E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

10-Apr-1996 08:48pm

TO: (See Below)

FROM: Christopher C. Jennings
Domestic Policy Council

SUBJECT: Medicaid update

The latest from the Hill seems to confirm that the Republicans are likley to release their Medicaid bill on Friday or Monday. While they may attempt to dress it up like a per capita/block grant hybrid, most people are fairly certain that they will retain the Republican cap (and therefore, block grant) in order to secure savings.

At least as important for you all to consider is the fact that, as a result of CBO's $24 billion lower Medicaid baseline, the same Republican block grant formula that yielded $85 billion will now yield $61 billion in savings. (This is because they cap spending; when you cap spending off of a lower base, you get less savings.)

At any rate, it appears very likely that the Republicans will say that they have moved to the President's number almost exactly and that he should therefore live with their formula. (Particularly, if the majority of Governors say that they are satisfied with the formula -- which they might well be able to say.)

At first blush, the media and others might believe they are giving up something, why shouldn't the Administration. It is extremely important for all of us to remember that their $60 billion in federal savings is very different from ours for two critical reasons:

1. THEIR SAVINGS PROPOSAL IS, IN REALITY, OVER TWICE WHAT THE PRESIDENT IS ADVOCATING. Since the Republicans will almost certainly retain the allowance for states to reduce their current match, the aggregate reduction (federal plus STATE) in Medicaid expenditures would be about $250 billion. (It is about $250 billion because their $60 billion in federal savings must be added to the states' lower matching formula, which would allow states -- nationally -- to reduce their spending by over an ADDITIONAL $150 billion.) The comparable number for us is that our total reduction in spending would be closer to $105 billion -- $59 billion in federal savings plus about $46 billion in state savings, (which comes automatically with a reduction in federal

spending).

2. THERE MAY WELL BE NO, OR VERY LITTLE ROOM, IN THEIR FORMULA FOR UNEXPECTED ENROLLMENT INCREASES. The "dollars follow people" principle will be totally undermined by this formula and will leave states holding the bag, particularly in the out-years, should there be an unexpected economic downturn.

I write you this now because I think we will need to get on top of this issue immediately IF the Republicans do release their bill. We cannot afford to let them spin this issue for even one day, because (again) at first glance, one could see it could have some gut-level appeal.

WHAT ABOUT THE DEM GOVERNORS?

From all reports that Marcia, Carol and I have received, the Dem Governors are still ready to exit out of this process IF the Republican formula is undermines and is inconsistent with their perception of the NGA compromise. Carol and Marcia (and I) continue to counsel: If the formula gives you an excuse, try to exit the Republican process onto the Breaux/Chafee process AND try to delink Medicaid from welfare.

WHAT ABOUT THE DEM HILL MEMBERS AND THE REPUBLICANS ON CHAFEE/BREAUX TEAM?

The Dems still seem very strongly unified behind a package of reforms that we (and the Dem Govs) could live with. The Breaux/Chafee package has not changed significantly in the last week or so, and it seems like it would continue to provide ample cover for us to support a bipartisan solution to the Medicaid reform challenge. The 5-10 Republicans are likely to stick with the Medicaid package, but ONLY in the context of a balanced budget. Except for a few, I doubt we can count on many to support this package outside their balanced budget proposal, (which they of course have yet to publicly release.)

As I hear/get additional info, I will update you...

cj

Distribution:

TO: Carol H. Rasco
TO: Laura D. Tyson
TO: John Hilley

CC: Gene B. Sperling
CC: Mark Angel
CC: Martha Foley
CC: Nancy-Ann E. Min

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 28, 1996
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 3103 -- Health Coverage Availability and Affordability Act
(Archer (R) TX and five cosponsors)

The Administration supports House passage of a "clean" health insurance reform bill, similar to S. 1028 (Kassebaum/Kennedy), as reported by the Senate Committee on Labor and Human Resources, and H.R. 2893, as introduced by Representative Roukema.

The Administration opposes controversial and such potentially harmful provisions in H.R. 3103 that could jeopardize bipartisan support for basic health insurance and effectively prevent enactment of much needed insurance reform legislation. The provisions include:

Medical Savings Accounts (MSAs). The provisions of H.R. 3103 that extend tax breaks to promote the sale of untested Medical Savings Accounts would cost an estimated $1.8 billion in revenue over seven years. MSAs will provide a tax break for the healthiest and wealthiest individuals (the only people who could afford high-deductible policies) and attract them out of the general health insurance market, potentially raising premiums for all other people. We strongly object to this provision and the use of Medicare anti-fraud savings to pay for the provision.

