Appendix B:
Recommendation Specifications

Reducing Health Care Costs and Increasing GNP Growth

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TASK FORCE ON INVESTMENT IN HUMAN RESOURCES

The Problem

Enhancing the productivity of American workers is essential to keeping America competitive in the world economy and providing the best support for the American people as we move toward the 21st century. A healthy work force is a key component of enhancing productivity.

Improvement of health status is complicated and involves many aspects beyond the financing of health care services. Improvements in education, housing, nutrition, and alcohol and drug abuse prevention and treatment must also be made if we are to ensure that Americans achieve their productivity potential.

The problems addressed by programs in health, education, housing, nutrition, and alcohol and drug abuse treatment programs are separate and dispersed across many different Federal agencies. A mechanism is needed to facilitate communication and coordination of Federal efforts in the preparation of a comprehensive strategy to maximize the ability of Americans to be competitive and productive workers.

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The Proposal

Establishment of Interagency Task Force

The Council recommends that the President establish an Interagency Task Force on Investment in Human Resources.

Composition

The Task Force would comprise:

- the Secretary of Health and Human Services, who would serve as Chair,
- the Secretary of Agriculture,
- the Secretary of Education,
- the Secretary of Housing and Urban Development,
- the Secretary of Labor,
- the Secretary of Commerce,
- Administrator, Environmental Protection Agency, and
- Chairman, United States Commission on Civil Rights.

The Council would be empowered to invite the participation of other Federal agencies not listed as it may require for particular issues.

Mission

The Task Force would be charged with developing a comprehensive inter-agency strategy to improve investment in American human resources and

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society and thereby improve productivity and competitiveness. In each of the areas that it considers, the Task Force would:

- develop a statement of national goals to be pursued,
- assess the status of that area in relation to those goals,
- identify the major impediments to achieving those goals, and
- propose alternative means of removing those impediments.

Areas of Concern

The Task Force would appraise the effects of the current state of education, housing, nutrition, and alcohol and drug abuse on the health status of the American workforce and the consequent effects of current health status on national productivity and competitiveness.

5-Year Strategy

The Task Force would develop a comprehensive 5-year strategy detailing how Federal agencies can address the problems identified. The strategy would include:

- the development of a plan that includes a process so that Federal agencies can work together to minimize duplication in programs addressing these problems and maximize the use of existing resources;
- a list of actions that can be taken by Federal agencies, without changes in law, to implement the strategy;
- a timetable for implementation of the strategy and a plan for evaluating and ensuring that the timetable is met; and

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- recommendations for changes in law that would be necessary to further the strategy.

Report

The Task Force would prepare semiannual reports to the President containing updates on the implementation of the strategy and recommendations for legislation.

Staffing

Staff for the Task Force would be drawn from personnel of the agencies represented.

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A PROPOSAL TO DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES

The Problem[27]

The cost of medical care is vastly increased by what is termed the "welfare uncertainty principle."[28] The principle holds that it is not possible to correlate the health of a population within a given hospital market area with the volume of health care services utilized within the area. In other words, population welfare may well be greater in a hospital market with less utilization than in one with more utilization.

The fundamental reason for this lack of correlation is that medical treatment theory is underevaluated. The absence of exact information on the probable outcomes of various treatment modalities opens the way to supplier-induced demand. Dr. John E. Wennberg has put the matter this way:

> There is no "invisible hand" arising from the doctor/patient relationship that regulates the supply of resources. Rather, underevaluated medical theory and the supply of resources are in equilibrium: The treatment theories governing the use of hospital beds are sufficiently flexible to allow the use of hospital beds, no matter what the per capita level of supply; the theories that establish the legitimacy of surgical treatment justify surgical workloads, no matter what the number of surgeons; and underevaluated medical treatment theory is

[27] The conceptual foundation of this recommendation has been supplied by a paper, "Iowa Leadership Consortium on Health Care Strategies for Reform," prepared by John E. Wennberg, M.D., M.P.H. Dr. Wennberg's recommendations go far beyond those contained in the instant proposal.

[28] Wennberg, op. cit. n.1, p.6.

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> sufficiently rich to deploy internists and family practitioners virtually without regard to how many there may be per capita.[29]

But, designed on the misapprehension that capacity will be limited by medical efficacy and patient demand, the major Federal programs of health care financing, as well as many private insurance programs, make resources freely available at the point of utilization. Confronted with the reality of *supplier-induced* demand fueled by alternative, underevaluated, treatment modalities, the programs are therefore generating a crisis in the cost, access, and quality of medical care.

