May 11, 1994

NOTE TO: Ken Thorpe

FROM: Bridgett Taylor

Karen Hein from Senate Finance would like to have another follow up meeting with you regarding benefits. The two options for times includes either Thursday, May 12 at 1:00 p.m. or Friday, May 13 at 4:30 p.m. Veronica will be letting me know which of these times you can make.

Her list for discussion includes looking at the pros and cons of the following options :

1. increase co-insurance from 20 - 25%?
2. increase deductible from 200%/400% to 500%/750?
3. increase out-of-pocket from 1500/3000 to 2500/?
4. increase deductible for prescription drugs from $5/$250 per admission to $10/?
5. add per admission deductible, something like $250 (BCBS) or like Medicare who has a $400 deductible for stays beyond 60 days.

She also wants to discuss:

6. The Chafee bill has a catastrophic minimum, what about supplemental insurance beyond the minimum using the Medigap model?
7. The HSA has an out-of-pocket max of 3.9%, what about a two tier system for cost sharing.
8. The Labor Committee proposal to expand FEHBP.
9. In last year's Breaux proposal they had a typical HMO premium amount of $2130 per person in 1995 which included Medicaid beneficiaries. What benefits could you include to reach this premium amount?
10. What would the subsidies be for a catastrophic only package (Lott/Michel).
11. On the benefits scenarios chart (see attached) why are the subsidies lower in option 5 than option 2?

Please call if you have any questions.

cc: Jerry Klepner
Karen Pollitz
Chris Jennings
Jennifer Klein

BENEFIT SCENARIOS

CBO-like Premiums, Subsidies

Scenario	Single Premium	Richness Percentile for Fortune 500 Co's.[1]	5-Year Premium Subsidies (Billion $)	5-Year Cost-Sharing Subsidies (Billion $)	Total	(HMO Premium) (with MC)[2]
Base - Health Security Act (HSA)	$2,200	Median	$384	$12	$396	$2,200
1. .25/$2,000	$2,051	30th	$357	$25	$383	$2,200
2. .25/$2,000 BCSO mental health	$1,948	15th	$327	$24	$351	$2,098
3. HSA w/o mental health	$1,980	20th	$332	$12	$344	$2,090
4. .25/$2,000, trimmed other benefits by $100	$1,937	15th	$324	$24	$348	$2,086
5. .25/$1,500	$2,101	35th	$355	$12	$367	$2,101
6. .25/$2,000 w/o mental, w/o prev, and w/o drugs	$1,541	5th	$194	$12	$206	$1,585

[1] Relative generosity of plan compared to all Fortune 500 Companies.

[2] HMO premium assuming 20% savings from "management".

Other Considerations

- oral health
- fertility-related treatments
- nutrition screening(link to either demonstration or population (e.g. elderly, pregnant women, children, diabetics)
- respiratory therapy (part of rehab)
- colorectal screening (occult blood, flexible sigmoidoscopy, colonoscopy schedules)
- speech pathology and audiology
- mammography standards: refer to NCI
- children's clinical preventive services: refer to Amer.Acad. Pediatrics
- mental health/substance abuse: consider new cost-estimates (APA, Stark Mark, Miller amendment)
- if limited package, consider children first (Matsui Bill)

Jen - would you go through this and see if I should keep, or perhaps you could use!

— Pam

HOUSE WAYS & MEANS BILL

Coverage

- Employer mandate for 80 percent of standard benefit package which is about eight percent below HSA in value; for firms over 100, mandate takes effect during 1996; for those under 100 during 1998.
- Firms under 100 have option to join a Medicare Part C program; Medicaid will also be folded in; Medicare will therefore cover 40-50 percent of all Americans.
- Subsidies provided for households and small businesses which in aggregate are almost as large as in HSA; more subsidies to households to cover higher cost sharing of benefit package; less subsidies to business than in HSA.
- Medicare drug benefit (with a $500 deductible and $1,000 out-of-pocket yearly limit); limited long-term care program.
- Benefit package has $500 deductible for individual, $750 for family plus 20 percent copays. Out-of-pocket yearly expenses are not capped until 2003 and then at $5,500 for an individual and $11,000 for a family (in 1994 dollars).

Cost Controls

- Medicare Part C has Medicare price controls; rest of private sector premiums have triggers in the year 2001 to impose price controls in 2003 if those premiums are rising too fast.

Insurance Reforms

- Community rated pools under 100; experience rating above 100.
- Employer choice rather than consumer choice.
- Allows trade and other groups to be exempt from community pool.

Financing

- Mandate.

- Very large Medicare cuts (much larger than in HSA over 10 years).
- Requires full premium payment for both workers in two-worker families.
- Smaller tobacco tax than ours.
- Tax cafeteria plans.

PROBLEMS WITH WAYS & MEANS BILL

- Medicare cuts might not be sustainable.
- More business subsidies may be needed.
- Insurance companies can still cherry pick on private side.
- Medicare C may be viewed as too much government. Program is really designed as a first step to spreading Medicare to the whole country.
- Price controls, quality systems and other proposals may be viewed as far more bureaucratic than HSA.
- Has major cost shift to private sector.
- Insufficient small business purchasing co-op structure.
- Hospitals, doctors, business likely to wage war on the bill. Seniors might also do so.

FINANCE COMMITTEE BILL

Coverage

- No mandate, but firms of 100+ must make plans available to employees.
- Subsidies for people up to 200 percent of poverty to help them buy insurance.
- Increased tax deductibility for self-employed to help them buy insurance.
- If by 2002, coverage doesn't reach 95 percent, Commission recommends steps to Congress to improve coverage; Congress does not have to act.
- Two national standard benefit packages; one comprehensive (8 percent below HSA); one catastrophic.
- Beginning in 1996, pregnant women and children receive full subsidy up to 185 percent of poverty and sliding scale up to 250 percent for health insurance.
- No Medicare drug benefit; limited long-term care program.
- Increased funding for academic centers.

Cost Control

- Within each group of plans in a region, (community rated and experience rated), the highest priced 40 percent are taxed at 25 percent of the difference between average premium in that group and the plan's premium.
- Cap on federal spending which delays implementation or cuts benefits if federal costs exceed projected baseline.

Insurance Reforms

- Age adjusted community pool for firms below 100; experience rating above.
- Voluntary purchasing pools for firms below 100; individuals and small groups can join FEHBP at community rate.
- Guaranteed renewability; limits on pre-existing condition exclusions; no exclusion for pregnancy.

Financing

- Bigger Medicaid cuts than in HSA.
- Smaller Medicare cuts than in HSA.
- Cigarette tax increased by $1 (HSA increases by 75 cents).
- Premium assessment for academic centers.
- Assessment on high cost plans.
- Tax cafeteria plan.

PROBLEMS WITH FINANCE COMMITTEE BILL

- No universal coverage (our estimate indicates between 88-90 percent coverage -- middle class left out; coverage declines eventually as premiums rise faster than wages.)
- No serious cost controls.
- Insurance companies can cherry pick groups above 100.
- Program not adequately funded to achieve even its limited goals.
- Labor, consumer groups and large unionized business likely to oppose high cost plan assessment.
- No Medicare drug benefit.
- Spends a lot to achieve very little.

MITCHELL STAFF DISCUSSIONS

These are preliminary discussions at the staff level. Provisions are changing day-to-day.

Coverage

- If by (1999 or 2000), (95 or 96 percent) coverage is not achieved, then Commission must recommend CBO certified path to universal coverage; if Congress fails to act or Commission fails to recommend, then a 50/50 employer and individual mandate (with a carve-out for firms below 25) goes into effect.

- Standard comprehensive benefit package at about eight percent below HSA guaranteed to all after trigger.

- In the interim, subsidies targeted to maximize coverage.

  - All children and pregnant women covered.

  - A means to cover people for six months (or more) after they leave a job (up to a specified income level).

  - Tax deductibility for the self-employed.

- Medicare drug program and limited long-term care program.

Cost Control

- Tax on high cost plans not in community pool (firms of 100 or 500 and under) as in Senate Finance proposal, except that a nationally defined benchmark will determine the average in each region of the county to set a baseline. (More effective than finance cost control).

- Firms outside of community pool would not be cost controlled or would be controlled only to limit rate of growth.

Insurance Reforms

- Community rating for firms of 500 and under (or possibly 100).

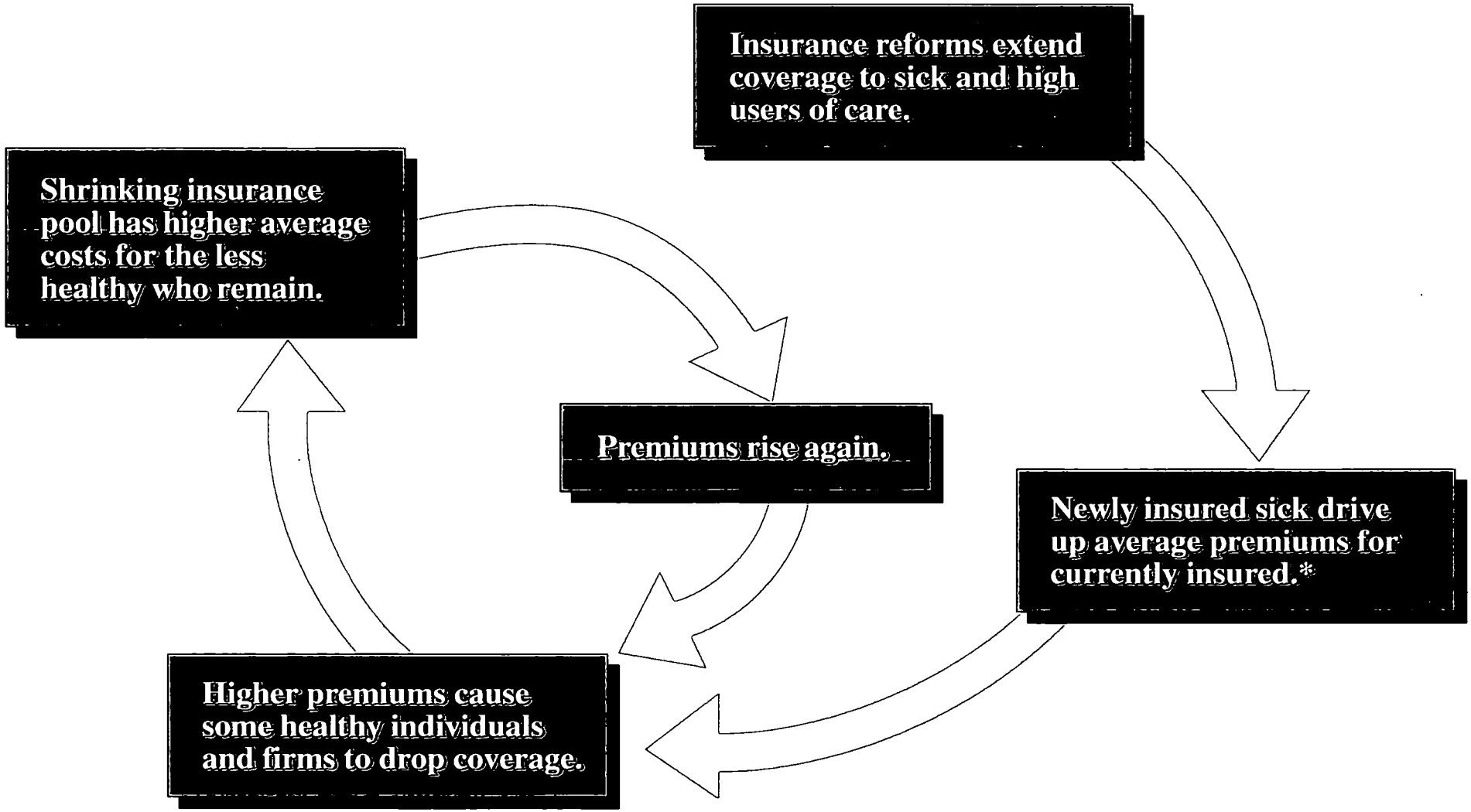
- Insurance reforms similar to HSA and Kennedy bill.
- Voluntary alliances as defined in Kennedy Committee bill with FEHBP back-up.

Financing

- Risk adjustment assessment on firms outside of community pool.
- High cost plan assessment.
- Medicare and Medicaid savings as in Senate Finance bill.
- Premium assessment for academic centers.
- Tobacco tax at Ways & Means level.
- Elimination of cafeteria tax preference.