Caps on medical malpractice awards and limits on malpractice actions. While we support medical malpractice reforms, we oppose federally-imposed caps on punitive and non-economic damage awards.

Preemption of state regulation of Multi-Employer Welfare Arrangements. H.R. 3103 severely limits the ability of states to regulate multiple employer welfare arrangements (MEWAs). It will have the effect of slowing or halting recent State efforts to prosecute illegal and fraudulent MEWAs. In addition it will encourage greater "cherry-picking" in the insurance market, potentially raising health insurance costs for other people.

Weakening ban on sale of duplicative insurance policies to Medicare enrollees. H.R. 3103 permits the sale of duplicative insurance policies (those that duplicate Medicare benefits and will not pay claims Medicare already pays) to individuals so long as they include some home health or long term care benefits. It will make the elderly once again vulnerable to the unscrupulous marketing of worthless, duplicative insurance policies. While this provision is defended as necessary to permit the sale of

legitimate long term care policies, such authority is granted elsewhere in H.R. 3103.

Weakening of anti-fraud and abuse protections. We strongly support efforts to combat health care fraud and abuse and have included a proposal in the President's fiscal year 1997 budget. However, H.R. 3103 exempts managed care arrangements from federal anti-kickback laws and raises the standard of proof necessary to impose civil money penalties for the submission of inappropriate Medicare claims. It also requires the issuance of advisory opinions that will distract law enforcement agencies and otherwise undermine their anti-fraud activities, and it does not provide for appropriate coordination of the federal agencies with current fraud and abuse enforcement authority. Together, these provisions cost the Medicare trust funds almost $1 billion over seven years, according to CBO.

Pay-As-You-Go Scoring

H.R. 3103 would affect both direct spending and receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's estimate of the pay-as-you-go effect of this bill is under development.

* * * * * * *

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
LEGISLATIVE AFFAIRS

PHONE: 395-4790 / FAX: 395 3729

TO: Jennifer Klein

FROM:

____ CHUCK KIEFFER ____ CHUCK KONIGSBERG

____ LISA KOUNTOUPES ____ ALICE SHUFFIELD

____ KRISTEN PANERALI ____ NANCY BRANDEL

comments:_____

_____

_____

_____

_____

_____

FAX #: 62878 PAGES:_____

PHONE NUMBER:_____ (includes cover page)

(5) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement,

(6) in the case of a plan or arrangement to which subparagraph (C), (D), or (E) of section 3(40) of the Employee Retirement Income Security Act of 1974 applies, to the extent necessary to meet the requirements of such subparagraph, or

(7) in the case of a multiple employer health plan (as defined in section 701(4) of such Act), for failure to meet the requirements under part 7 of subtitle B of title I of such Act for exemption under section 514(b)(6)(B) of such Act.

In section 104(a), insert "(other than subsection (e))" after "section 103" each place it appears.

In section 104(c)(1)(A), insert "(other than section 103(e))" after "subtitle".

In section 104(c)(2), insert "(other than section 103(e))" after "103".

In section 1171 of the Social Security Act, as proposed to be added by section 252 of the bill—

(1) in paragraph (4)(A), strike "insurance" and insert "health";

(2) in paragraph (5)—

(A) strike subparagraph (E) and redesignate subparagraphs (F) through (L) as subparagraphs (E) through (K), respectively;

(B) in subparagraph (E) (as so redesignated), strike "An employee" and insert "Health benefits of an employee"; and

(C) strike subparagraph (M);

(3) in paragraph (6)(A) strike "insurance" and insert "health"; and

(4) strike paragraph (7) and redesignate paragraphs (8) and (9) as paragraphs (7) and (8), respectively.

In section 1172 of the Social Security Act, as proposed to be added by section 252 of the bill—

(1) in subsection (a)(1), strike "insurance" and insert "health"; and

(2) in subsection (c)(2)(A)(i), strike "insurance" and insert "health".

In section 1173 of the Social Security Act, as proposed to be added by section 252 of the bill—

(1) in subsection (b)(1), strike "insurance" each place such term appears and insert "health";

(2) in subsection (e), strike the period at the end of the first sentence and insert "transmitted in

connection with the transactions referred to in subsection (a)(1).";

(3) in subsection (f)(2), strike "insurance" and insert "health"; and

(4) in subsection (g)—

(A) in the subsection heading, strike "INSURANCE" and insert "HEALTH"; and

(B) strike "insurance" each place such term appears and insert "health".