The Proposal

The Department of Health and Human Services, through the Agency for Health Care Policy and Research (AHCPR), is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. They would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

The Advisory Council recommends that AHCPR develop a system that would produce comprehensive reports on the performance of local and regional health care markets. The reports could be used to repair flaws in three critical policy areas: information, finance, and manpower. As

[29] Wennberg, *op. cit.* n.1, p.3.

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proposed by Dr. Wennberg, reports would include the following information:[30]

- the location of local and regional market areas;
- the per capita allocation of hospital beds, physician, and other manpower in each market;
- expenditure and reimbursements and transfer payments between regional and local markets;
- procedure charges;
- utilization rates; and
- certain outcomes.

The reports would be invaluable for supporting alternative strategies for containing capacity. Information on outcomes of alternative treatment modalities, standing alone, would make a serious contribution to reducing supplier-induced demand.

[30] Wennberg, *op. cit.* n.1, p.9.

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A PROPOSAL FOR AN ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS

The Problem

The increasing cost of malpractice insurance inflates the cost of Federal health care and health care financing programs and may reduce the availability of some types of health care. In part, this increasing cost is attributable to the inefficiency of the civil judicial system, the high cost of access to that system, and the ineffectiveness of professional licensing and disciplinary bodies in policing the quality of medical care provided by their members and licensees.

Further, the existing system fails to compensate, or compensate adequately, many—possibly most—victims of medical malpractice, while very generously compensating—perhaps overcompensating—a few such victims.

The proposal described below adopts an administrative alternative to the present system of tort liability. Administrative alternatives, either as a supplement to, or replacement of, the existing system have been proposed in the Health Care Provider Liability Reform bill, based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Ensuring Access Through Medical Liability Reform bill, introduced in the last Congress by Senator Orrin Hatch (S. 2934, 101st Cong.), the Medicare Malpractice Dispute Resolution bill of 1990, introduced in the last Congress by Rep. Nancy Johnson of Connecticut. The American Medical Association's Medical Liability Project, in its January 1988 report entitled "A Fault-Based, Administrative System," also recommends adoption of an administrative model.

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In developing the proposal, the following approaches to medical malpractice litigation were considered.

The Health Care Provider Liability Reform Act

Based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Health Care Provider Liability Reform Act offers a comprehensive solution to malpractice claims abuses. Proposed as a model act, the bill continues to await action by the several States. Because widespread adoption of the act seems unlikely in the immediate future, the act does not offer a reasonably prompt solution to the malpractice problem and, in the best of foreseeable circumstances, will provide only piecemeal reform.

The Ensuring Access Through Medical Liability Reform Act

Introduced in the last Congress by Senator Hatch (S. 2934, 101st Cong.) the "Ensuring Access Through Medical Liability Reform Act," as with the Task Force bill, attempts a global approach to the full range of malpractice claims. Also like the Task Force bill, the Hatch bill depends, in large part, upon the creation of alternative dispute resolution systems by individual States. Beyond this, however, it seeks to impose national standards on the adjudication of all malpractice claims, even though many, perhaps most, of those claims arise from treatment unconnected to any Federal program. This degree of Federal intrusiveness, as it will surely be termed by its critics, seems certain to impede the bill's prospects for enactment. In addition, the bill would establish a variety of new grant programs that, given the recent amendments to the Gramm-Rudman-Hollings law, Congress would have difficulty in funding.

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The Medicare Malpractice Dispute Resolution Act of 1990

Also introduced in the last Congress, the "Medicare Malpractice Dispute Resolution Act of 1990" (Rep. Johnson of Connecticut) covers only malpractice claims by Medicare beneficiaries. As in the case of the previously described proposals, the bill would involve States in the establishment of statewide Medical Services Dispute Resolution Organizations, which would function within a malpractice arbitration system guided by the Secretary of Health and Human Services.

The instant proposal takes some of its direction from the Johnson bill. It differs, nevertheless, in two fundamental ways. First, it is based on the premise that better policy calls for one *organization* to apply uniform national standards to resolving the claims of Federal beneficiaries as to their treatment under a Federal direct care or federally financed program. Second, it would apply to all Federal beneficiaries.

The proposal is divided into two parts: a Federal Beneficiary Malpractice Adjudication Act and a Model State Malpractice Adjudication Act. These are described below.

The Federal Beneficiary Malpractice Adjudication Act

In General

The Federal Beneficiary Adjudication Act would establish a national administrative tribunal to hear malpractice claims arising from the medical care of Federal beneficiaries, i.e., individuals entitled to receive or be reimbursed for health care from the Federal Government. Using expeditious procedures, the tribunal would award a prevailing claimant compensation for economic losses resulting from physical harm caused by negligent treatment.