The Vicious, Upward Spiral

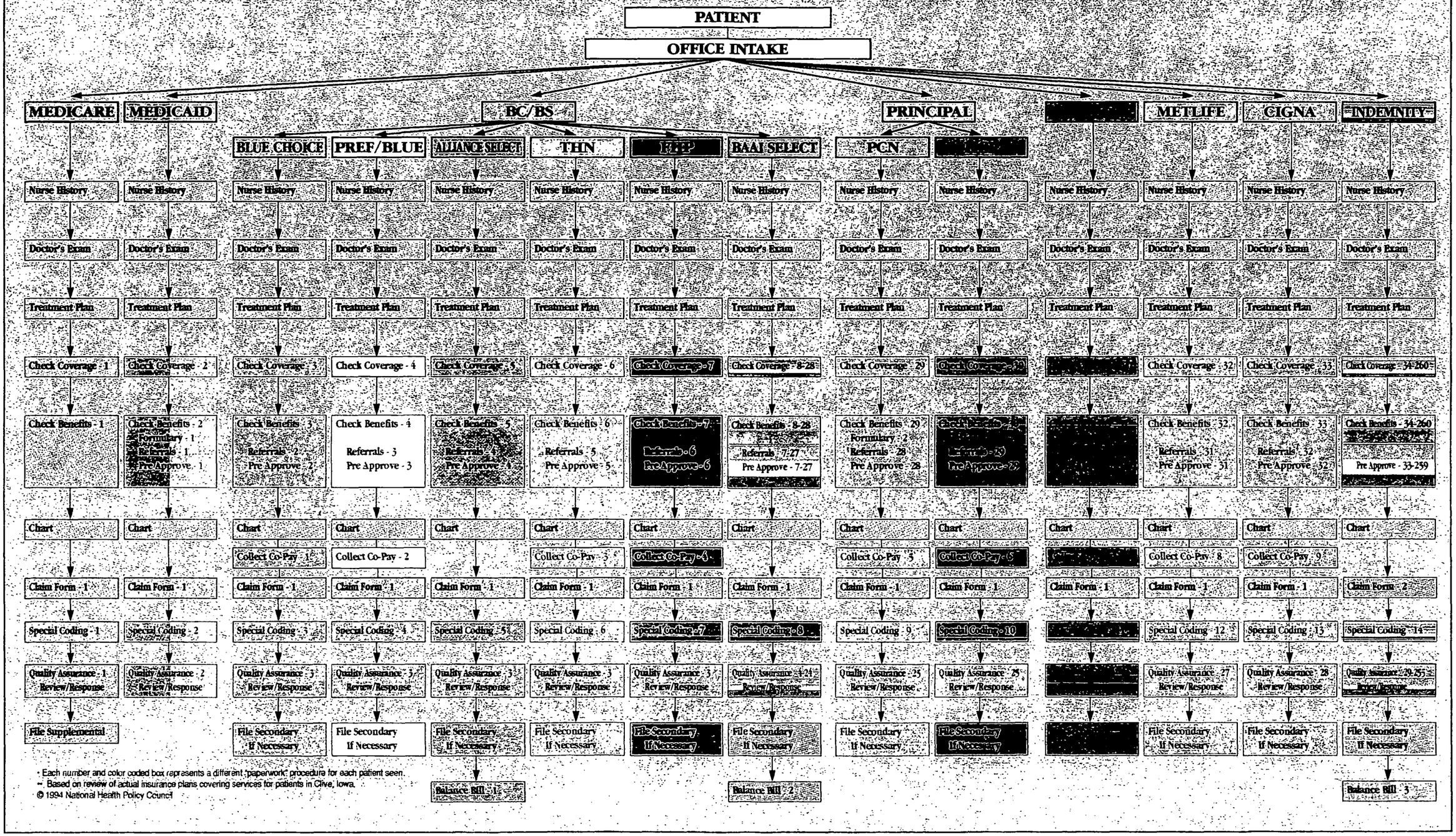
Incremental Reform Increases Insurance Premiums and the Number of Uninsured



*Universal coverage averts this problem by also including healthier, lower-cost individuals in the insurance pool, thereby holding down average premiums.

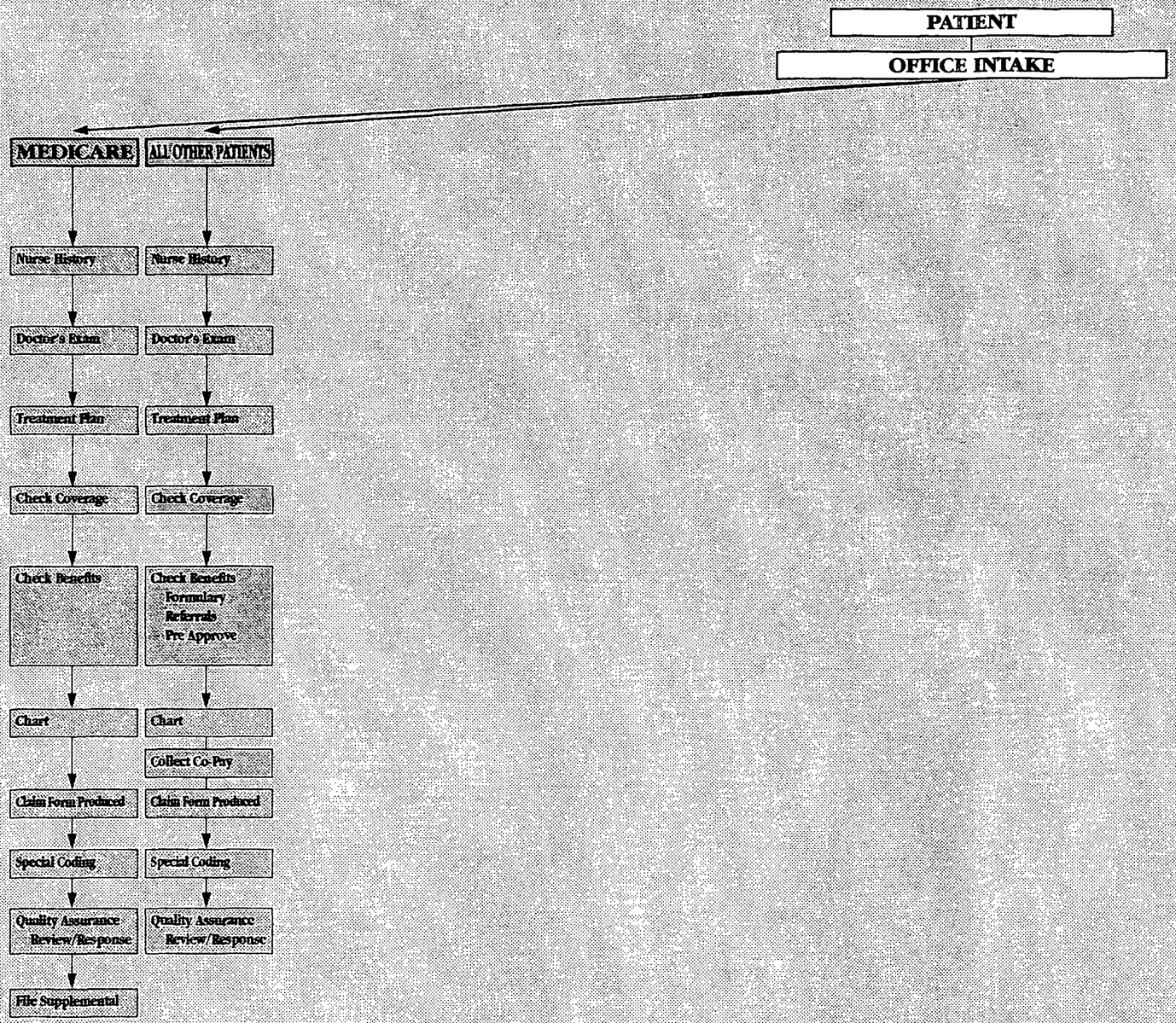
Source: The Catholic Health Association of the United States

Dr. Gleason's Office Before President Clinton's Plan



- Each number and color coded box represents a different "paperwork" procedure for each patient seen.
- Based on review of actual insurance plans covering services for patients in Clive, Iowa.

Dr. Gleason's Office <u>After</u> President Clinton's Plan



* Each number and color coded box represents a different "paperwork" procedure for each patient seen.
** Based on review of actual insurance plans covering services for patients in Clive, Iowa.

STATEMENT ISSUED BY ACADEMIC HEALTH LEADERS

The best health care in the world can be found here in America. But our health care system is in need of reform. Millions of Americans are without health insurance coverage and health care costs continue to increase in excess of inflation. In the absence of reform current trends will lead to further deterioration in quality of and access to health care for many Americans.

As leaders of American medical schools and teaching hospitals, we believe that all Americans should have access to high quality health care, and we applaud the efforts of the President and many in Congress to achieve reform, including universal coverage.

Our institutions are committed to enhancing the quality of health care by attracting and educating an outstanding medical work force for the future and by conducting pathbreaking biomedical and clinical research. Also part of our institutional mission is the provision of care to the medically indigent and to those without insurance. As a result we see, first hand, the dire medical and social consequences of people having no, or insufficient insurance: they have less access to needed medical care; they fail to obtain needed preventive services; they are more likely to delay going to the doctor; and they are more likely to come to our emergency units already beset with severe medical problems that might have been avoided or treated with far less expense or risk.

Until quite recently, institutions like ours served the uninsured in part by passing the costs of that care onto the insured. But in today's more competitive marketplace this is no longer possible. As a result, the burdens of "uncompensated care" are falling squarely on those who provide it, threatening the educational, research and care missions of our academic health centers, so vital to the future quality of care for all our citizens.

We believe universal coverage is not just an issue of equity; it is important to the health and security of all patients and to the general public.

The Administration's reform proposal -- while some may not agree with

all its elements -- appropriately identifies universal coverage as the highest priority.

It is also critical that reform preserve the many strengths of American health care, and include a responsible financing mechanism that will ensure needed health security for all.

A new health system must also preserve the high quality of American health care and emphasize choice so that consumers can choose quality care. We must work toward a system that provides appropriate benefits and ready access to primary and preventive care. The system must encourage medical research and the best possible education for health care professionals.

Organizations and individuals will have differences with various proposals. But the last thing our country needs is an end result in which everyone's efforts to protect their own interests result in an overall failure to secure the public's interest.

We urge other concerned Americans, of all political persuasions and parties, to join us in this historic challenge to guarantee health care coverage to the entire nation.

SIGNATORIES FOR ACADEMIC HEALTH LEADER STATEMENT

Bobby Ray Alford, MD
Baylor College of Medicine
Houston, TX

Christine St. Andre
Executive Director
University of Utah Hospital
Salt Lake City, Utah

Carol Ann Aschenbrener, MD
Chancellor
University of Nebraska Medical Center
Omaha, NE

Steven D. Baron, President
The Miriam Hospital
Providence, RI

Jane T. Barry
VP Network Devel. & Community Affairs
The University Hospital
Boston, MA

Harry Nelson Beaty, MD
Dean
Northwestern University Medical School
Chicago, Ill

Stanley Silver Bergen, Jr., MD
President
UMDNJ-New Jersey Medical School
Newark, NJ

Giles G. Bole, MD
Dean
University of Michigan Medical School
Ann Arbor, MI

Stuart Osborne Bondurant, MD
Dean
University of North Carolina at Chapel Hill
School of Medicine
Chapel Hill, North Carolina

Leo P. Brideau
Executive Director
University of Rochester
Strong Memorial Hospital
Rochester, NY

Lester Richard Bryant, MD, Sc.D.
Dean
University of Missouri-Columbia School of Medicine
Columbia, MO

Roger James Bulger, MD
President, Association of Academic Health Centers
Washington, DC

Gerard Noel Burrow, MD
Dean
Yale University School of Medicine
New Haven, CT

Marie Cameron
Interim Executive Director, CEO
Howard University Hospital
Washington, DC

Robert M. Carey, MD
Dean
University of Virginia School of Medicine
Charlottesville, VA

Aram V. Chobanian, MD
Dean
Boston University School of Medicine
Boston, MA

Thomas Joseph Cinque, MD
Dean
Creighton University School of Medicine
Omaha, NE

Jordan Jay Cohen, MD
President, Association of American Medical Colleges
Washington, DC

Richard Alan Cooper, MD
Executive Vice President and Dean
Medical College of Wisconsin
Milwaukee, WI

Stacey Todd Cyphert, Ph.D.
The University of Iowa
Iowa City, IA

Charles Harry Epps, Jr., MD
Dean
Howard University College of Medicine
Washington, DC

Charles McCollister Evarts, MD
Senior Vice President for Health Affairs and
Dean, College of Medicine
Hershey Medical Center at Pennsylvania State University

Hersehy, PA

Harold J. Fallon, MD
Dean
Univesrsity of Alabama School of Medicine
Birminghan, AL

Philip Jack Fialkow, MD
Vice President for Medical Affairs and Dean
University of Washington School of Medicine
Seattle, WA

Carl Fischer
Executive Director
Medical College of Virginia
Richmond, VA

Robert Clifford Fore, MD
Associate Dean
Mercer University School of Medicine
Macon, GA

Spencer Foreman, MD
President
Montefiore Medical Center
Bronx, NY

Mr. Ralph Reed Fraley
Executive Director
The Ohio State University Hospitals
Columbus, Ohio

Ronald Dwyer Franks, MD
Dean
University of Minnesota-Duluth School of Medicine
Duluth, Minnesota

Paul Bernard Gardent
Sen. VP/COO
Mary Hitchcock Memorial Hospital
Dartmouth Hitchcock Medical Center
Lebanon, NH

Kim Goldenberg, MD
Wright State University School of Medicine
Dayton, OH

James Anthony Hallock, MD
Dean., School of Medicine - Vice Chancellor
East Carolina University School of Medicine
Greenvilles, NC

Donald C. Harrison, MD
Senior VP and Provost for Health Education
University of Cincinnati College of Medicine
Cincinnati, Ohio

John James Hutton, Jr., MD
Dean
University of Cincinnati College of Medicine
Cincinnati, OH

Michael E. Johns, MD
Dean of Medicine
Johns Hopkins University School of Medicine
Baltimore, MD

William Johnson, Jr.
CEO
University of New Mexico Hospital
Albuquerque, NM

William Nimmons Kelley, MD
Executive Vice President for the Medical Center and Dean
University of Pennsylvania School of Medicine
Philadelphia, PA

William Bernard Kerr
Director, Medical Center
Medical Center at the University of California, San Francisco
San Francisco, CA

David Korn
Stanford University School of Medicine
Stanford, CA

Donald L. McDowell, Pres.
Maine Medical Center
Portland, ME

Leon S. Malmud, MD
Senior Vice President for the Health Sciences Center
Temple University
Philadelphia, PA

Donald J. Marsh, MD
Dean of Medicine and Biological Sciences
Brown University School of Medicine
Providence, RI

Mitchell T. Rabkin, MD
President
Beth Israel Hospital
Boston, MA

Morton I. Rapoport, MD
President/CEO
U. Maryland Medical system
Baltimore, MD

Perry G. Rigby, MD
Chancellor of the Medical Center
Louisiana State University School of Medicine in New Orleans
New Orleans, LA