In section 1175 of the Social Security Act, as proposed to be added by section 252 of the bill—

(1) in subsection (a), strike "insurance" each place such term appears and insert "health"; and

(2) in subsection (b)—

(A) in the subparagraph heading in subparagraph (B) of paragraph (1), strike "INSURANCE" and insert "HEALTH"; and

(B) strike "insurance" each place such term appears and insert "health".

In section 1178(a)(1) of the Social Security Act, as proposed to be added by section 252 of the bill, strike "insurance" and insert "health".

In section 306(k)(2) of the Public Health Service Act, as proposed to be amended by section 253 of the bill, strike "appointed, not later than 60 days after the

date of the enactment of the Health Coverage Availability and Affordability Act of 1996, from" and insert "appointed from".

In section 306(k)(3) of the Public Health Service Act, as proposed to be inserted by section 253 of the bill, strike "appointed by" in each of subparagraphs (A) and (B) and insert "appointed, not later than 60 days after the date of the enactment of the Health Coverage Availability and Affordability Act of 1996, by".

Min
Clendenon
Miller
Jennings
Klein
Dems offered - all were rejected

Amendments to the rule on H.R. 3103,
Health Coverage, Availability, and Affordability Act of 1996

1. Eshoo: Raises the aggregate dollar lifetime limit for individual health insurance coverage from $1,000,000 to $10,000,000 with respect to coverage under an employee health benefits plan or group health plan.

2. Dingell: Strikes subtitle G of title II (Duplication and Coordination of Medicare-Related Plans) which would redefine "duplication" to be limited to situations when a health insurance policy makes a specific payment for identical items and services covered under other health coverage. Subtitle G would also eliminate the current prohibition on the sale to Medicare beneficiaries of long-term care insurance that "coordinates" with Medicare and would preempt state laws which are more restrictive in the definition of "duplication". The provisions of this subtitle would be effective as if enacted as part of OBRA 1990.

3. Green: Strikes the provisions of the bill relating to the preemption of State regulations for multiple employer welfare arrangements (MEWA).

4. Cardin en bloc: Strikes the provision in the bill which requires HHS to issue binding advisory opinions to the public on the Medicare/Medicaid anti-kickback statute.

Cardin: Strikes the provision in the bill which would establish a broad new exception under the anti-kickback statute for any arrangement where a medical provider is at "substantial financial risk" whether through a "withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement."

Levin: Strikes the provision of the bill which makes civil monetary penalties for fraudulent Medicare/Medicaid claims more difficult to enforce by relieving providers of the duty to use "reasonable diligence" to ensure that their claims are true and accurate.

5. Miller (CA): Provides that new mothers automatically will be allowed and covered for a minimum hospital stay of 48 hours following a vaginal birth and 96 hours following a cesarian section.

~~6. Dingell~~: To the Archer substitute -- makes changes the CLIA by removing the current requirement for biennial inspections of all labs; mandating that all lab inspections must be announced in advance so that patient care will not be interrupted and compromised by such inspections; and reducing CLIA application requirements and removing requirements for periodic recertification of labs.

7. Johnson (CT): Eliminates the requirement that laid-off or down-sized employees be required to exhaust their eligibility for COBRA before being able to purchase an individual policy without facing a loss of coverage for preexisting conditions.

W

8. Gunderson/Roberts Poshard/Gutknecht: Provides anti-trust relief to small rural hospitals attempting to consolidate or share health care services and expands telemedicine in rural areas by directing HHS to develop a payment methodology for telecommunications performed in underserved areas.

4-7

9. Amendments offered en bloc:

W

Furse: Prevents preemption of state regulation of health insurance reform.

Meek: Encourages the furnishing of health care services to low income individuals by extending federal liability coverage to health professionals who volunteer to provide free health care to these individuals.

Richardson/ Coburn: Prevents group health plans and insurers or HMO's offering health insurance coverage in connection with a group health plan from imposing treatment limits or financial requirements with respect to treatment of severe mental illness services which are not imposed on services for other conditions.

Peterson (FL): Substitute portability provisions which would apply the guaranteed issue insurance provisions to every American rather than just those who have been employed and insured for the previous 12 to 18 months; and would provide a system of modified community rating to ensure premiums remain affordable and are not priced differently based on an individual's health status.

