions far into the future.

We urge that no Senator support Senator Dole and those who have already co-sponsored his bill should reconsider that cosponsorship and withdraw.

Older Americans want real health reform now. Senator Dole's bill is bad medicine in the extreme.

Sincerely,

LTS

Lawrence T. Smedley
Executive Director

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island Second Vice President, George J. Kourpias, Washington, DC
Third Vice President, Dorothy Walker, Detroit, Michigan Fourth Vice President, Royetta K. Sanford, Washington, DC
Secretary-Treasurer, Jack Turner, Detroit, Michigan General Counsel, Robert J. Mozer, New York

SENIORGRAM

JULY 12, 1994

TO: NCSC Executive Board, State Council Presidents and Executive Directors, Activists and Clubs

FROM: Lawrence T. Smedley, Executive Director

RE: Senate Action

The Senate will begin floor debate on health reform soon—probably before the end of the month. Many Senators have taken refuge by hiding behind two bad bills—bills that are especially unfair to America's senior citizens. The Senators listed on the back have not clearly committed to a Senate bill that incorporates REAL REFORM. **YOUR HELP IS NEEDED** TO TELL THE SENATE: **DON'T TREAD ON SENIOR CITIZENS!**

Background: Two health care reform bills now before the U.S. Senate are inadequate responses to the health crisis—and both are unfair to senior citizens. One is the bill approved by the Senate Finance Committee on July 2, 1994. The other is a proposal recently unveiled by Senate Minority Leader Bob Dole (R-KS), which has been endorsed by 40 of the 44 Republicans in the Senate. These bills do little for most Americans and they are *harmful to senior citizens!* Your Senator(s)—see target list on back—has not yet decided to support real reform and may vote for either the Dole bill or the Finance Committee bill, or a "compromise" between them.

Both the Finance Committee bill and the Dole alternative are seriously flawed proposals which take health care backwards. NCSC opposes both these bills. Neither of them will provide universal coverage to health care, and neither has meaningful provisions to bring spiralling health care costs under control.

Both bills have huge cuts in Medicare. The Kennedy proposal (Senate Labor Committee) would use some Medicare savings to finance needed benefits for seniors like long-term care and prescription drugs. The Finance and Dole bills have little or nothing to benefit seniors and still they cut and slash Medicare!

THE DOLE BILL ***has no prescription drugs*** for seniors and ***no long-term care!*** It would allow insurance companies to charge higher premiums to older persons and would allow the companies to delay coverage for preexisting conditions

THE FINANCE BILL ***does not provide prescription drug*** coverage for seniors. While

WHAT YOU MUST DO: Call your Senator(s) at (202) 224-3121 **TODAY!** Tell him/her you are outraged by the Dole bill and you can't support the Finance bill. Let him/her know you are dismayed that so much of the legislation is paid for through deep cuts in the Medicare program. Urge him/her to support the REAL THING instead of cheap imitations. And tell your Senator to stand up to the special interests. Tell your Senator that all Americans must get what every Senator gets—guaranteed health insurance paid for by the Senator's employer—the American people--YOU!

Tell others about this alert. Tell everyone you know who is concerned about Medicare and about fairness to senior citizens! Together we can pass a real health care bill!

TARGET LIST

State	Senator	Senator
Alabama	Heflin (D)	Shelby (D)
Arizona	DeConcini (D)	
California	Feinstein (D)	
Colorado	Campbell (D)	
Connecticut	Leiberman (D)	
Delaware	Biden (D)	
Georgia	Nunn (D)	
Kansas	Kassenbaum (R)	
Kentucky	Ford (D)	
Louisiana	Johnston (D)	Breaux (D)
Maine	Cohen (R)	
Minnesota	Durenberger (R)	
Missouri	Bond (R)	Danforth (R)
Montana	Baucus (D)	
Nebraska	Exon (D)	Kerrey (D)
Nevada	Bryan (D)	
New Jersey	Bradley (D)	Lautenberg (D)
New York	Moynihan (D)	
New Mexico	Domenici (D)	
North Dakota	Conrad (D)	Dorgan (D)
Oklahoma	Boren (D)	
Oregon	Hatfield (R)	Packwood (R)
Pennsylvania	Specter (R)	
Rhode Island	Chafee (R)	