A COMPARISON OF THE HSA, GEPHARDT, AND MITCHELL BILLS

FINAL 8/3

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Coverage	Universal coverage achieved by 1998.	Universal coverage achieved by 1999.	If 95% of the population is not covered by 2000 through voluntary measures, a Commission makes recommendations to achieve universal coverage, which Congress must consider on a fast track. If Congress does not act on the recommendations, then a 50-50 employer-individual mandate goes into effect for firms with 25 or more workers in States with less than 95% coverage. Firms with less than 25 workers are exempted. If 95% coverage is achieved through voluntary measures, then the Commission makes recommendations to achieve universal coverage, which Congress must consider in an expedited fashion.
Subsidies	Individual costs capped at 3.9% of wages. Workers earning up to 150% of poverty level and nonworkers with incomes of up to 250% of poverty eligible for subsidies. Employer costs would be capped at 7.9% of payroll; firms with fewer than 75 workers and average wages of less than $24,000 eligible for caps of between 3.5% to 7.9% of payroll.	Individuals under 100% of poverty would receive a full premium subsidy, which phases out between 100 and 240% of poverty. Employers with 50 or fewer workers and average payroll of less than $26,000 would be eligible for a tax credit which would reduce their liability for health premiums. Firms with under 25 workers would be eligible for a maximum credit of 40 percent of the Medicare Part C premium (50% of the employer share); firms with 26 to 50 workers would be eligible for a credit equal to 30% of the premium.	Individuals: Subsidies available for low-income individuals (up to 200% of poverty) beginning in 1997. Pregnant women and children up to 300% of poverty are also eligible for subsidies on a sliding scale. Temporarily unemployed people are eligible for enhanced income protection subsidies for up to 6 months. Employers who expand coverage to all employees also eligible for subsidies beginning in 1997 for currently uninsured employees and available for 5 years; firms pay the lesser of 50% of premium or 8% of newly-insured workers wages.
Employer / Individual Requirements	Employers required to contribute 80 percent of the average price plan in a geographic area. Subsidies available for small, low-wage firms (see above). All individuals required to have insurance and pay 20% of the premium, with subsidies available for low-income individuals.	Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Subsidies in the form of tax credits available to firms of 50 or fewer workers, based on average payroll. Small businesses could enroll workers in Medicare Part C. Individuals required to buy insurance. Employees of small (100 or fewer) businesses could choose expanded FEHBP or Medicare Part C (if low-wage). Unemployed covered under new Medicare Part C or private plan.	No required employer contribution until possibly 2002 (see Coverage). States could enact their own reforms, which could include employer requirements. Large employers (500 or more) must offer a choice of at least three plans (FFS, POS, HMO) to their employees and have option to self-insure; small firms must offer their employees option to join a HIPC and may provide choice of at least three plans through private insurer. Employers who contribute for any workers must contribute for all. No individual mandate until possibly 2002. However, workers must buy policies through employer-offered plans or their local HIPC to qualify for premium contribution from their employers.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Cost Containment	Competition among health plans is the main cost control mechanism. Limits on premium increases through a national health care budget, reducing to CPI plus per capita over 5 years for covered services. Incentives for individuals to choose lower cost plans. Slowdowns in growth of Medicare and Medicaid.	Competition among health plans is the main cost control mechanism, but this bill contains stronger public (Medicare Parts A,B, C held to strict spending targets) and private (backup of a hard trigger of Medicare-like fee schedules) cost containment than the Senate bill. A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 to control costs if expenditures were exceeding targets. Congress must either approve cost containment provisions along the lines of Medicare's payment methods or pass alternate measures to hold down health spending.	Competition among health plans is the main cost control mechanism. High cost health plans would be assessed 25% on the portion of their costs above a target. A National Cost and Coverage Commission would issue annual reports starting in 1999 on national and State trends. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, a Commission makes recommendations to Congress, who must act on them in an expedited fashion. A "fail safe" limit in Federal health care spending starting in 1997 included as backup protection; if costs exceed projected baseline, reform spending (except subsidies for pregnant women and children) would be reduced. (Also see Financing)
Financing	Cigarette tax increased $.75; assessment on self-insured plans; tax deductibility of cafeteria plans phased-out; savings in Federal programs.	Cigarette tax increased $.45. 2% surcharge on private premiums (not Medicare Part C). A portion of the premiums paid by non-enrolling employers would be retained during a transition period. Tax deductibility for health benefits which are part of cafeteria plans also eliminated.	Cigarette tax increased $.45. Includes an assessment on premiums of high growth plans. Also eliminates tax deductibility of health benefits as part of cafeteria plans. 1.75% surcharge on private premiums.