Roukema: Ensures that eligible individuals entering the individual market would be able to select from a variety of insurance plans, rather than be relegated to a single plan providing an "actuarially average" benefits package.

10. Moakley Strikes medical malpractice

VV

11. Inst Strikes last line of rule which waives the requirement for 3/5 vote to increase taxes.

-Forsgren

104th Congress
2nd Session

H. RES. _____

H.R. 3103 -- the Health Coverage Availability and Affordability Act of 1996

1. Modified closed rule.

2. Provides that the amendment in the nature of a substitute consisting of the text of H.R. 3160, modified by the amendment specified in part 1 of the report of the Committee on Rules, will be considered as adopted. See attached

3. Waives all points of order against the bill, as amended and against its consideration (except those arising under section 425(a) of the Congressional Budget Act of 1974, relating to unfunded mandates).

4. Provides that the previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage, without intervening motion except as specified.

5. Provides for two hours of debate with 45 minutes equally divided between the chairman and ranking minority member of the Committee on Ways and Means, 45 minutes equally divided between the chairman and ranking minority member of the Committee on Commerce, and 30 minutes equally divided between the chairman and ranking minority member of the Committee on Economic and Educational Opportunities.

6. Provides for one amendment in the nature of a substitute to be offered by the Minority Leader or his designee, specified in part 2 of the report of the Committee on Rules, which shall be in order without the intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) or demand for division of the question, and shall be debatable for one hour to be equally divided between the proponent and an opponent.

7. Provides for one motion to recommit, which may include instructions only if offered by the Minority Leader or his designee.

8. Provides that the yeas and nays are ordered on final passage and that the provisions of clause 5(c) of Rule XXI (requiring three-fifths vote on any amendment or measure containing a Federal income tax rate increase) shall not apply to the votes on the bill, amendments thereto or conference reports thereon.

RESOLUTION

Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes. An amendment in the nature of a substitute consisting of the text of H.R. 3160, modified by the amendment specified in part 1 of the report of the Committee on Rules accompanying this resolution, shall be considered as adopted. All points of order against the bill, as amended, and against its consideration are waived (except those arising under section 425(a) of the Congressional Budget Act of 1974). The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) two hours of debate on the bill, as amended, with 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means, 45 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce, and 30 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Economic and Educational Opportunities; (2) the further amendment specified in part 2 of the report of the Committee on Rules, if offered by the Minority Leader or his designee, which shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) or demand for division of the question, shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit, which may include instructions only if offered by the Minority Leader or his designee. The yeas and nays shall be considered as ordered on the question of passage of the bill and on any conference report thereon. Clause 5(c) of rule XXI shall not apply to the bill, amendments thereto, or conference reports thereon.

- Fitzpatrick
- Forsgren

104th Congress
2d Session

H. RES. _____

H.R. 3136 -- The Contract With America Advancement Act of 1996

1. Closed rule.

2. Provides for consideration in the House of the bill as modified by the amendment designated in the Rules Committee's report on the resolution.

3. Waives all points of order against consideration of the bill except sec. 425(a) of the Budget Act (unfunded mandate point or order).

4. Orders the previous question to final passage without intervening motion except: (1) one hour of debate equally divided between the chairman and ranking minority memberof the Ways and Means Committee; (2) one amendment to be offered by Rep. Archer or his designee, debatbale for 10 minuts; and (3) one motion to recommit which, if containing instructions, may only be offered by the Minority Leader or his designee.

5. Orders the previous question to final passage without intervening motion except one motion to recommit which, if containing instructions, may only be offered by the Minority Leader or his designee.

6. Provides that if the Clerk has, before March 30, 1996, received a message from the Senate that the Senate has adopted the conference report on S. 4, the Line Item Veto Act, then the Clerk shall delete title II (the Line Item Veto Act) from the engrossment of the bill (unless amended), and the House shall be considered to have adopted the conference report.

- makes another amend in order pending dep. w/ Panetta on outside earning limit

RESOLUTION

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) to consider in the House the bill (H.R. 3136) to provide for enactment of the Senior Citizens' Right to Work Act of 1996, the Line Item Veto Act, and the Small Business Growth and Fairness Act of 1996, and to provide for a permanent increase in the public debt limit. The amendments specified in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) one hour of debate

on the bill, as amended, equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means; (2) a further amendment, if offered by the chairman of the Committee on Ways and Means, which shall be in order without intervention of any point of order (except those arising under section 425(a) of the Congressional Budget Act of 1974) or demand for division of the question, shall be considered as read, and shall be separately debatable for 10 minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit, which may include instructions only if offered by the Minority Leader or his designee.