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and reasonable attorney fees. By enabling an individual to obtain prompt resolution of a medical malpractice claim against a health professional or other health care provider, the Act may also be expected to encourage prompt and effective pre-hearing mediation and settlement.

This remedy would be the exclusive remedy available to Federal beneficiaries under State and Federal law.

The proposal would continue to allow the award of noneconomic damages for medical malpractice, but not to exceed $200,000 per claimant. It would abolish derivative damages, such as a spouse's right to damages for loss of consortium.

The proposal would also require the Agency for Health Care Policy and Research, a component of the Public Health Service, to survey medical literature in order to develop practice parameters, i.e., formal guidance to physicians and other health professionals as to the best contemporary health care practice. The parameters would be of use to the tribunal in evaluating claims of malpractice under the program.

The Secretary would inform the pertinent State medical associations and licensure authorities of the tribunal's findings in each case. The Secretary would also be empowered to disallow a health professional or other health care provider from providing health care services under a Federal program and from being compensated for future services to Federal beneficiaries if repeated or extreme malpractice had characterized prior services.

Administrative Structure

Office of Malpractice Adjudication. The Act would establish, within the Department of Health and Human Services, an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Secretary or the Secretary's designee.

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Administrative tribunal. Each malpractice claim would be heard by an administrative tribunal consisting of a presiding officer, who would be an administrative law judge meeting the qualifications for hearing examiners established by the Administrative Procedure Act, and two individuals determined by the Secretary to be expert in the field of health care or health care management. A decision of the tribunal would be by majority vote. Panels of the tribunal would be located in major population centers throughout the United States for the purpose of hearing malpractice claims against health professionals, and other health care providers, who provided health care wholly or partially paid for by a Federal program.

Administrative appeal. A party would be entitled to appeal a final determination of a tribunal to an administrative appeal council, a panel of which would be established within each region of the Department. The panel would be required to accept the tribunal's findings of fact, unless arbitrary, capricious, or unreasonable. The appeals council would be obligated to hear and decide the appeal within 4 months after the tribunal's decision.

Appeal to United States Courts of Appeal. The judgment of the appeals council could be appealed, on matters of law, to the United States court of appeal for the circuit within which the malpractice claim arose. The court would be without jurisdiction to reexamine findings of fact affirmed on administrative appeal, although it could remand the case to the agency with instructions to find additional facts. The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

Claims Adjudication Procedure

In general. Procedures for the adjudication of malpractice claims would be established by the Secretary's regulations, subject to these constraints:

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Time for adjudication. A claim would be heard, after allowing such continuances as the administrative tribunal may find proper, within 6 months of filing, and a decision rendered within 2 weeks after hearing.

Discovery. Discovery would be freely granted, in conformity with the Federal Rules of Civil Procedure.

Subpoenas. Subpoenas would run within the United States, except that a party subpoenaed outside the State in which the hearing is held could apply to a United States district court for relief on the grounds of hardship.

Enforcement of order. The violation of a proper order of a tribunal under the Act would be punishable as a contempt in the United States district court for the district in which the hearing is scheduled to be held.

Record; evidence. A tribunal would decide a claim on the record before it but would receive such evidence as it finds credible and give that evidence such weight as it may find appropriate.

Form of decision. The decision of the tribunal would be in writing, would recite findings of fact and conclusions of law, and would be prepared after all parties have had the opportunity to present their cases in the presence of each other.

Enforcement of judgment. A judgment of the tribunal would be limited to an award of money and would be enforceable by a United States district court.

The Judgment

Economic loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical injury attributable to malpractice.

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Collateral source reduction.

Amounts not deriving from a Federal program. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from a Federal program).

Amounts deriving from a Federal program. A judgment would be reduced by one-half of any amount deriving from a Federal program. In such case a supplementary judgment would be issued in favor of the United States for the balance of the payments. In the case of Medicare, this latter amount would, upon payment, be credited to the pertinent Medicare trust fund. In the case of a Federal direct care program, the amount would be deposited in the general fund of the treasury. In the case of a federally assisted State program, the money would be divided, as appropriate, between the general fund of the treasury and the State.

Noneconomic damages. Noneconomic damages, such as pain and suffering, would be limited to $200,000. Derivative damages, such as a spouse's claim for pain and suffering, would be abolished.

Attorney's fees. A judgment for the claimant would include an amount for attorney's fees, in accordance with a schedule established by regulation within a ceiling set by the statute. The proposed ceiling is 25 percent of the first $100,000, 15 percent of the next $200,000, and 10 percent of the remainder.