Insurance Reform	Interim insurance reforms, including portability, guaranteed renewal, and pre-existing condition limitations, all begin right away. Guaranteed issue, community rating, standard benefits package and elimination of lifetime limits begin when a State phases in to universal coverage (outside date: January 1, 1998).	Insurance reforms include guaranteed issue, guaranteed renewal, standard benefits package, ban on pre-existing condition exclusions and an end to lifetime limits. Insurers selling in individual and small group insurance markets must offer insurance at community rate (no age bands). Firms above 100 can self-insure Not clear when reforms implemented.	Beginning in 1996, portability, guaranteed renewal and a limit on pre-existing condition exclusions (6 months for previously uninsured) Starting in 1997, insurance reforms include guaranteed issue, standard benefits package, elimination of lifetime limits and community rating (modified until 2002 for age with a band of 2:1). Insurers required to cover unmarried children under age 25. Firms/groups above 500 can self-insure or buy experience-rated policies. Risk adjustment across experience-rated and community-rated plans.
Medicare	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1996-2000=$118.3 billion.	Retained and strengthened through added coverage for prescription drugs, mammography and mental health services. Medicare expanded through new "Part C' option for employees of small businesses, unemployed and others who don't receive insurance through the workforce, effective in 1999. Savings levels not yet clear, but are likely to be more than the Senate proposal.	Retained and strengthened through added coverage for prescription drugs. Medicare savings 1995-1999 = $55 billion; 10 year figure = $278 billion.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Medicaid	All current Medicaid recipients choose from among community rated plans available through the regional alliance system. If a low cost sharing plan (HMO) is available at or below the weighted average premium, then AFDC and SSI recipients who choose that plan have their cost sharing reduced to $2 for a physician visit and $1 per prescription; the HMO must absorb this extra cost-sharing subsidy. If no low cost sharing plan is available at or below the weighted average premium, AFDC and SSI recipients can choose a high cost sharing plan and be subsidized down to the $2/$1 level. State and local governments pay the plan for most of this subsidy. "Wrap-around" benefits extended to AFDC and SSI recipients and "non cash" children.	Medicaid recipients with modified adjusted gross incomes under 100% of poverty would receive a full premium subsidy; those with incomes above 100% of poverty would be required to pay part of their premium. Medicaid recipients, like other individuals, could enroll in Medicare Part C or could apply a voucher toward the purchase of a private plan. All AFDC and SSI recipients get a full subsidy and they are eligible for supplemental benefits currently covered by EPSDT. Non cash recipients will receive the same subsidies as low-income people. Payments for supplemental would be made out of the Part C trust fund.	AFDC and non-cash recipients with incomes below 100% of poverty and pregnant women under 185% of poverty receive a full premium subsidy. Non cash recipients with incomes above 100% of poverty (who are not pregnant women or children) pay for part of their premium if they want coverage. AFDC recipients in HMOs pay 20% of the cost sharing amount otherwise required. Cost sharing is absorbed by the plan or paid for by the government.
Benefits	Comprehensive benefits include hospital and health professional services, preventive services (w/ no cost sharing), prescription drugs, mental illness and substance abuses services, pregnancy-related services (including abortion) and family planning. Three kinds of cost sharing offered: lower (HMO), higher (fee-for-service) and combination (PPO). Out-of-pocket costs capped at $1500/individual and $3000/family.	Similar to benefits offered in HSA. Includes benefits currently covered under Medicare as well as preventive services for children (with no cost sharing), preventive services for adults (some without cost sharing), prescription drugs, mental illness and substance abuse services, pregnancy-related services (which appear to cover abortion) and family planning services. Out-of-pocket costs capped at $1500/individual and $3000/family.	Sixteen categories of covered services in the standard package are specified in the bill, including nearly all those in the HSA package. Abortion and family planning are covered. A National Benefits Board will define scope and duration of services and can seek parity (ie some cost sharing) for mental illness and substance abuse services. Three cost-sharing schedules (as in HSA) will be specified by the Board. Individuals also have option of purchasing an "alternative standard" package with a high deductible. The actuarial value of the package is the value of the FEHBP Blue Cross/Blue Shield Standard Option.
Alliances/ Purchasing Cooperatives	Individuals in firms with 5000 or fewer workers must belong to a single, mandatory regional health alliance, which collects premiums and pay health plans on behalf of enrollees. Firms above 5000 have option to self-insure.	States could establish voluntary or mandatory health cooperatives. Health plans sold through a health cooperative would be sold at the community rate that would otherwise apply, adjusted by an administrative discount.	Health Insurance Purchasing Cooperatives (HIPCs) set up as voluntary competing non profit agencies responsible for contracting with plans and employers, enrolling individuals, collecting and distributing premiums and publishing information on plans. HIPCs must accept all enrollees and offer choice of at least a fee-for-service plan, a point-of-service option, and an HMO. If a HIPC not available in community-rated area, then FEHBP is required to sponsor a HIPC in that area. (see FEHBP)