Fitzpatrick

* * *

THE AMENDMENT TO BE CONSIDERED AS ADOPTED IS AS FOLLOWS:

The amendment printed in the Congressional Record of March 26, 1996, by Representative Hyde of Illinois and numbered 2 pursuant to clause 6 of rule XXIII, modified by the following:

In section 331(a) , section 504(a) of title 5, U.S. Code as proposed to be amended is amended in the new paragraph (4) by striking the words "brought by an agency" and inserting in lieu thereof "arising from an agency action to enforce a party's compliance with a statutory or regulatory requirement".

In section 331(a), section 504(a) of title 5, U.S. Code as proposed to be amended is amended in the new paragraph (4) by adding at the end of the paragraph the following new sentence: "Fees and expenses awarded under this paragraph shall be paid only as a consequence of appropriations provided in advance.".

In section 332(a), section 2412(d)(1) of title 28, United States Code as proposed to be amended is amended in the new subparagraph (D) by inserting after "United States" the first time it appears the following: "or a proceeding for judicial review of an adversary adjudication described in section 504(a)(4) of title 5".

In section 332(a), section 2412(d)(1) of title 28, United States Code as proposed to be amended is amended by adding at the end of the new subparagraph (D) the following new sentence: "Fees and expenses awarded under this subparagraph shall be paid only as a consequence of appropriations provided in advance.".

In section 341(a)(1)(A), delete the words "of general applicability".

In section 344(e)(1), delete the words "; or in developing a final rule, the extent to which the covered agency took into consideration the comments filed by the individuals identified in subsection (b) (2)".

other than—

(1) for nonpayment of contributions,

(2) for fraud or other intentional misrepresentation of material fact by the employer,

(3) for noncompliance with material plan or arrangement provisions,

(4) because the plan or arrangement is ceasing to offer any coverage in a geographic area,

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION

FROM:

KAREN L. POLLITZ
DEPUTY ASSISTANT SECRETARY FOR LEGISLATION
OFFICE OF HEALTH LEGISLATION
ROOM 405H, HHH BUILDING
PHONE: 690-7450
FAX: 690-8425

TO:

NAME: Chris / Jen

OFFICE:

ROOM:

PHONE:

FAX: 456 5342 / 2878

DATE:

PAGES: 13 15
(Including Cover)

Jen - Disregard previous Fax.

REMARKS: SAP points and CBO estimates.
NCSL has a letter opposing MEWA provisions. Attached. ~~will fax when I get it.~~ NAIC will probably oppose - won't know till Thurs.

DRAFT

Harmful provisions in H.R. 3160

Medical Savings Accounts H.R. 3160 extends tax breaks to promote the sale of risky Medical Savings Accounts. MSAs will benefit the healthiest and wealthiest individuals (the only people who could afford high-deductible policies) and attract them out of the general health insurance market, thereby raising premiums for everyone else. Use of Medicare anti-fraud savings to finance MSAs is particularly objectionable.

Preemption of state regulation of MEWAs H.R. 3160 severely limits the ability of states to regulate legitimate multiple employer welfare arrangement but does not do enough to assist states in prosecuting illegal MEWAs. Furthermore, the bill encourages greater cherry-picking of the insurance market by MEWAs and association plans, raising health insurance costs for everyone else.

Weakening ban on sale of worthless insurance policies to Medicare enrollees H.R. 3160 permits the sale of worthless insurance policies (those that duplicate Medicare benefit and will not pay claims Medicare already pays) to individuals so long as they include some home health or long term care benefits. Further, it preempts States from providing greater protection against such policies for their own citizens. It will make the elderly once again vulnerable to the unscrupulous marketing of worthless, duplicative insurance policies. While this provision is defended as necessary to permit the sale of legitimate long term care policies, such permission is granted elsewhere in H.R. 3160.

Limits on medical malpractice actions and awards H.R. 3160 places limits on the bringing of medical malpractice suits and strictly limits the amount of punitive and non-economic damages that can be awarded in such lawsuits. These controversial provisions arbitrarily limit consumer redress against malpractice and will threaten the enactment of insurance portability reforms.