Stephen Joseph Ryan, MD
President
University of Southern California School of Medicine
Los Angeles, CA

Raymond Gilbert Schultze, MD
Director
UCLA Medical Center
Los Angeles, CA

Clarence Edward Schwartz, Director
Univ. Nebraska Hospital
Omaha, Nebraska

Morton S. Silberman, MD
Assistant Director
Woodruff Health Science Center at Emery University

Steve Gene Sloate
Associate Vice Chancellor For Health Affairs
Duke University School
Durham, NC

Mr. Larry Smith
Chief Operating Officer
New England Medical Center
Boston, MA

Ralph Snyderman, MD
Chancellor for Health Affairs
Duke University School of Medicine
Durham, NC

Jay Harold Stein, MD
Provost and Senior Vice President for Health Sciences
University of Oklahoma College of Medicine
Oklahoma City, OK

Robert Cochran Talley, MD
University of South Dakota School of Medicine
Sioux Falls, SD

Dr. Daniel Tosteson
Dean
Harvard Medical School
Boston, MA

Ms. Lorraine Tregde
Executive Director
Bronx Municipal Hospital Center
Bronx, NY

Reed Vaughn Tuckson, MD
President of the University
Charles R. Drew University of Medicine and Science
Los Angelles, CA 90059

Manuel Tzagournis, MD
Dean, College of Medicine
Ohio State University
Columbus, OH

Ms. Farah M. Walters, Pres.
University Hospitals of Cleveland
University Circle
Clevland, OH

Harry P. Ward
Chancellor
University of Arkansas for Medical Services
Little Rock, Ar

Gail L. Warden
President/ CEO
Henry Ford Health System
Detroit, Michigan

Donald Edward Wilson, MD
Dean
University of Maryland School of Medicine
Baltimore, MD

Emery Allen Wilson, MD
Dean
University of Kentucky College of Medicine
Lexington, KY

Ivan Dodd Wilson, MD
Dean
University of Arkansas College of Medicine
Little Rock, AR

Theresa Bischoff
New York University Medical Center
New York, NY

SQUEEZING THE STATES:

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

July 18, 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 $3.5 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 1996-2003 would total an astounding $115 billion.

- Some states would be particularly hard hit. Over 8 years, California will face $13.1 billion in additional costs, Texas will face $8.4 billion, and New York will face $13.4 billion more in total Medicaid costs.

- The plan's 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 a means of providing some fiscal relief from constantly rising Medicaid costs, but the Dole plan would only exacerbate this fiscal 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 reimbursements to state governments for acute care services, less disproportionate share spending, to an annual payment cap for each recipient. Total federal reimbursement for each state would be determined by multiplying the capped per recipient amount by the number of Medicaid recipients in the state. The cap would limit this per recipient federal spending to increases of only 6% annually from FY 1996 through FY 2000, and 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 eligibility 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 the 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 could 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 enforced is very unclear. It is also unclear whether the low-income subsidies would be adequate, since the Dole plan specifically reduces such subsidies to avoid deficit spending.

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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 (as they did in New York), 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. The Dole plan also makes cuts in Medicare that will adversely impact public hospitals and teaching institutions which rely on federal and 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	FY2002 Additional Cost to State if Dole cap	FY2003 Additional Cost to State if Dole cap	TOTAL ADDED COST TO STATE w/CAP
TOTAL	905,366,097	2,707,478,776	4,732,942,862	7,066,963,348	13,865,121,227	18,716,077,888	24,671,408,482	73,366,378,744
AL	11,573,981	34,610,906	60,602,458	101,852,695	174,849,408	239,282,084	315,380,330	936,132,854
AK	2,136,256	6,366,944	11,162,044	18,758,718	32,274,818	44,144,307	58,184,380	173,072,444
AZ	17,097,220	50,948,331	89,062,794	149,800,641	257,531,831	352,229,841	464,867,406	1,380,867,834
AR	10,050,833	30,066,146	52,541,140	88,431,404	151,820,868	207,792,307	273,861,161	814,673,868
CA	93,162,863	278,853,582	487,114,308	818,856,488	1,408,471,849	1,926,465,442	2,539,178,908	7,552,821,864
CO	9,650,066	28,867,856	50,440,061	84,905,300	146,442,830	199,808,586	262,666,144	782,144,831
CT	6,816,646	20,381,286	35,626,642	59,966,000	103,018,548	140,806,836	186,780,879	553,486,330
DE	1,626,458	4,880,791	8,487,042	14,301,277	24,608,865	33,604,535	44,288,838	131,780,407
DC	4,071,754	12,176,806	21,265,274	35,828,008	61,548,548	84,190,068	110,863,738	330,037,808
FL	41,763,448	134,889,878	218,820,141	367,452,186	631,264,229	863,420,333	1,136,007,243	3,386,180,860
GA	22,618,481	67,636,381	118,234,905	199,009,637	341,663,887	467,617,308	616,544,009	1,833,347,068
HI	2,366,004	7,048,816	12,318,285	20,729,267	36,812,002	48,708,874	64,300,863	190,868,141
ID	2,812,348	7,812,005	13,658,181	22,984,538	39,498,381	54,009,065	71,166,482	211,744,884
IL	30,618,466	91,266,867	158,526,080	266,496,578	461,203,508	630,801,700	831,881,636	2,473,832,734
IN	22,267,869	66,800,105	116,405,148	196,921,881	336,689,801	460,306,805	608,790,236	1,804,926,865
IA	7,217,305	21,582,864	37,728,174	63,501,851	108,092,448	148,213,212	196,678,840	585,007,871
KS	7,098,326	21,211,874	37,080,847	62,610,081	107,817,263	148,848,283	193,880,281	574,861,864
KY	18,474,453	55,244,868	96,576,909	162,545,817	279,346,848	381,843,401	503,421,437	1,497,483,087
LA	30,720,391	92,102,815	161,005,083	270,986,852	466,536,867	639,760,886	830,271,878	2,498,456,188
ME	4,824,077	13,867,808	24,172,584	40,884,868	69,804,006	95,806,816	126,804,284	374,808,168
MD	14,411,447	43,006,184	75,308,438	126,787,889	217,602,363	297,844,347	392,708,146	1,168,184,713
MA	21,268,106	63,800,440	111,179,814	187,128,868	321,472,418	439,809,848	578,847,486	1,723,883,847
MI	31,294,186	93,542,472	163,561,486	275,308,016	473,016,477	646,878,788	852,766,878	2,536,558,866
MN	12,043,029	36,018,836	62,966,431	106,890,861	182,039,180	249,879,384	328,147,738	976,161,801
MS	11,586,811	34,665,387	60,580,887	101,963,180	175,197,676	239,588,604	316,780,408	939,308,861
MO	12,257,586	36,655,260	64,077,861	107,847,367	185,276,829	253,418,161	334,014,286	993,543,879
MT	3,662,717	10,863,009	19,147,004	32,228,106	55,362,821	75,723,638	99,807,876	296,882,767
NE	4,251,861	12,665,013	22,182,288	37,303,870	63,966,888	87,480,978	116,316,509	343,014,913
NV	2,216,416	6,627,895	11,586,408	19,500,844	33,501,654	45,822,479	60,396,491	179,862,308
NH	2,242,138	6,704,913	11,720,858	19,727,342	33,880,408	46,354,328	61,097,300	181,787,674
NJ	26,341,203	75,760,842	132,472,847	222,963,328	383,039,538	523,909,308	690,540,070	2,054,047,164
NM	6,452,069	19,304,316	33,728,368	56,767,876	97,634,350	133,390,707	176,816,949	522,979,821
NY	92,035,183	276,222,249	481,117,804	809,763,808	1,391,133,170	1,902,748,142	2,507,921,858	7,438,948,161
NC	21,111,610	63,132,144	110,361,368	185,747,843	319,108,379	436,462,899	575,280,191	1,711,200,641
ND	3,340,126	9,869,318	16,807,896	28,307,906	48,676,226	66,906,788	86,392,102	262,828,417
OH	33,453,487	100,039,758	174,879,478	294,337,868	506,067,829	691,822,034	911,894,119	2,711,883,782
OK	9,887,260	26,619,450	50,370,874	84,772,703	145,609,718	199,242,456	262,612,007	781,182,876
OR	8,614,338	25,760,632	45,031,804	75,782,838	130,302,717	178,094,016	234,787,264	698,328,087
PA	40,551,265	121,265,050	211,963,404	356,768,886	612,841,799	838,362,481	1,105,005,738	3,286,800,842
RI	4,486,876	13,353,917	23,342,408	39,287,345	67,485,883	92,316,707	121,676,844	361,934,358
SC	11,809,962	35,316,840	61,737,010	103,906,870	178,510,178	244,180,881	321,818,467	957,268,708
SD	2,249,722	6,724,810	11,768,386	19,765,184	33,966,861	46,490,306	61,276,765	182,270,866
TN	21,290,457	63,667,371	111,296,740	187,322,387	321,816,211	440,161,678	580,152,437	1,725,705,287
TX	51,348,404	153,553,138	268,432,303	451,786,136	776,143,985	1,061,565,874	1,399,225,976	4,162,087,380
UT	5,336,447	15,895,192	27,801,267	46,843,490	80,949,610	110,305,768	145,268,700	432,408,486
VT	1,878,487	5,618,465	10,047,880	17,418,361	28,920,408	40,824,182	53,840,222	160,448,007
VA	11,453,278	34,250,037	59,872,481	100,770,702	173,118,807	236,780,068	312,087,238	928,340,348
WA	14,828,671	44,843,487	78,841,285	131,350,414	225,863,352	308,841,300	406,806,762	1,210,084,720
WV	13,302,762	39,780,758	69,540,750	117,048,229	201,074,305	275,022,148	362,484,928	1,078,268,888
WI	14,956,287	44,725,318	78,184,858	131,591,722	226,087,608	309,208,565	407,883,108	1,212,287,770
WY	1,372	4,104,881	7,175,759	12,077,430	20,748,430	28,378,040	37,405,071	111,283,316

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 [illegible]	FY97 DSH reduced by [illegible]	FY98 DSH reduced by [illegible]	FY99 DSH reduced by [illegible]	FY2000 DSH reduced by [illegible]	FY2001 DSH reduced by [illegible]	FY2002 DSH reduced by [illegible]	FY2003 DSH reduced by [illegible]	TOTAL DSH reduced FY96-2003
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AK	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AZ	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AR	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
FL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HI	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ID	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
IL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
IN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
IA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
KS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
KY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
LA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ME	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MD	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MI	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NH	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NJ	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ND	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OH	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OK	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OR	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RI	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SD	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TX	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
VT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
VA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WI	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