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
FEHBP	Terminates on December 31, 1997 (except for employees abroad).	An expanded "Universal" FEHBP established after insurance reforms take effect and will contract on a competitive basis with community-rated plans. A small (less than 100 employees) employer has option to offer coverage through UFEHBP.	OPM contracts with a local HIPC, or will establish one, in each coverage area for federal employees. Premiums for federal workers will be based on current methodology and will not be age-adjusted. Workers in firms with less than 500 employees, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at an age-adjusted community rate. Federal workers and nonfederal individuals will pay same community-rated premium after the phase-out of age-rating in 2002.
Choice of Plan/Provider	Individuals guaranteed choice of menu of health plans, including one fee-for-service plan and a point-of-service option for HMOs. Any willing provider who accepts the fees, terms and conditions of any fee-for-service plan guaranteed the right to contract with that plan.	Individuals have choice of at least one fee-for-service, and one managed care plan, depending on what employer offers: Medicare Part C (for individuals not connected to the workforce, part-time and seasonal workers and low income persons and their dependents in firms with under 100 employees), UFEHBP (for employees of firms with less than 100 workers), vouchers to buy a private plan or a catastrophic plan with a medical savings account. Medicare Part C option will offer at least a fee-for-service and an HMO. Modified any willing provider clause: any qualified provider willing to accept the fees, terms and conditions of any plan (other than staff-model and group-model HMOs) is guaranteed the right to contract with that plan, though	Individual have choice of at least 3 health plans, including 1 fee-for-service plan. Small and medium sized employers must offer workers the chance to buy a policy through a HIPC and may also offer a choice of 3 plans, including a fee-for-service plan, and HMO, and a POS plan. Workers in firms with less than 500 workers, nonworkers, AFDC recipients, and self-employed may purchase coverage through the FEHBP HIPC at the age adjusted community rate. No any willing provider provision for any plan.
State Duties	Must establish alliances, assure enrollment and eligibility, regulate budgets, monitor quality standards and implement risk adjustment mechanisms. States could opt for single-payer, all-payer or other mechanism so long as coverage levels attained.	States can design individual reform programs, including a single payer option, so long as they meet coverage and cost control targets. States are responsible for implementing a long-term care program, an enrollment assistance program and solvency standards for self-insured plans.	States have ability to implement federal reforms on a "fast track", and could recapture federal savings from Medicaid integration. States could choose the single-payer option, and existing state waivers would be grandfathered. Responsibilities include certification of HIPCs and maintenance of effort for certain Medicaid recipients; States can pay per capita amount for SSI/Medicaid recipients who go into certified health plans.