Weakening of anti-fraud and abuse protections H.R. 3160 exempts managed care arrangements from federal anti-kickback laws and raises the standard of proof necessary to impose civil money penalties for the submission of inappropriate Medicare claims. It also requires the issuance of advisory opinions that will distract law enforcement agencies and otherwise undermine their anti-fraud activities. Together, these provisions cost the Medicare trust funds almost $1 billion over seven years, according to CBO.

Repeal of CLIA for physician office labs (if permitted under the Rule) An amendment may be offered to repeal national quality standards for clinical lab tests performed in physician offices. Survey data clearly show more quality deficiencies, including many that endanger patient health, in physician office labs than in other clinical labs. The Though responsible reform of CLIA is desirable, repeal of quality protections is not.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'N
Director

March 25, 1996

F41 -
Holly

Honorable Bill Archer
Chairman
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Congressional Budget Office (CBO) has reviewed H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, as ordered reported by the House Committee on Ways and Means on March 19, 1996. Enclosed are CBO's federal cost estimate and estimates of the costs of intergovernmental and private sector mandates.

If you wish further details on these estimates, we will be pleased to provide them. The CBO staff contacts are identified in the separate estimates.

Sincerely,

June E. O'Neill

June E. O'Neill

Enclosures

cc: Honorable Sam Gibbons
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE

FEDERAL COST ESTIMATE

March 25, 1996

1. BILL NUMBER: H.R. 3103

2. BILL TITLE: Health Coverage Availability and Affordability Act of 1996

3. BILL STATUS: As ordered reported by the House Committee Ways and Means on March 19, 1996.

4. BILL PURPOSE:

Title I would make it easier for people who change jobs to maintain health insurance coverage by limiting exclusions for preexisting conditions and increasing portability of coverage.

Title II would prevent health care fraud and abuse and would simplify the administration of health insurance.

Titles III and IV would change the tax treatment of Medical Savings Accounts (MSAs), increase the deductibility of health insurance costs of self-employed individuals, and make other changes to the tax code.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

CBO and the Joint Committee on Taxation (JCT) estimate that H.R. 3103 would increase the federal deficit by about $300 million over seven years, with outlays falling by $2.2 billion and revenues falling by $2.5 billion over the period (see the attached table).

CBO estimates that title I, concerning portability of group health coverage, would increase private group health premiums by a small amount, resulting in a slight increase in employer-paid premiums. A portion of this increase would be passed on to employees as reduced wages and salaries. Federal income and payroll taxes, therefore, would be reduced slightly as well. CBO and JCT estimate that revenues would be reduced by $0.2 billion over seven years as a result of this section.

03/27/96 13:38 CONG. BENJAMIN L. CARDIN → 20206425 NO.004 P008

03/27/96 13:38 CONG. BENJAMIN L. CARDIN → 20206425 NO.004 P009

03/27/96 13:38 CONG. BENJAMIN L. CARDIN → 20206425 NO.004 P010

03/27/96 13:38 CONG. BENJAMIN L. CARDIN → 20206425 NO.004 P011

[redacted] policies retroactive to January 1996. Since most carriers' local policies regarding [redacted]ocumentation of medical necessity were established by 1995, these policies could [redacted]ain in place until the uniform policies were fully implemented. Thus, this proposal would [redacted]ost the federal government about $240 million over seven years.

An independent lab would also be allowed to select a single carrier to process its Medicare claims under this proposal; currently, labs use multiple carriers to process claims. This provision would increase costs to the federal government for independent lab services, although the magnitude of these costs is difficult to estimate. If independent labs were permitted to select a single carrier, carriers would face incentives to adopt more lenient policies to attract a higher volume of business. Also, the carrier processing lab test claims for a beneficiary might not be the same carrier handling other claims for that person. This fragmentation could make it more difficult for the Health Care Financing Administration to determine the medical necessity of tests performed by independent labs. If this provision were to increase Medicare costs for independent lab services by one-half of one percent annually, it would cost the federal government an additional $90 million over seven years.

Titles III and IV, Tax Provisions

Medical Savings Accounts (MSAs)

Under the legislation, individuals covered by high-deductible health insurance plans could make deductible contributions to MSAs, or their employers could make contributions on their behalf that would be excluded from earnings for income and payroll tax purposes. Investment earnings of amounts in the MSA would also be excluded from taxable income in the year earned. Withdrawals from MSAs for medical expenses would be tax-free, but withdrawals for other purposes would be included in taxable income and subject to an additional tax of 10 percent. The additional tax would be waived if the account holder were over age 59-1/2, disabled, or had died.