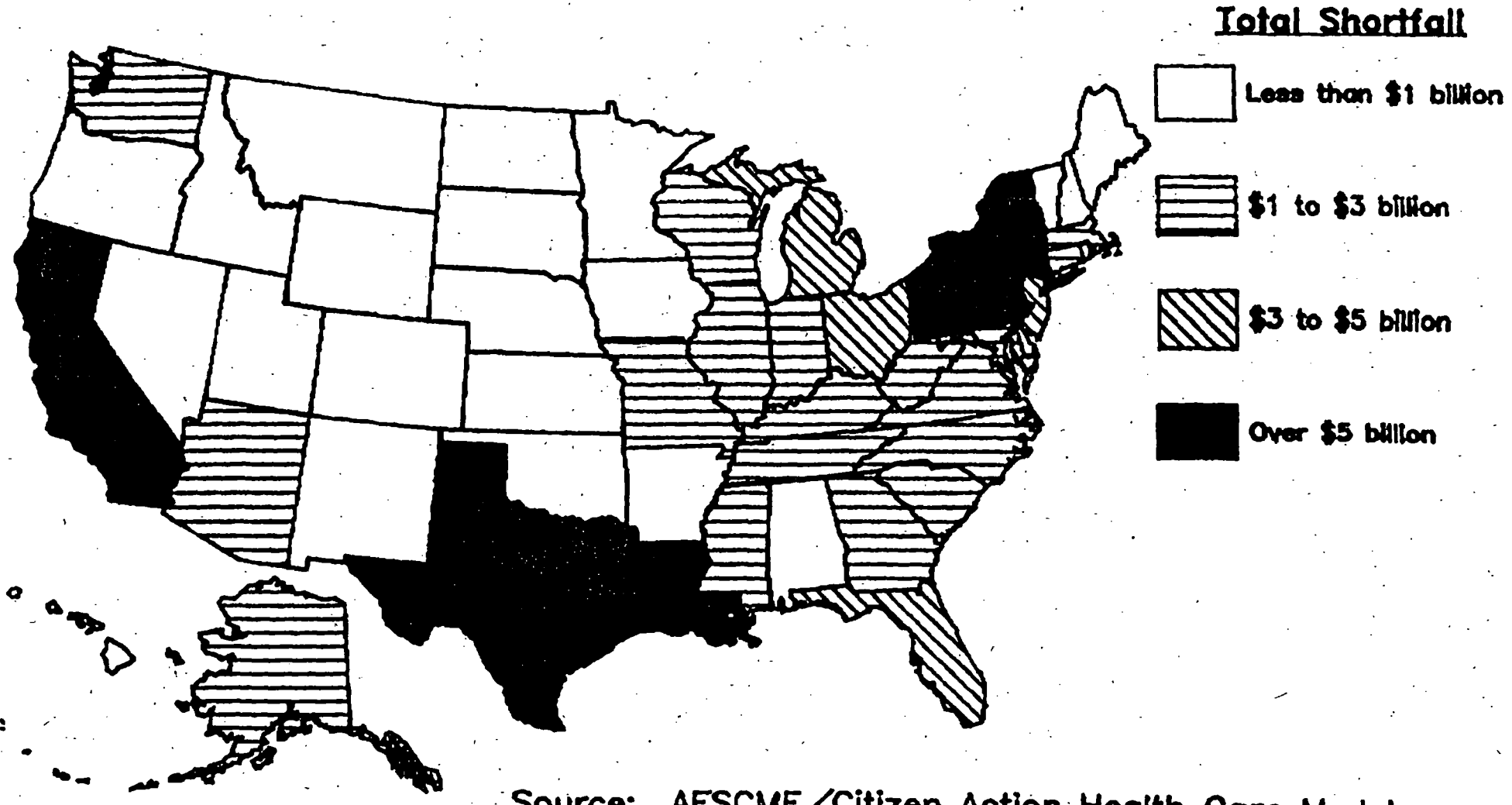
TABLE 3

TOTAL SHORTFALL DUE TO DOLE MEDICAID CUTS OVER 8 YEARS 1996-2003

Alabama	$2,238,239,893	Montana	$298,541,283
Alaska	$293,029,370	Nebraksa	$351,910,442
Arizona	$1,641,581,255	Nevada	$361,831,786
Arkansas	$822,886,112	New Hampshire	$263,357,795
California	$13,071,822,666	New Jersey	$4,416,187,944
Colorado	$1,090,617,561	New Mexico	$561,122,841
Connecticut	$1,441,607,270	New York	$13,373,673,255
Delaware	$143,024,591	North Carolina	$2,700,080,141
Dist. of Columbia	$430,070,552	North Dakota	$262,664,004
Florida	$3,967,783,375	Ohio	$3,885,059,134
Georgia	$2,667,278,942	Oklahoma	$852,149,280
Hawaii	$286,318,710	Oregon	$754,036,356
Idaho	$214,771,527	Pennsylvania	$5,240,584,812
Illinois	$2,994,682,500	Rhode Island	$588,189,157
Indiana	$1,897,612,230	South Carolina	$2,321,065,825
Iowa	$595,882,771	South Dakota	$182,305,487
Kansas	$1,040,751,113	Tennessee	$2,987,801,204
Kentucky	$1,923,802,498	Texas	$8,394,834,231
Louisiana	$5,636,100,901	Utah	$447,024,435
Maine	$830,548,080	Vermont	$206,779,240
Maryland	$1,337,043,132	Virginia	$1,212,176,153
Massachusetts	$2,775,540,456	Washington	$1,824,034,237
Michigan	$3,857,128,581	West Virginia	$1,427,064,348
Minnesota	$1,053,081,719	Wisconsin	$1,232,218,165
Mississippi	$1,461,881,624	Wyoming	$111,533,168
Missouri	$2,832,879,569	TOTAL	$114,737,126,429

Source: AFSCME/Citizen Action Health Care Model

Total Shortfall Due To Dole
Medicaid Cuts Over 8 Years, FY 1996–2003



Source: AFSCME/Citizen Action Health Care Model

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.

The attached list of large businesses have expressed support for universal coverage and employer responsibility. They have expressed this support as individual companies or members of various organizations or coalitions, and have publicly and specifically indicated in letters or statements their support for universal coverage and employer mandates.

COMPANY
ALCOA
ALLIED-SIGNAL, INC.
AMERICAN AIRLINES
AMERICAN CYANAMID COMPANY
AMERICAN STORES COMPANY
AMERITECH
AMOCO CORPORATION
AMTRAK
ANHEUSER-BUSCH COMPANIES, INC.
ARAMCO SERVICES, INC.
ARCHER DANIELS MIDLAND COMPANY
ARCO
ASEA BROWN BOVERI, INC.
AT&T
AUDIOVOX CELLULAR COMMUNICATIONS
BACARDI CORPORATION
BACARDI IMPORTS, INC.
BANK SOUTH CORP.
BELL ATLANTIC CORPORATION
BETHLEHEM STEEL CORPORATION
BLACK ENTERPRISE
BOEING COMPANY
BROWN-FORMAN CORPORATION
BURLINGTON COAT FACTORY
CERIDIAN CORPORATION
CHEVRON
CHRYSLER CORPORATION
COMMONWEALTH EDISON COMPANY
COX ENTERPRISES

COMPANY

DEL MONTE FOODS

DIGITAL EQUIPMENT CORPORATION

DISTILLED SPIRITS COUNCIL OF THE U.S.

DOW CHEMICAL COMPANY

DOW CORNING CORPORATION

DRUMMOND COMPANY

E.I. DU PONT DE NEMOURS & COMPANY

ECKERD CORPORATION

ELECTRONIC DATA SYSTEMS

ENRON CORPORATION

FIRST INTERSTATE BANCORP

FLAGSTAR

FOOD 4 LESS SUPERMARKETS, INC.

FORD MOTOR COMPANY

GENERAL ELECTRIC

GENERAL MOTORS CORPORATION

GEORGIA-PACIFIC CORPORATION

GIANT FOOD INC.

GREAT ATLANTIC & PACIFIC TEA COMPANY

GTE CORPORATION

GUESS, INC.

H.J. HEINZ COMPANY

HECHINGER COMPANY

HERSHEY FOODS CORPORATION

HEWLETT-PACKARD COMPANY

HIRAM WALKER GROUP

HOME DEPOT, INC.

IBM CORPORATION

INLAND STEEL INDUSTRIES, INC.

COMPANY
INTEL CORPORATION
INTERNATIONAL MULTIFOODS
INVACARE
JAMES RIVER CORPORATION
KEEBLER COMPANY
LOCKHEED CORPORATION
LORAL CORPORATION
LTV CORPORATION
LUKENS INC.
MAIDENFORM, INC.
MAYTAG CORPORATION
MCDONNELL DOUGLAS CORPORATION
MEAD CORPORATION
NATIONAL STEEL CORPORATION
NAVISTAR INTERNATIONAL CORPORATION
NORWEST CORPORATION
NYNEX
OWENS-ILLINOIS
PACIFIC TELESIS GROUP
PARAMOUNT COMMUNICATIONS INC.
PIONEER HI-BRED INTERNATIONAL INC.
RALPH'S GROCERY COMPANY
RITE AID CORPORATION
ROHM & HAAS COMPANY
RYDER SYSTEMS, INC.
SAFEWAY STORES, INC.
SARA LEE CORPORATION
SCOTT PAPER COMPANY
SOUTHERN CALIFORNIA EDISON COMPANY

COMPANY
SOUTHWESTERN BELL CORPORATION
SUN COMPANY
THRIFT DRUG INC.
TIME WARNER INC.
U.S. BANCORP
UNITED AIRLINES
UPS
USX CORPORATION
VONS COMPANIES
WESTINGHOUSE ELECTRIC CORPORATION
WHEELING-PITTSBURGH CORPORATION
XEROX CORPORATION
ZENITH ELECTRONICS CORPORATION

For Release: Immediate
Monday, July 18, 1994

Contact: Laura Quinn, 202-224-6472
Senator Rockefeller's Office

Charles Leonard, 202-289-5900
for the Catholic Health Association

Lawrence Lewin, 703-218-5500
for Lewin-VHI

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.

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THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

Embargoed until 1:30 pm EST, July 18, 1994

LEWIN-VHI STUDY HIGHLIGHTS

The Catholic Health Association commissioned Lewin-VHI to prepare an analysis of the impact of several health reform plans on household spending for health care at various income levels. Lewin-VHI compared reform with universal coverage to reform that achieves partial coverage through insurance market regulation and subsidies. The universal coverage approach was considered both with and without cost constraints. For the first time, the Lewin-VHI study provides conclusive evidence that:

- Health care reform without universal coverage will mean higher, *not lower*, health care costs for middle class Americans who presently have health insurance.

- Additionally, reform with universal coverage achieved by requiring all employers to contribute to their employee premiums -- and including cost constraints -- will reduce spending for middle class Americans that already have insurance in comparison with what they now pay.

- "In addition," the study concluded, "for currently insured households earning less than $100,000 annually, health spending will decline under universal coverage with an employer mandate and cost constraints."

- An important reason for higher health care costs under the non-universal approach is that the voluntary approach results in bringing only higher consumers of health care, such as older American and people with pre-existing conditions, into the system. This increases the level of risk in insurance pools without the benefit of any offsetting factors. Increased premium costs in turn drive young, healthy people with insurance out of risk pools, which further raises premium costs for those who remain and increases the cost shift as well if these people remain uninsured.

- In contrast, an increase in average premiums is largely averted under universal coverage because al individuals would participate in insurance pools, including healthier individuals who receive little healt care, spreading risk evenly across insurance pools. Universal coverage also eliminates a major source o cost shifting.

- In addition, subsidies without universal coverage will likely cause many employers who presently provid health insurance to reduce coverage or drop coverage entirely.

- Moreover, partial reform will "perpetuate the destabilizing effects of the cost shift" as much of the care t the uninsured would continue to be shifted to the privately insured.

- In sum, eliminating cost constraints from health care reform will force the insured middle class to pay mo for health care. Eliminating employer contributions from health reform also forces the insured middle cla to pay more. And failing to achieve universal coverage forces the insured middle class to pay more.

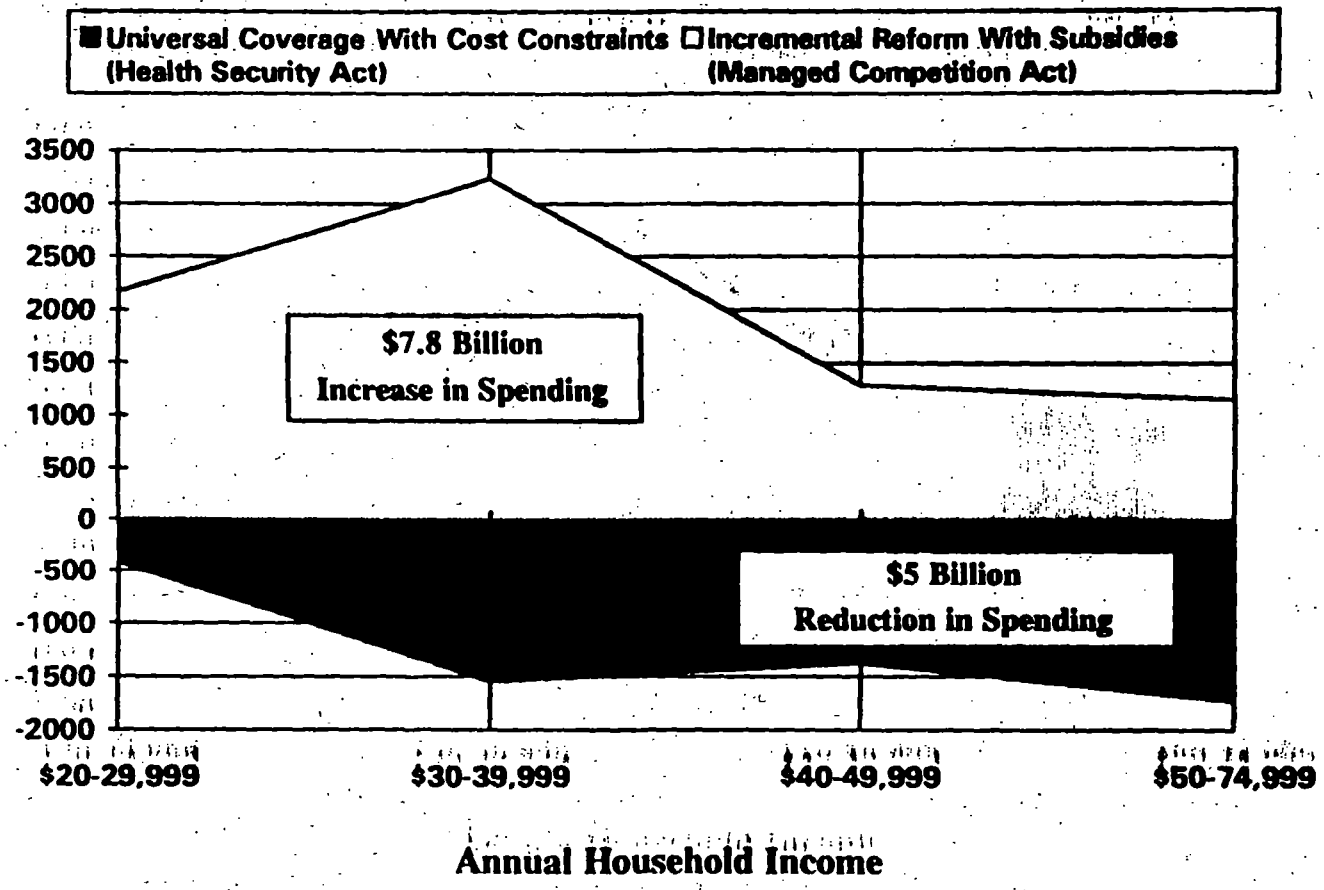
Household Spending Implications of Health Reform