PROVISIONS OF INTEREST TO SMALL BUSINESSES IN THE HEALTH SECURITY ACT, GEPHARDT, AND MITCHELL BILLS

8/3 4:30

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Mandates	Employers required to contribute 80 percent of the average price plan in a geographic area. Subsidies available for small, low-wage firms (see below).	Employers required to contribute 80% of the cost of employees premiums by 1997; small (100 or fewer workers) firms not required to contribute until 1999. Small businesses could enroll workers in new Medicare Part C or an expanded "Universal" FEHBP.	No employer contribution required until possibly 2002, after which time a 50-50 employer-individual mandate goes into effect only if 95% of the population is not covered and Congress has not acted on a coverage commission's recommendations. Firms with less than 25 workers are exempted from the mandate.
Subsidies	Firm costs would be capped at 7.9% of payroll; firms with fewer than 75 workers and average wages of less than $24,000 eligible for caps of between 3.5% to 7.9% of payroll.	Employers with 50 or fewer workers and average payroll of less than $26,000 would be eligible for a tax credit which would reduce their liability for health premiums. Firms with under 25 workers would be eligible for a maximum credit of 40 percent of the Medicare Part C premium (50% of the employer share); firms with 26 to 50 workers would be eligible for a credit equal to 30% of the premium.	Employers who expand coverage from existing levels to all employees eligible for subsidies for five years; firms pay the lesser of 50% of premium or 8% of newly-insured workers wages.
Cost Containment	Competition among health plans is the main cost control mechanism. Limits on premium increases through a national health care budget, reducing to CPI plus per capita over 5 years for covered services. Incentives for individuals to choose lower cost plans. Slowdowns in growth of Medicare and Medicaid	Competition among health plans is the main cost control mechanism, but this bill contains stronger public (Medicare Parts A,B, C held to strict spending targets) and private (backup of a hard trigger of Medicare-like fee schedules) cost containment than the Senate bill. A National Health Cost Commission would monitor national health care costs and make recommendations to Congress in 2000 to control costs if expenditures were exceeding targets. Congress must either approve cost containment provisions along the lines of Medicare's payment methods or pass alternate measures to hold down health spending.	Competition among health plans is the main cost control mechanism. High cost health plans would be assessed 25% on the portion of their costs above a target. A National Cost and Coverage Commission would issue annual reports starting in 1999 on national and State trends. If fewer than 35% of eligible enrollees are able to enroll in a plan with premium at/below the target rate for an area, a Commission makes recommendations to Congress, who must act on them in an expedited fashion. A "fail safe" limit in Federal health care spending starting in 1997 included as backup protection; if costs exceed projected baseline, reform spending (except subsidies for pregnant women and children) would be reduced.

	Health Security Act	House Democratic Leadership	Senate Democratic Leadership
Self-employed	Self employed can deduct 100 percent of health insurance premium from taxes.	Self-employed can deduct 80% of health insurance premium.	Self employed individuals not eligible for employer-subsidized health insurance can deduct 50% of cost of premium for standard benefits package beginning in 1996 (remains 25% from 1993 to 1996). The 50% deduction will be reduced by a proportionate share if a self-employed individual with at least one full-time worker (who has been working for 6 months) provides less than 50% coverage to his worker.
Alliances/ Purchasing Cooperatives	Individuals in firms with 5000 or fewer workers must belong to a single, mandatory regional health alliance, which collects premiums and pay health plans on behalf of enrollees. (Firms above 5000 have option to self-insure).	States could establish voluntary or mandatory health cooperatives. Health plans sold through a health cooperative would be sold at the community rate that would otherwise apply, adjusted by an administrative discount.	Health Insurance Purchasing Cooperatives (HIPCs) set up as voluntary competing non profit agencies responsible for contracting with plans and employers, enrolling individuals, collecting and distributing premiums and publishing information on plans. HIPCs must accept all enrollees and offer choice of at least a fee-for-service plan, a point-of-service option, and an HMO. If a HIPC not available in community-rated area, then FEHBP is required to sponsor HIPCs in that area.
Independent Contractor	Treasury Department would issue prospective regulations for worker classification.	Treasury Department submits a legislative proposal providing statutory standards for the classification of workers as independent contractors to the Congressional tax writing committees by January 1, 1996.	Same as in House Democratic version.
Subchapter S Corporations	Anyone owning over 2% of stock and materially participate in a service business would be treated as having net earnings from self-employment.	Net earnings from self-employment would include 80% of a shareholder's 2% pro-rata share of taxable income from a service related business.	The self-employment tax base will be modified to 1) include 80 percent of an owner-service provider's service related provider's share of an S corporation's income derived from service-related businesses in the case of shareholders owning more than 2 percent of the stock of the corporation; 2) provide similar rules for limited partners who provide significant services to partnerships; and 3) provide special exclusion for 40 percent of income derived from inventory for all taxpayers.

BENEFITS

THE MITCHELL BILL GUARANTEES COMPREHENSIVE BENEFITS

Mitchell — Under the Mitchell bill, all Americans are guaranteed a comprehensive package of benefits that includes preventive services at no cost to the individual.