High-deductible insurance would be defined as insurance having a deductible of at least $1,500 per person covered, and a deductible of at least $3,000 per family. Contributions would be limited to the lesser of the deductible of the insurance plan or $2,000 for individual coverage and $4,000 for family coverage. To be eligible for an MSA, individuals and families could not have other insurance policies that covered the deductible of the high-deductible policy. Allowable medical expenses would be those permitted under the itemized deduction for medical expenses, except for certain insurance premiums. Expenses for long-term care would also qualify as medical expenses.

The proposal would be effective for taxable years beginning after December 31, 1996, and is projected by the Joint Committee on Taxation to reduce income tax revenues by $1.778 billion in 1997-2002.

Deduction for Health Insurance Expenses of Self-Employed Individuals

Under current law, self-employed individuals are allowed to deduct 30 percent of the cost of health insurance premiums they pay for coverage of themselves, their spouse, and dependents, as long as they are not also eligible for insurance provided by an employer. The proposal would increase the fraction deductible to 50 percent in the following steps:

- 35 percent for 1998;
- 40 percent for 1999, 2000, and 2001;
- 45 percent for 2002; and
- 50 percent for 2003 and years thereafter.

The Joint Committee on Taxation estimates that this proposal would reduce revenues by $1.058 billion between fiscal years 1998 and 2002.

Other Tax Provisions

The Joint Committee on Taxation estimates that the combined effect of other provisions in Titles III and IV of H.R. 3103 would increase revenues by $457 million over seven years.

7. PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

(by fiscal year, in millions of dollars)

	1996	1997	1998
Change in Outlays	0	340	-40
Change in Revenues	127	262	-97

8. PREVIOUS CBO ESTIMATE:

CBO has prepared cost estimates for several health care reform bills--S. 1028 as reported by the Senate Committee on Labor and Human Resources, H.R. 995 as reported by the House Committee on Economic and Educational Opportunities, H.R. 3070 as reported by the House Committee on Commerce, and H.R. 3103 as reported by the House Committee on Ways and Means. All four bills contain provisions restricting preexisting conditions and increasing portability of health insurance. In addition, H.R. 3070 and H.R. 3103 contain provisions designed to reduce fraud and abuse in Medicare and simplify the administration of health insurance.

9. ESTIMATE PREPARED BY: Jeff Lemieux (insurance reform), Anne Hunt (administrative simplification), Cynthia Dudzinski (fraud and abuse). They can be reached at 226-9010.

10. ESTIMATE APPROVED BY:

Paul Van de Water

Paul N. Van de Water
Assistant Director
for Budget Analysis

Effects of H.R. 3103

[illegible]	1	1	1	1999	2			Total
DIRECT SPENDING								
	0	0	0	0	0	0	0	0
Abuse								
coveries from Payment Safeguards and Law Enforcement	0	330	-110	-490	-780	-890	-960	-2,900
et of Additional Health Care Fraud and Abuse Guidance	0	60	60	60	70	70	70	390
w and Increased Civil Monetary Penalties	0	-30	-50	-50	-60	-60	-70	-320
ditional Exclusion Authorities	0	-10	-10	-40	-40	-50	-50	-190
minal Provisions	0	-10	10	40	90	190	190	510
ner	0	a	a	a	a	a	a	-30
al, Fraud and Abuse	0	330	-160	-480	-730	-740	-810	-2,640
nistrative Simplification								
ministrative Simplification Standards /b	0	0	0	0	0	0	0	0
ministrative Simplification for Labs	0	10	60	60	60	70	70	330
al, Administrative Simplification	0	10	60	60	60	70	70	330
otal, Title II	0	340	-40	-420	-670	-670	-740	-2,290
ES and IV	0	0	0	0	0	0	0	0
otal, Outlays	0	340	-40	-420	-670	-670	-740	-2,290
REVENUES								
E I	0	0	-24	-35	-35	-35	-35	-164
E II	0	0	0	0	0	0	0	0
ES and IV								
edical Savings Accounts	0	-134	-246	-290	-340	-369	-399	-1,778
eduction for the Self-Employed	0	0	-36	-153	-250	-272	-347	-1,056
ther	127	396	209	46	-10	-99	-212	457
, Titles III and IV	127	262	-73	-397	-600	-740	-958	-2,379
tal, Revenues	127	262	-97	-432	-635	-775	-993	-2,643
DEFICIT								
AL	-127	78	57	12	-35	105	253	343

E: Estimate based on CBO December 1995 baseline assumptions.

avings or cost of less than $10 million
of about $10 million per year for this provision would be discretionary spending.