"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

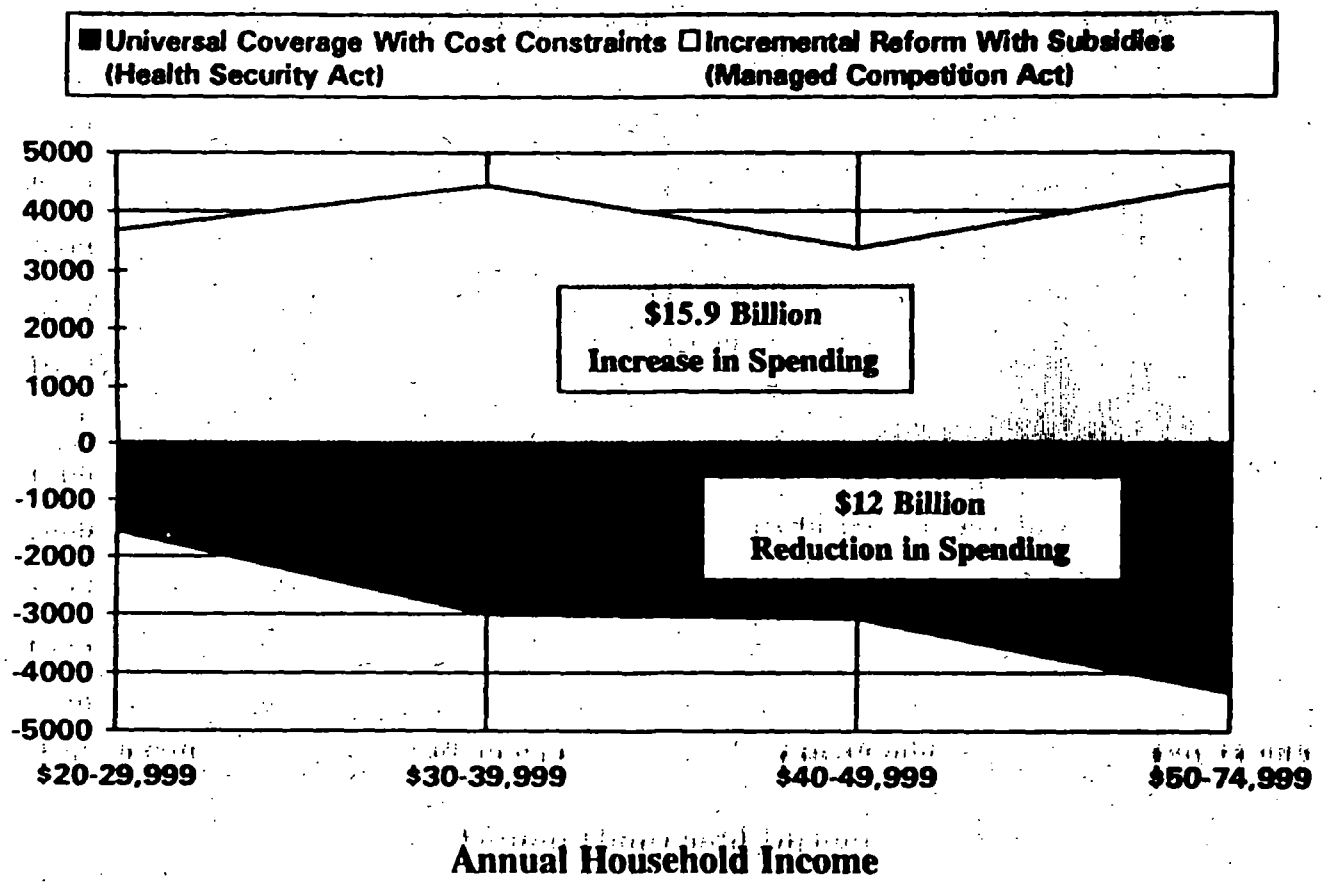
(with wage effects)



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

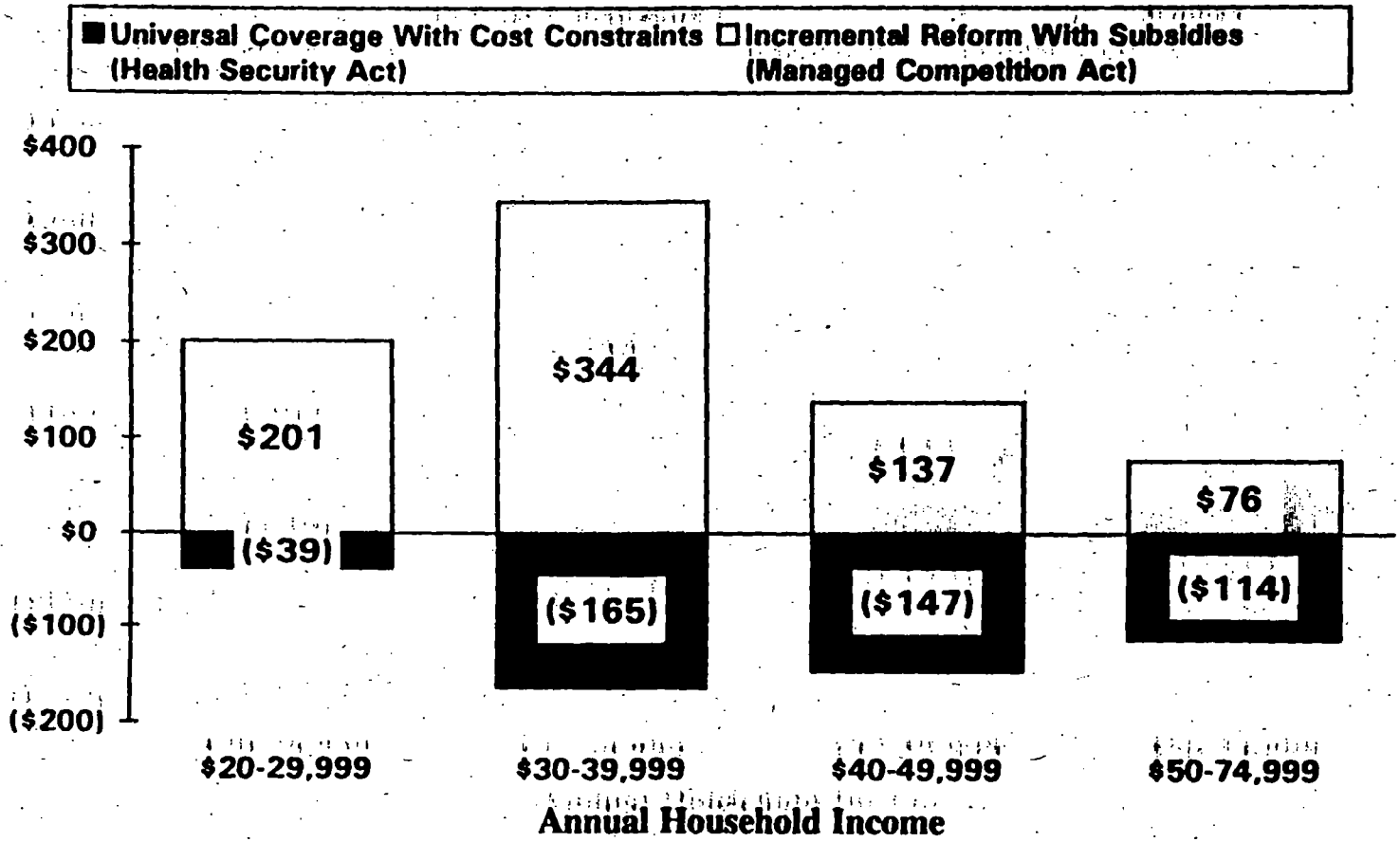
(without wage effects)



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

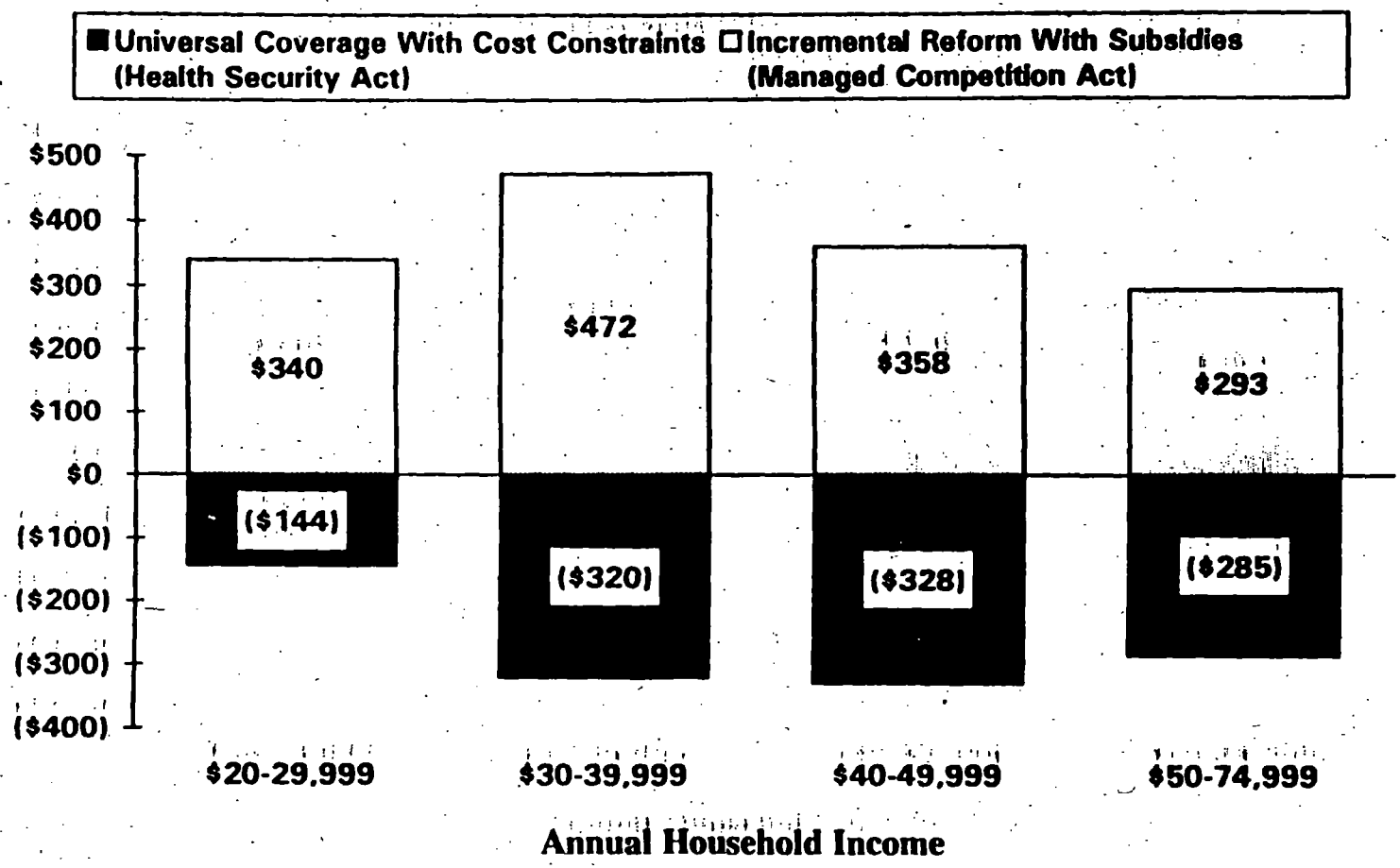
(with wage effects)



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 Proposals on Insured Household Spending

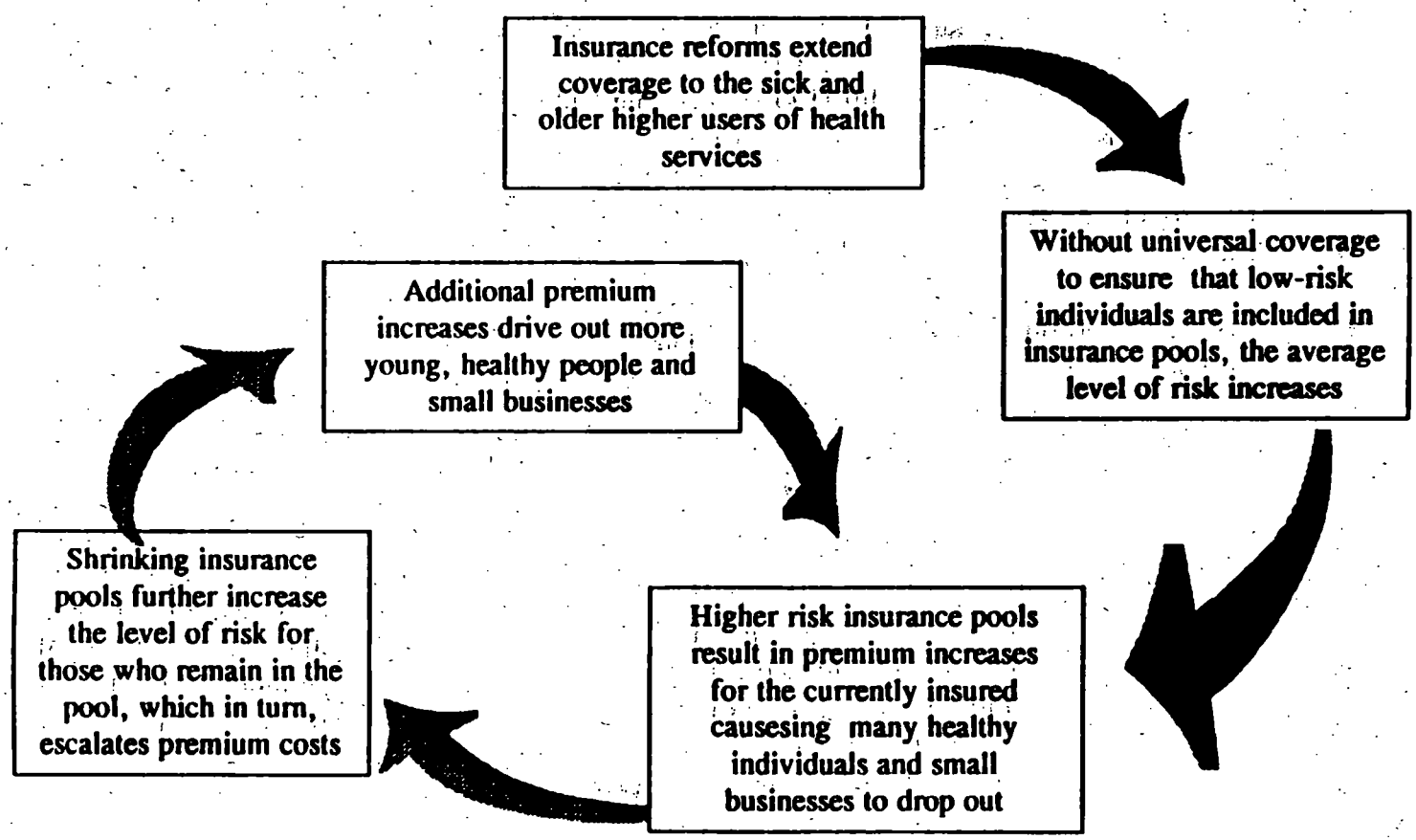
(without wage effects)



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.