Dole — By contrast, the Dole bill does not guarantee benefits. In fact, the bill creates incentives for employers to offer only catastrophic coverage to their workers and encourages people to invest in Medical Savings Accounts. This approach discourages patients from getting preventive care -- which both improves health and saves health care dollars. According to the American Medical News, "Medical Savings Accounts threaten quality." (American Medical News)

Finance — The Mitchell bill builds on the structure of the Finance Committee bill by establishing categories of benefits that are covered and leaving the definition of those services to a National Health Benefits Board. However, unlike the Mitchell bill, the Finance bill does not require that preventive services be provided without cost sharing.

Gephardt — The Gephardt bill more explicitly defines the comprehensive package of benefits and the cost sharing that applies to those services. The package includes a broad range of preventive services without cost sharing. Under the Gephardt bill, all individuals receive the standard package rather than a plan with a high deductible, as under Mitchell.

Issues

- Both Gephardt and Mitchell cover pregnancy-related services (including abortion). The Senate Finance Committee Report includes a statement that in areas where abortion services are not currently available, health plans would not have to offer abortion services. This is a disturbing interpretation of the language of the amendment that passed.

- The Mitchell and Finance bills require the National Benefits Board to treat mental health and substance

abuse services in the same way other medical conditions are covered. The Gephardt bill includes limitations on mental illness and substance abuse services that do not apply to other services.

GEORGE J. MITCHELL
MAINE

United States Senate
Office of the Majority Leader
Washington, DC 20510-7010

FOR IMMEDIATE RELEASE
Thursday, July 21, 1994

CONTACT: Mary Ann Hill
202/224-2939

STATEMENT OF SENATE MAJORITY LEADER GEORGE J. MITCHELL REGARDING HEALTH CARE REFORM LEGISLATION

Speaker Foley, Majority Leader Gephardt, and I had a very good meeting with the President on the subject of health care. We've listened to America. We've listened to Republicans as well as Democrats, and we told the President that we're going to suggest different approaches to achieve the same objectives.

Our plans will be less bureaucratic, more voluntary, and will be phased in over a longer period of time. Our objectives remain:

-- health insurance for all Americans, which means providing security for those Americans who now have insurance as well as providing health insurance to those who don't have it;

-- cost containment, which means that health insurance becomes affordable to all Americans as well as controlling federal spending on health care;

-- greater emphasis on preventive and primary care;

-- maintaining the highest possible quality of care and maintaining individual choice of physicians and providing choice of health insurance plans.

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MEMORANDUM FOR DISTRIBUTION

FR: Paul Jamieson
RE: Talking Points
DATE: August 4, 1994

Attached are the war room's documents on Senate Finance and on Dole. I am trying to track down a summary of Senate Finance and will circulate it as soon as it is available.

A note on format of the talking points, since it was not clear at the end of our meeting today. The headlines for each section ought to emphasize the positive about Mitchell (tying in the current system if appropriate), then criticize Dole and Senate Finance, and then mention positive on Gephardt. At the bottom of the page, you ought to list issues that could hurt us in such a comparison. For example:

IMPACT ON SMALL BUSINESSES

MITCHELL LOWERS COSTS AND LEVELS THE PLAYING FIELD FOR SMALL BUSINESSES

Mitchell Under the Mitchell bill, firms with 500 or fewer employees will pay a community rated premium, significantly reducing small businesses' current insurance rates, which are as much as 30 percent higher than those charged to large businesses today.

Dole By contrast, Senator Dole's plan exempts trade associations from community rating -- a loophole which continues insurance market discrimination and will keep premiums high for small firms.

Senate Fin. The Senate Finance committee's bill only assists small firms by providing for voluntary purchasing cooperatives.

Gephardt The Gephardt bill will lower insurance costs for small firms by forcing insurers selling in small group insurance markets to offer community rated premiums (with no age bands) and by allowing small firms to join purchasing cooperatives, giving them expanded purchasing power.

Followed by similar outline for other headlines, such as:

MITCHELL GIVES SMALL FIRMS INCENTIVES TO EXPAND COVERAGE

MORE CHOICES FOR SMALL BUSINESSES AND THEIR WORKERS UNDER MITCHELL

[PROBLEM ISSUES]
example: Tax deductibility of self employed under Mitchell vs Dole.