NATIONAL CONFERENCE OF STATE LEGISLATURES

444 NORTH CAPITOL STREET, N.W. SUITE 515 WASHINGTON, D.C. 20001
202-624-5400 FAX: 202-737-1069

JAMES J. LACK
STATE SENATOR
NEW YORK
PRESIDENT, NCSL

ALFRED W. SPEER
CLERK OF THE HOUSE
LOUISIANA
STAFF CHAIR, NCSL

WILLIAM POUND
EXECUTIVE DIRECTOR

Via Facsimile

March 27, 1996

The Honorable John Joseph Moakley
Ranking Member, Committee on Rules
U.S. House of Representatives
Washington, D.C. 20515-6269

Dear Representative Moakley:

On behalf of the National Conference of State Legislatures, I would like to share our thoughts on H.R. 3160, pending health insurance reform legislation. NCSL supports efforts to extend portability to individuals covered by ERISA plans and to establish minimum federal standards for insured plans. We are pleased that Title I, Subtitles A and B, build on the foundation for reform built by states over the last several years. We have been assured that the intent of Subtitles A and B is to continue to support state regulation and innovation in the small group and individual markets. We are pleased that changes have been made since the mark-up of H.R. 3070 and H.R. 3103, to provide additional clarity with regard to the ability of states to exceed the federal standards established in the bill. We continue to have some concerns. For example, Section 103(b)(1) that states, "... A group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan, may not require a participant or beneficiary to pay a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary solely on the basis of the health status of the participant or beneficiary." NCSL is concerned that state rating laws that prohibit or restrict the use of health status in a manner different than prescribed in the bill, may be preempted. For example, in cases where plans that include a rating component in addition to health status, state rating reforms may not apply. We hope to work with you to obtain additional clarity.

While we support the thrust of Subtitles A and B of Title I, **NCSL opposes Subtitle C and urges you not to include these provisions in the House health insurance reform bill.** Subtitle C fails to recognize the traditional role of states in the regulation of insurance and the important contributions state legislators have made in increasing accessibility and portability of health insurance and addressing fraud and consumer protection issues with regard to Multiple Employer Welfare Associations, by eliminating state authority to oversee Multiple Employer Welfare Associations (MEWAs). Instead, Subtitle C: (1) creates incentives for the establishment of federally regulated MEWAs, moving more individuals out of the reach of state insurance regulators and the protections those regulators provide; (2) permits some MEWAs to operate without receiving full federal approval; and (3) expands the Department of Labor's (DOL) authority over employer solvency and MEWAs, but fails to authorize funds for expanding DOL staff to perform these functions. **NCSL opposes this preemption of state authority and the deregulation of MEWAs.**

The MEWA provisions of H.R. 3160 would: (1) disrupt the existing health insurance market, undermining existing state efforts to improve access to health care and adversely affecting insurance premiums overall, and (2) make it easier for unscrupulous individuals to commit fraud under the protective umbrella of this proposed federal law which fails to provide adequate protections for plan participants. NCSL supports and encourages the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to negotiate affordable health care coverage on the same basis as large groups. We also believe that these entities should and must be regulated and that consumers must be protected. Work remains to be done at both the state and federal government levels to strike a reasonable balance for MEWAs. **NCSL urges you to retain the state role in regulating MEWAs.**

States have made tremendous progress in reforming the small group insurance market. Since 1990 at least, 43 states have enacted laws that require carriers to renew coverage (guaranteed renewal); 37 states have enacted laws that require carriers to offer coverage to small groups regardless of the health status of their employees or previous claims experience (guaranteed issue); and 45 states limit pre-existing condition waiting periods and require carriers to give individuals credit for previous coverage. In addition, similar efforts are underway in a number of states with respect to the individual insurance market. Since 1991 at least, 16 states have enacted guaranteed renewal; 11 states have enacted guaranteed issue; and 22 states have limited pre-existing condition waiting periods. Twenty-four states have established state high-risk health insurance pools that enrolled over 100,000 individuals last year. Finally, states are continuing to work with MEWAs to strike a balance between reasonable state regulation, plan flexibility and consumer protection.

NCSL joins the many other groups in urging you to move forward without further delay on these incremental, but important steps toward health care reform. NCSL looks forward to working with you and your colleagues in the future as we work together toward expanding health care access and affordability.

Sincerely,

William Pound
Executive Director