PREPARED BY:

ALLEN DOBSON, PH.D.
JEFFREY K. BLEND
ROBERT MECHANIC
LEWIN-VHI, INC.

JULY 18, 1994

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.

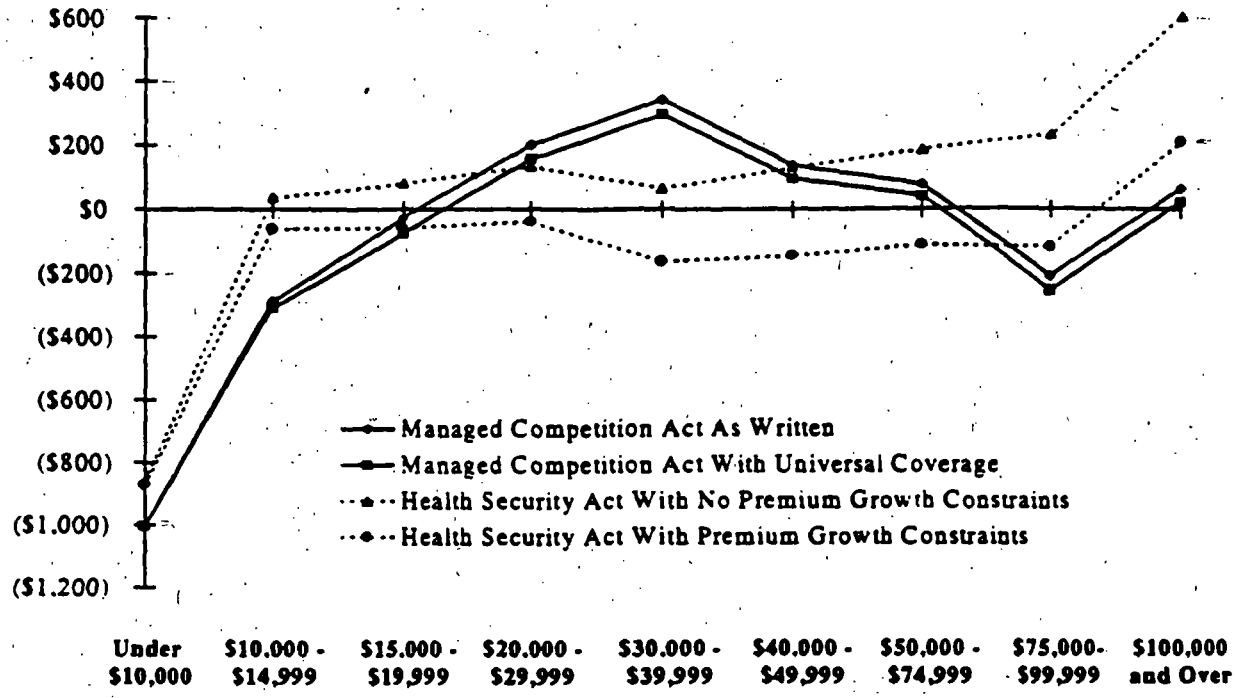
For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects.[ES-4] ***Figure ES-1*** shows the net changes in household health spending for the currently insured population 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.

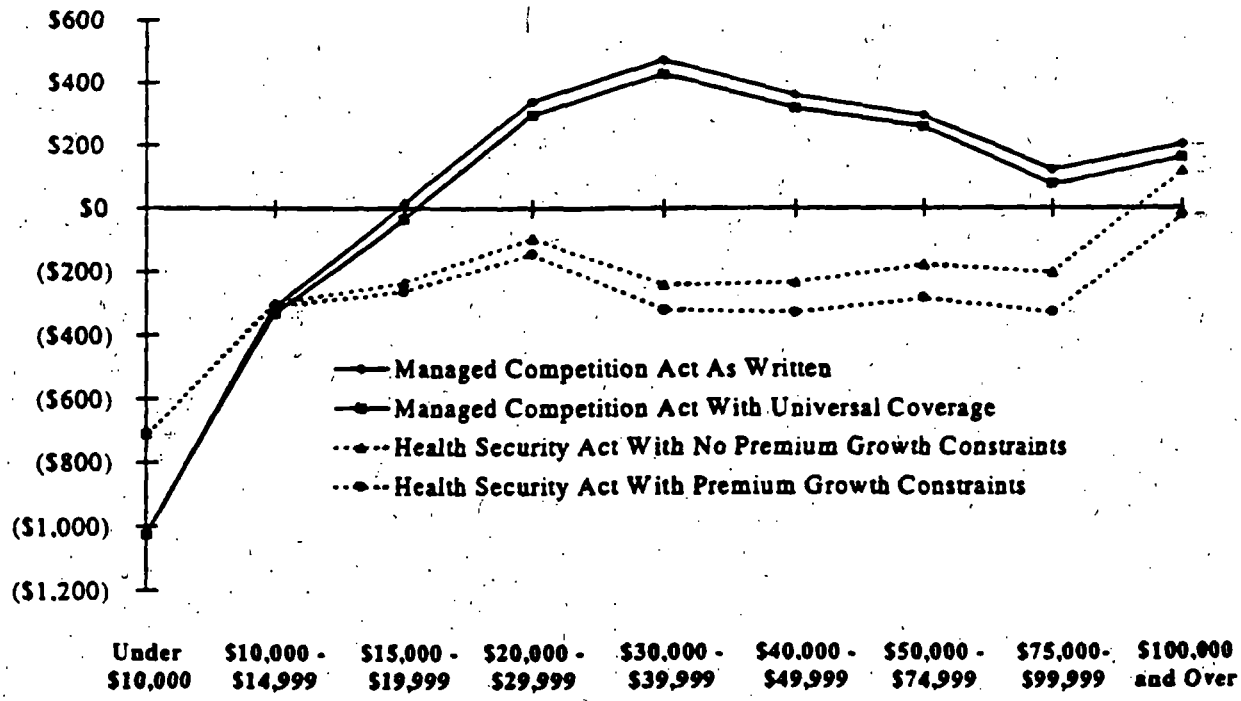
ES-4 To estimate the wage effect, we assume that 88 percent of new employer costs (based on econometric studies) are eventually passed on to employees in the form of wage reductions, *and* that 88 percent of new employer savings are generally passed on to employees in the form of wage increases.

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).

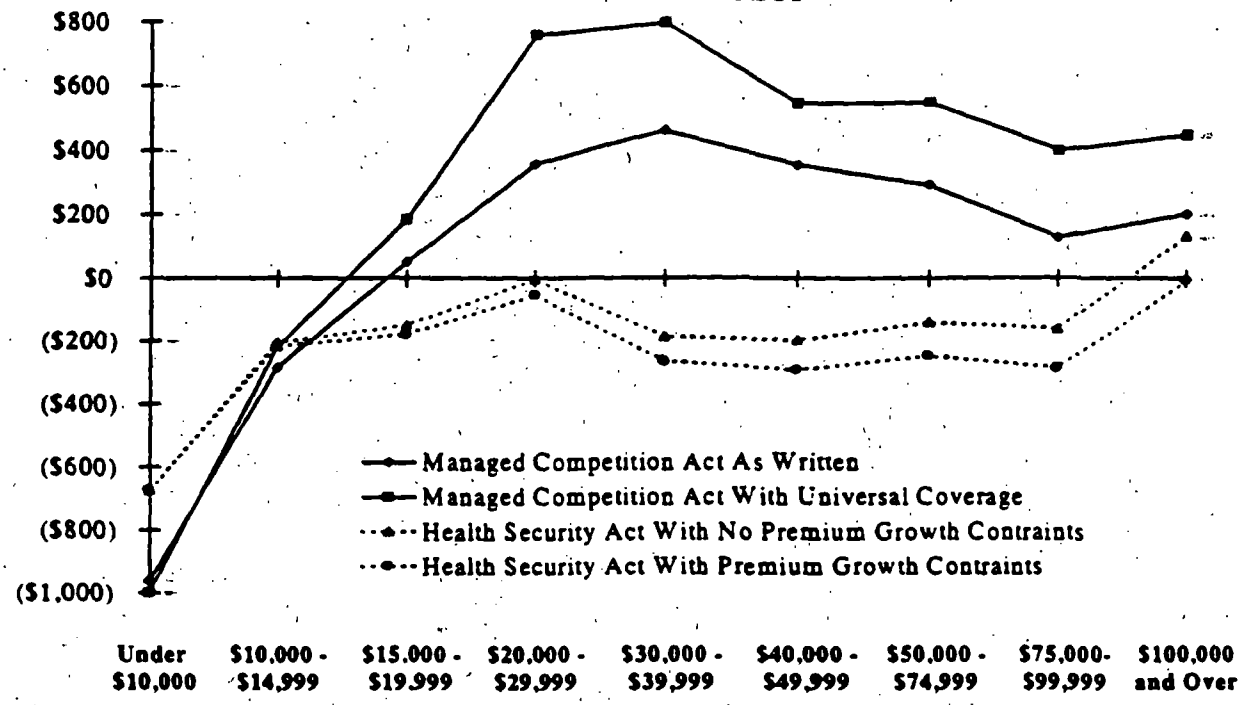
Employers who currently do not provide insurance will see a proportionally larger increase in employee health care costs under the HSA than employers who do provide insurance. Therefore, the currently uninsured will experience a greater wage effect than the currently insured as reflected in ***Table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

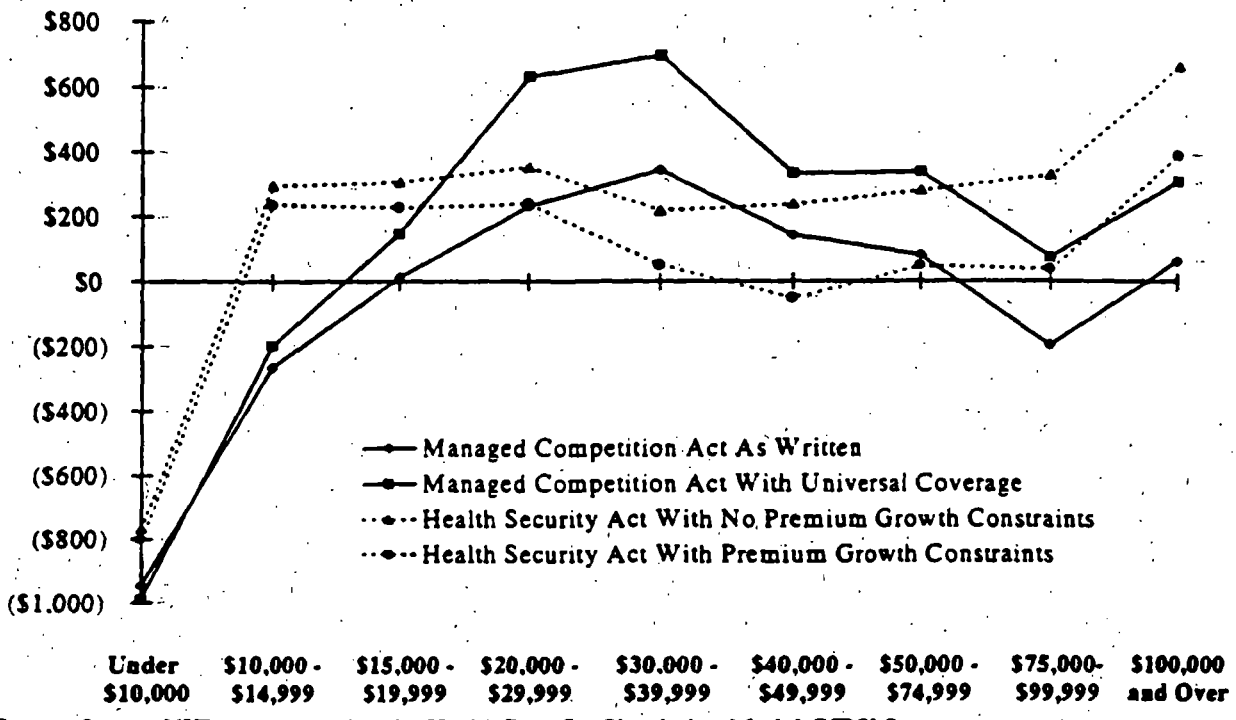


Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

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.