Costs of proceeding. The tribunal could, in its discretion, assess either or all parties an amount, established by regulation and payable to the general fund of the Treasury, equivalent to all or part of the administrative costs of the proceeding. As appropriate, costs would be assessed so as to discourage frivolous proceedings.

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Comparative negligence. An award for the claimant would be reduced in proportion to the degree to which the tribunal found that the claimant's negligence had contributed to the injury.

Liability of parties defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

Award for future economic loss. An award for future economic loss would not require the payment, within a calendar year, of an amount that exceeded the loss anticipated for that year, but such award would not be subject to future adjustment.

Derivative rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

Exclusions

The Office would be without the power to adjudicate a malpractice claim alleging:

- Wrongful death or
- Willful injury.

Exclusivity of Remedy

Except as otherwise provided by this Act, no court of any State, or of the United States, would have jurisdiction to adjudicate any claim arising from or alleging malpractice if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available to Federal beneficiaries for pressing malpractice claims.

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Notification

Notification of State and local agencies and organizations. In every case of malpractice, the Act would require the Secretary to transmit the final judgment of the tribunal to the pertinent State medical or health professional society and the State professional licensure or certification authority.

Notification of Health Care Financing Administration. The Office would transmit every decision of the tribunal and the administrative appeal council to the Health Care Financing Administration for its use in peer review or otherwise, as HCFA may determine.

Debarment

The Act would require the Secretary to review each case in which malpractice was found. In any case in which the Secretary determined there had been gross negligence, or a health professional or other health care provider had been responsible for repeated instances of malpractice, the Secretary, after opportunity for hearing, could bar the health professional or other health care provider from treating Federal beneficiaries or from receiving compensation for any care rendered by that health professional or other health care provider to a Federal beneficiary and would notify the pertinent State medical or health professional society and the State professional licensure or certification authority.

Practice Parameters

The Act would direct the Agency for Health Care Policy and Research to develop health care practice parameters, i.e., formal guidance to physicians and other health professionals, based on a comprehensive survey of medical literature, as to the best contemporary health care practice. The tribunal would use the parameters as a screening device in evaluating claims of malpractice, not as a means of differentiating good care from bad care.

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Model State Malpractice Adjudication Act

In General

This part outlines specifications for a model State statute, the *State Malpractice Adjudication Act*, to be prepared within the Department of Health and Human Services in consultation with the States, intended to deal with those claims of medical malpractice not addressed by the Federal Beneficiary Malpractice Adjudication Act. Like the proposed Federal act, the model State act would seek to restrain further growth in the cost of malpractice insurance, which has both inflated the cost of medical care and reduced the availability of health care in some medical specialties.

The proposal follows the outlines of the Federal Beneficiary Malpractice Adjudication Act proposal. It would establish a State administrative adjudication mechanism to hear malpractice claims arising under State law. It would enable a claimant to obtain prompt resolution of a medical malpractice claim against a health professional or other health care provider over whom the State courts have jurisdiction. A prevailing claimant would be awarded compensation for economic losses resulting from physical harm caused by negligent treatment, and reasonable attorney fees.

This remedy would be the exclusive remedy available to a claimant under State law for medical malpractice.

The proposal would continue to allow the award of noneconomic damages, but not to exceed $200,000 per claimant. It would abolish derivative damages, such as a wife's right to damages for loss of consortium.

Also, the proposal would establish a State Advisory Council on Standards of Health Care to develop guidelines for use in evaluating claims of malpractice under the program.

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The Secretary of Health and Human Services would develop a Model State Act on the Adjudication of Malpractice Claims. Major features of the Act follow.

Administrative Structure

Office of Medical Malpractice Adjudication. The Act would establish within the State an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Governor or such subordinate official as the Governor may designate.

Employment of hearing examiners. The Office would employ hearing examiners, located in major population centers within the State, to hear malpractice claims against health professionals and other health care providers over whom the courts of the State would have jurisdiction.

Administrative appeal. The Office would contain an administrative appellate tribunal to hear and promptly resolve administrative appeals from the judgment of a hearing examiner.

Claims Adjudication Procedure

In general. Procedures for the adjudication of malpractice claims would be established by regulations of the Office, subject to these constraints:

- ***Time for adjudication.*** A claim would be heard, after allowing such continuances as the hearing examiner may find proper, within 6 months of filing, and a decision rendered within 2 weeks after hearing.
- ***Discovery.*** Discovery would be freely granted.
- ***Subpoenas.*** Subpoenas would run within the State.

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- ***Enforcement of order.*** The violation of a proper order of a hearing examiner under the Act would be punishable as a contempt in any court of the State.

- ***Record; evidence.*** A hearing examiner would decide a claim on the record before him, but would receive such evidence as he finds credible, for such weight as may be appropriate.