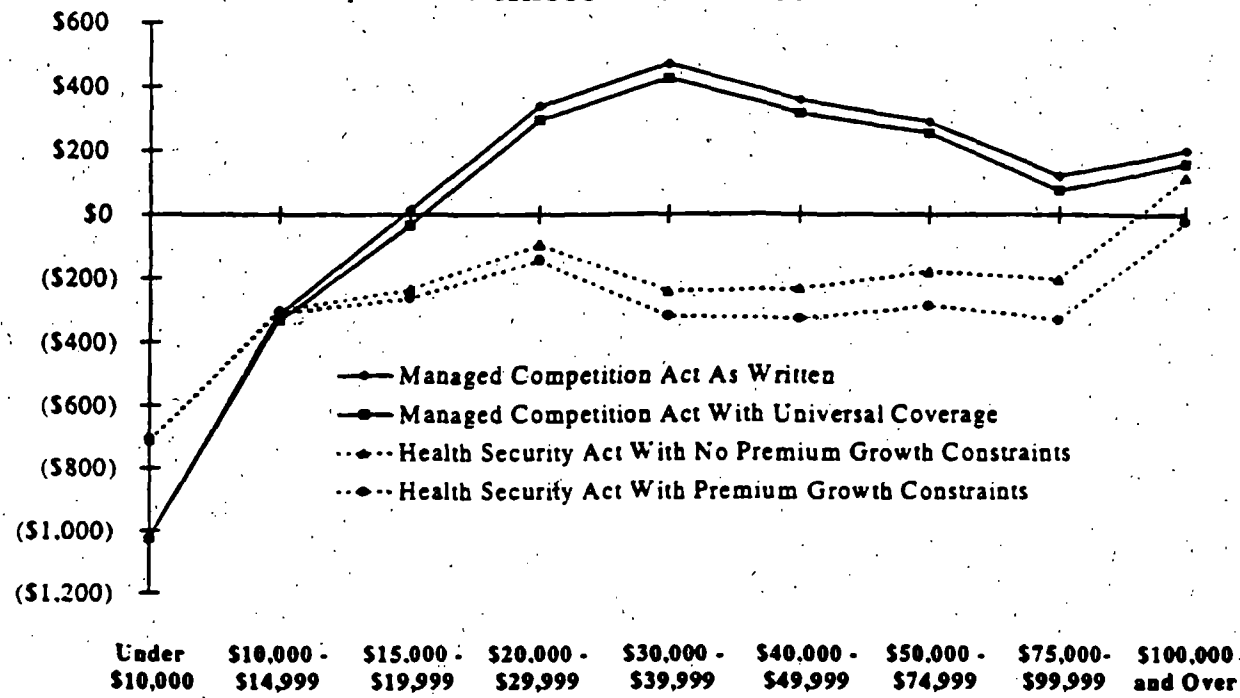
FIGURE 2
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998
FOR AGGREGATE UNDER AGE 65 POPULATION
WITH WAGE EFFECT



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



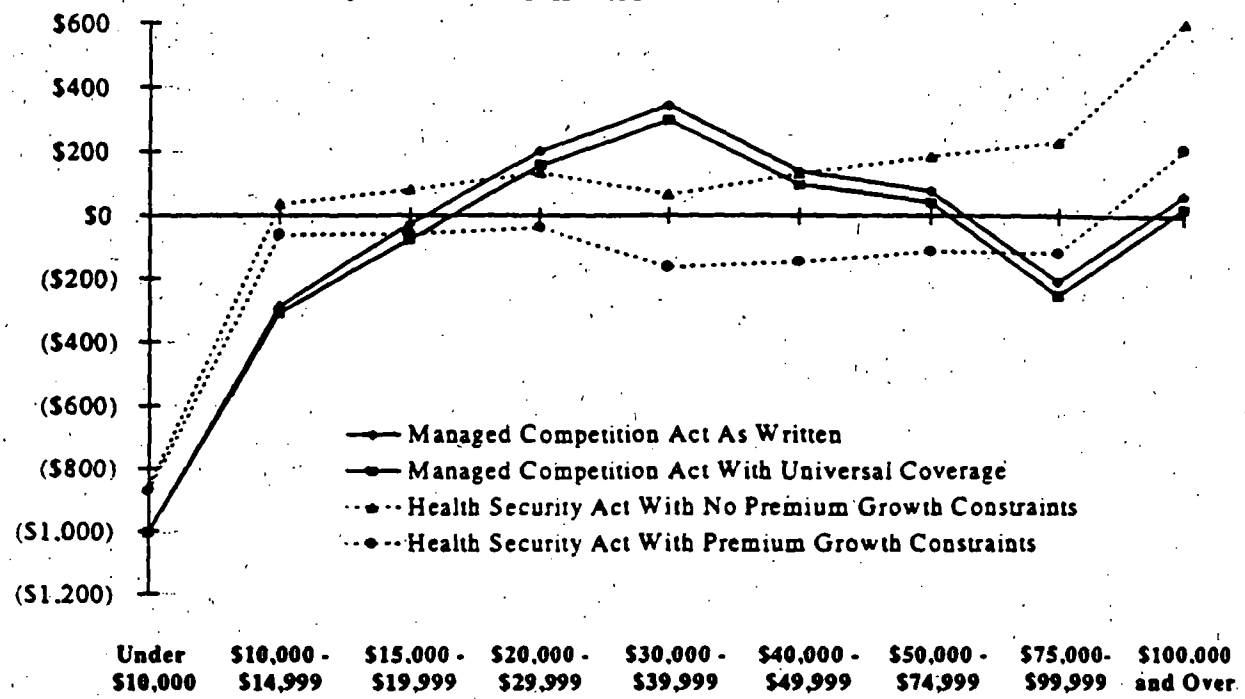
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

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)

Shared Responsibility: The American Way

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

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

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

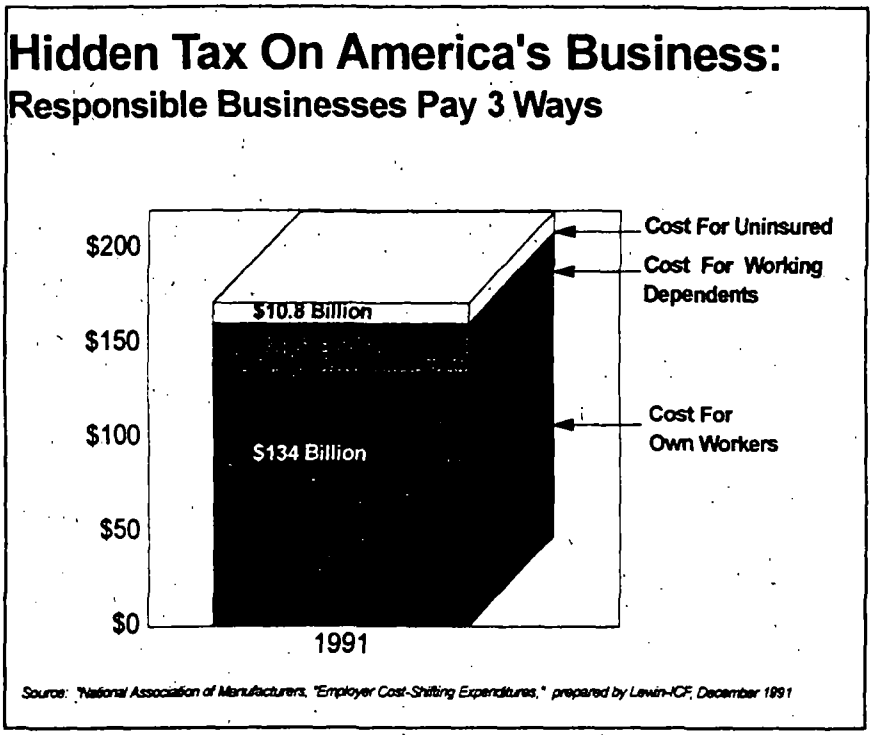
The American people overwhelmingly support Universal Coverage: 78% according to a recent *ABC News/Washington Post* Poll [June 27, 1994]. And shared responsibility is the fairest, and least disruptive way to get there.

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

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

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

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

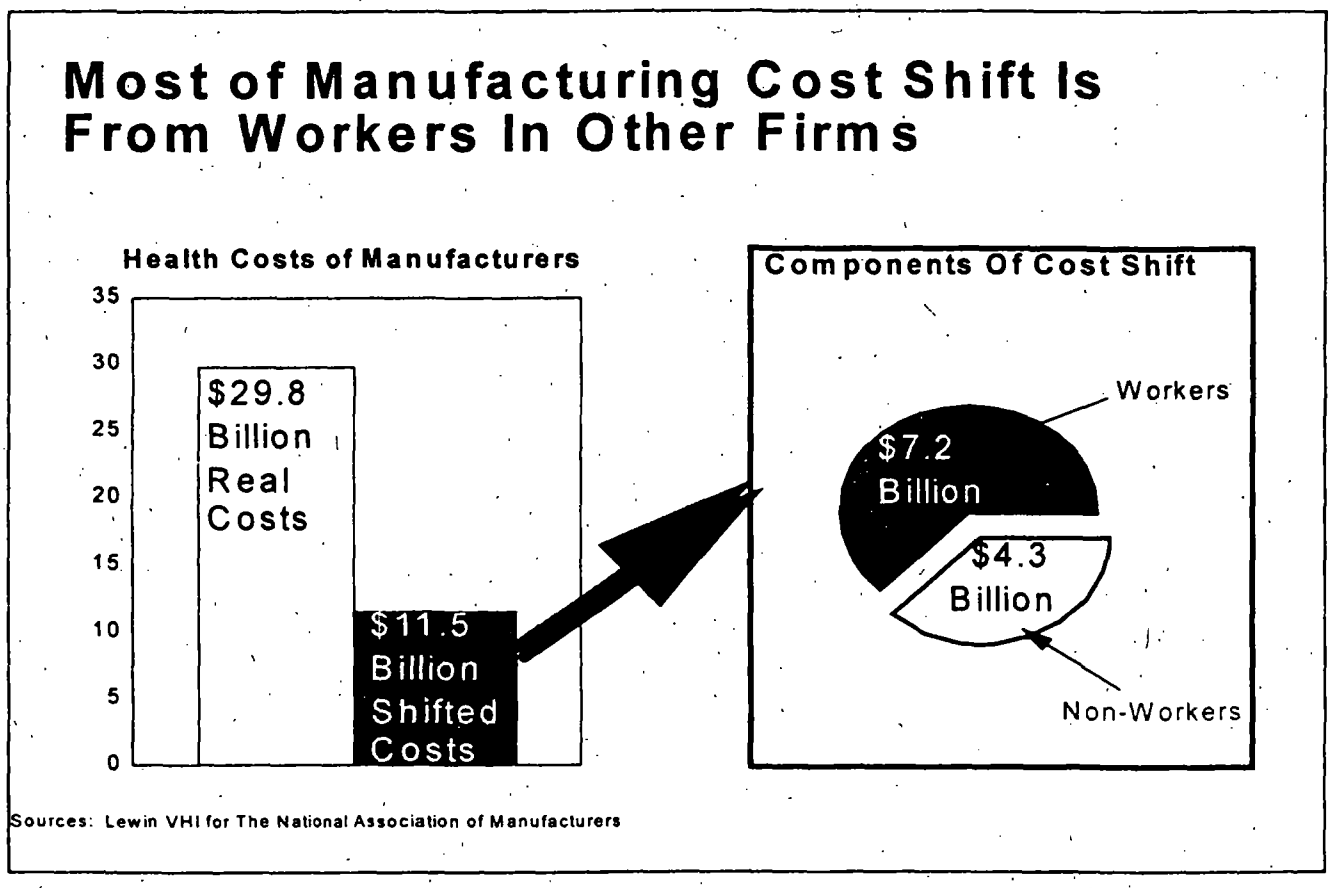


- That same year, employers who took responsibility for their employees' insurance also had an additional $10.8 billion added to their premiums to cover the uncompensated hospital costs of people without any insurance. Nearly half of these were to pay for **"workers, or dependents of workers, in firms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

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

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

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



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

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

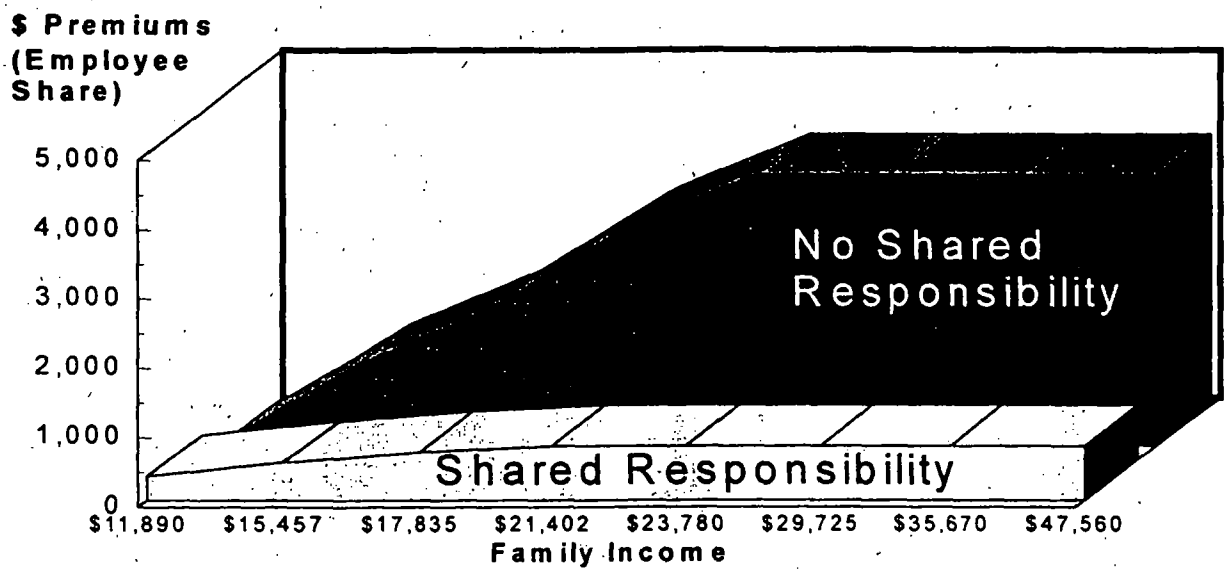
"For those who have suggested that the best policy may be to muddle through with only small, incremental changes, our analysis suggests that the number of uninsured workers in small businesses will continue to grow. If our survey proves true, in the years ahead ***30 percent of small businesses currently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

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

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

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

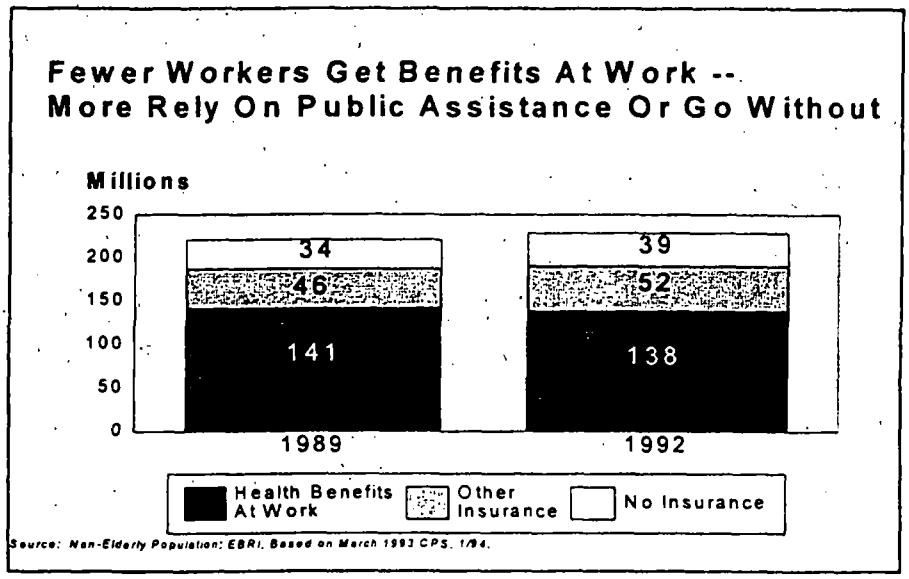
Families Save With Shared Responsibility



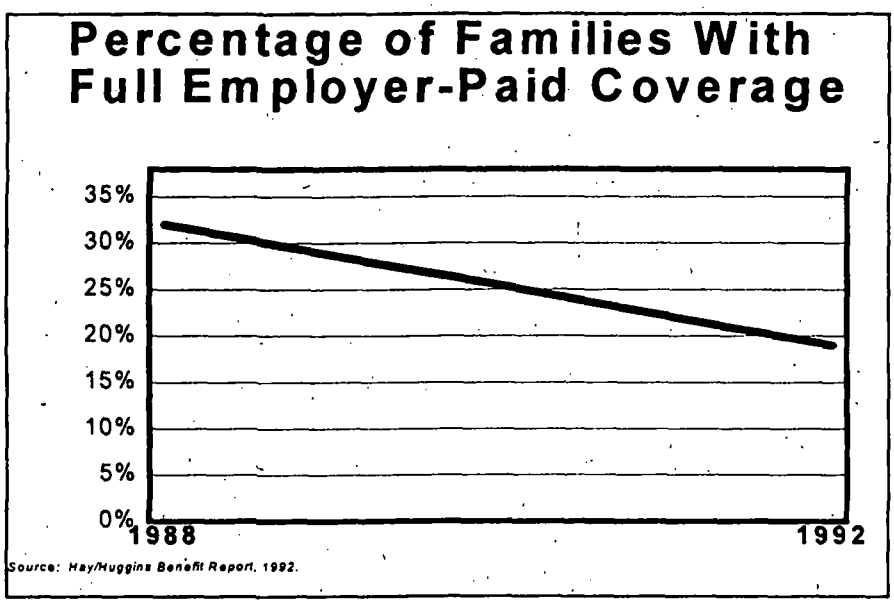
Source: "Families and National Health Reform," Kaiser Commission on the Future of Medicaid, 5/94. Based on a comparision of the Clinton and Cooper plans. Cooper plan does not require employers to contribute.

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

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



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

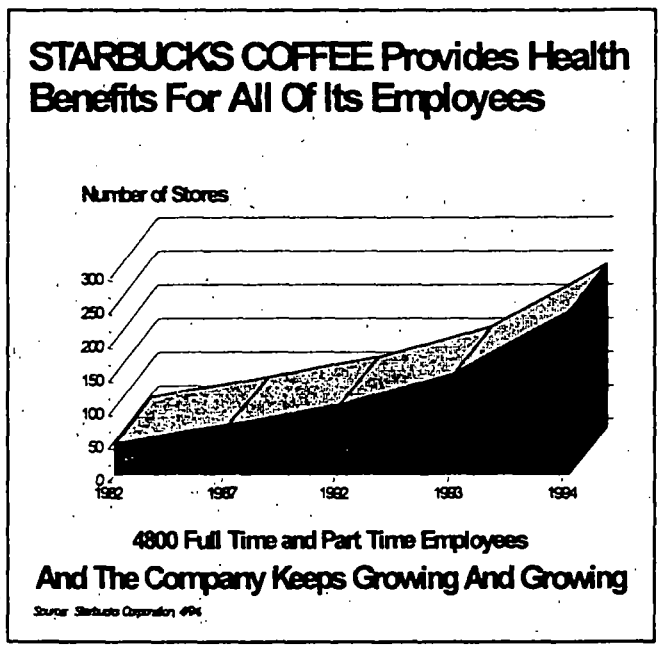


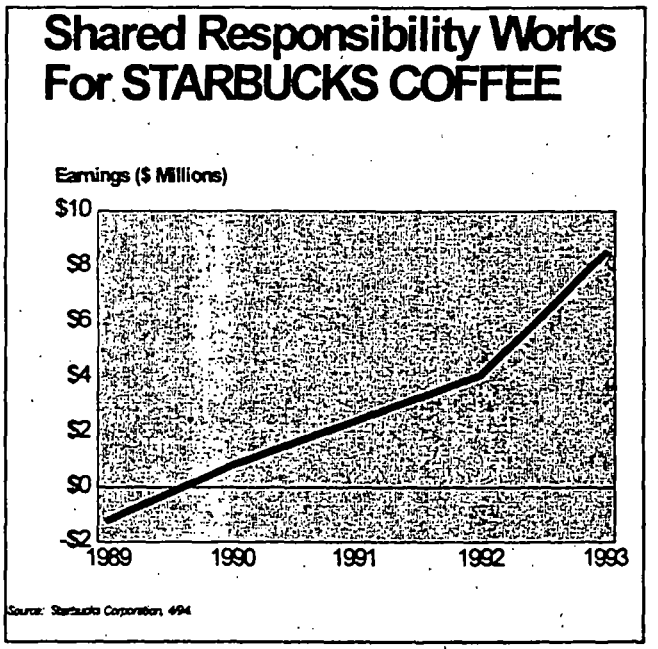
- Steve Burd, President and Chief Executive Officer of **Safeway** Inc. -- one of the world's largest food retailers -- said his company competes "*with some very large companies that don't offer the same kind of coverage.*" If health reform doesn't pass with the employer mandate, Burd fears that Safeway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

III. SHARED RESPONSIBILITY IS GOOD BUSINESS

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

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





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

Shared responsibility works around the world.

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

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

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

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

IV. SHARED RESPONSIBILITY HAS A SMALL IMPACT ON BUSINESS

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

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

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

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

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

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

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

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

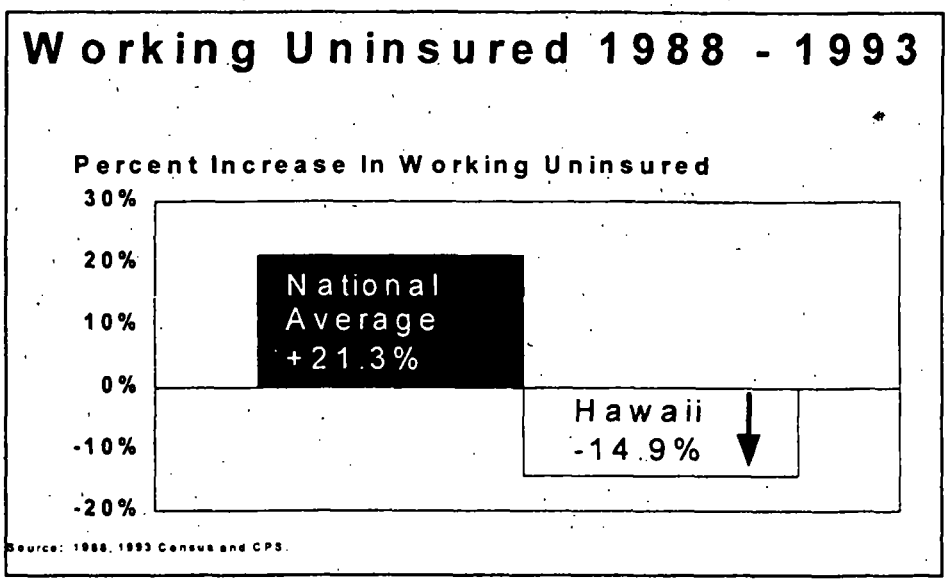
V. HAWAII: HEALTHIER BUSINESSES, HEALTHIER PEOPLE

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

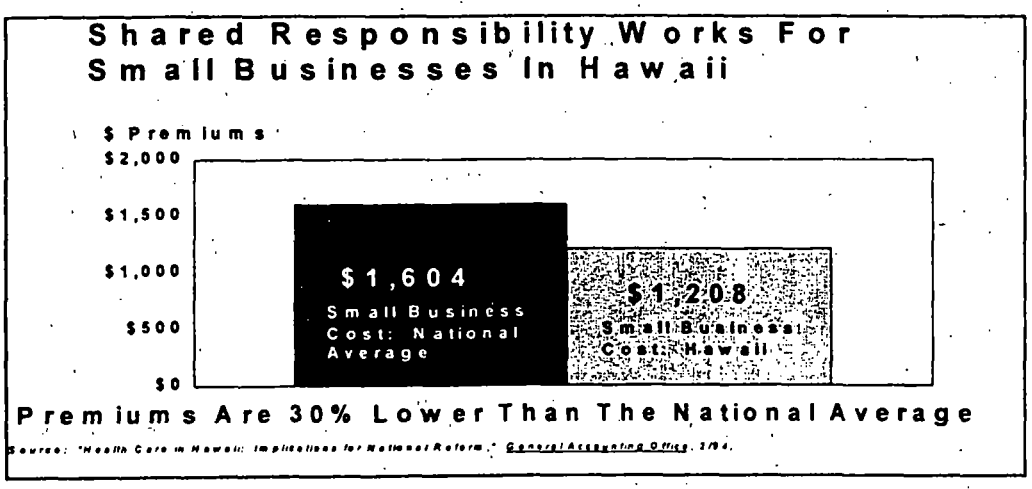
Shared responsibility is neither an untried novelty nor an exotic import unsuited to the American way of business.

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

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



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



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

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

The Republican Strategy on Health Care Reform: "Opposition Without Apology"

"It [succesful health reform] will revive the reputation of the . . . Democrats as the generous protector of middle class interests ..... and it will at the same time strike a punishing blow against Republican claims to defend the middle-class ...."

- Bill Kristol, December 1993

"The appropriate Republican response is to take the noble road of opposing any alternative that Democrats offer and insist on starting over in '95. We should send them to the voters empty-handed."

- Bill Kristol, July 1994

Strategist Bill Kristol -- the Republican who still swears there's no health care crisis-- is at it again. He is urging Republicans to follow a health care strategy of "Opposition Without Apology": pulling out all the stops to make sure no meaningful health care reform passes this year. They've decided the Republican party can't afford to let health care pass, because as Bob Dole said, "we've got a party to think of."

So despite repeated attempts by the President and Democratic leadership, Bill Kristol's Republicans have decided to block any bill -- sight unseen -- and delay needed reforms. As the Kristol memo says: "The appropriate Republican response is to take the noble road of opposing any alternative that Democrats offer and insist on starting over in '95."

It was bad enough when Bob Dole and his Republican colleagues were claiming there was no health care crisis. But now its worse: they acknowledge there's a crisis, but refuse to do anything about it. Senator Dole, Rep. Gingrich and other anti-reform Republicans are threatening to hold up legislation for expanding trade and fighting crime unless the President and Democratic members of Congress give up on their goal of private health insurance for all Americans.

These Republicans are putting politics ahead of people -- vowing to defeat any alternative offered by Democrats, no matter how much help it could bring to working people and American business.

And Kristol said of Democrats fighting for reform: "We should send them to the voters empty-handed." These Republicans just don't get it. If we don't pass health care, it won't be the politicians left empty handed -- Members of Congress get great health care. If we don't reform health care, its hardworking middle class people who are left empty-handed -- losing their health care or finding they can longer afford it.

As the Vice President implored legislators in his speech to the ADA rally: *"Don't punish Americans in the name of hardball politics. Don't sacrifice the health of American families on the altar of ideologies."*

Send a message to the anti-reform Republicans: Health care reform's not about them -- it's about you.

The Kristol Memos: Deny Democrats a Victory by Denying Americans Health Care

- In a December 2 memo to Republicans, Kristol warns that if the Clinton health care plan succeeds, the Democratic party will re-emerge as the ***"protector of middle class interests ..... and it will at the same time strike a punishing blow against Republican claims to defend the middle-class ...."***

- In a January 10 memo, Kristol wrote, ***"there is no health care crisis"***, and that "Republicans must consistently and aggressively debunk the Administration's "crisis" rhetoric.."

- In an April memo, Kristol urged Republicans to reject ***universal coverage,*** saying it ***"is a bad idea"*** an ***"we should be proud to oppose it."*** The memo asserted that those left unisured "would continue to receive medical care as they do now: from compassionate physicians and at walk-in clinics and hospital emergency rooms." [AP 4/7/94]

- In a June 7 memo, Kristol urged republicans to reject a bill, even a watered down bill, that would allow the President to honor his veto pledge, since it would "protect the President's 'read my lips' pledge on health care." Kristol's advice: ***"Republicans should hold off on health care negotiations until Mr. Clinton eats his words."***

- In a July 22 memo, Kristol writes: ***"At bottom line this debate is now a political one....the appropriate Republican response is to take the noble road of opposing any alternatives the Democrats offer and insist on starting over in '95. We should do so with prie and without a speck of guilt. We should send them [Democrats] to the voters empty-handed."***