- ***Form of decision.*** The decision of the hearing examiner would be in writing, would recite findings of fact and conclusions of law, and would be prepared after all parties have had the opportunity to present their case in the presence of each other.

- ***Enforcement of judgment.*** A judgment of the hearing examiner would be limited to an award of money and would be enforceable by the court.

Malpractice Defined

Malpractice, for purposes of this Act, would include injury or illness associated with a given course of treatment, even if not arising from its negligent provision, if the injury or illness were a known risk of the treatment provided and the health care professional or other health care provider had failed fully to inform the claimant of such risk.

The Judgment

Economic loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical injury attributable to medical malpractice.

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Collateral source reduction.

Amounts not deriving from Medicare or Medicaid. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from Medicare or Medicaid).

Amounts deriving from Medicare or Medicaid. A judgment would be reduced by one-half of any amount deriving from Medicare or Medicaid. In such case a supplementary judgment would be issued in favor of the United States for the balance of the Medicare or Medicaid payments, which amount would, upon payment, be credited to the pertinent Medicare trust fund or the Medicaid appropriation, as applicable. The Department of Health and Human Services would thereafter pay over to a State so much of the payment attributable to Medicaid as represents the State's share of that payment.

Noneconomic damages. Noneconomic damages, such as pain and suffering would be limited to $200,000. Derivative damages, such as a wife's claim for pain and suffering, would be abolished.

Attorney's fees. A judgment for the claimant would include an amount for attorney's fees, in accordance with a schedule established by the Office within a ceiling set by the Act. The proposed ceiling is 25 percent of the first $100,000, 15 percent of the next $200,000, and 10 percent of the remainder.

Costs of proceeding. The hearing examiner could, in his discretion, assess either or all parties an amount, established by regulation and payable to the State, equivalent to all or part of the administrative costs of the proceeding.

Comparative negligence. An award for the claimant would be reduced in proportion to the degree to which the hearing examiner found that the claimant's negligence had contributed to the injury.

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Liability of parties defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

Award for future economic loss. An award for future economic loss would not require the payment, within a calendar year, of an amount that exceeded the loss anticipated for that year; but such award would not be subject to future adjustment.

Derivative rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

Administrative Appeal

A party would be entitled to appeal a final determination of a hearing examiner to an appellate tribunal established by the Office. The tribunal would be required to hear and decide the appeal within 4 months after that determination.

Appeal to State Appellate Court

The judgment of the appeals council could be appealed to the appropriate State court of appeals.

- The court would not have jurisdiction to reexamine any administrative finding of fact, although it could remand the case to the agency with instructions to find additional facts.

- The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

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Exclusions

The Office would be without the power to adjudicate a malpractice claim alleging:

- Wrongful death or
- Willful injury.

Exclusivity of Remedy

Except as otherwise provided by this Act, no other court would have jurisdiction to adjudicate any claim arising from, or alleging, medical malpractice if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available for pressing malpractice claims within the state.

Licensing and Relicensing

The appropriate State licensing body would be required to review each case in which malpractice were found. In any case in which it determined there had been gross negligence, or a health professional or other health care provider had been responsible for repeated instances of malpractice, it would be authorized, after opportunity for hearing, to suspend or revoke the license of the professional or other health care provider to provide health care services within the State, or to direct (in the case of a health care professional) that the individual submit to a relicensing examination.

Advisory Council on Standards of Health Care

The bill would establish an Advisory Council on Standards of Health Care to develop guidelines for use in evaluating claims of malpractice under the program.

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Establishment of Council panels; appointment of members. The Director of the Office would establish panels of the Council to advise on various aspects of health care, including medical and surgical practice, and nursing care, and, in consultation with the appropriate professional licensing bodies and professional associations concerned with the provision of health care within the State, would appoint to these panels distinguished members of the health care professions.

Development of practice guidelines. Each panel would develop for the Council, and the Council would recommend to the Director, guidelines for use in evaluating the quality and appropriateness of health care with respect to the various medical conditions. The Director would publish the guidelines, and they would be available as a resource to the Office in adjudicating malpractice claims filed with it.

Adoption of Model Act; Application of Federal Act to Non-Federal Beneficiaries

If a State adopts the Malpractice Adjudication Act before Congress enacts th Federal Beneficiary Malpractice Adjudication Act, the State statute would apply to all Federal beneficiaries and health care professionals and other health care providers over whom the State has jurisdiction, until enactment o the Federal act. If a State does not adopt the Malpractice Adjudication Act within 5 years after the Secretary promulgates it, and Congress has enacted the Federal Beneficiary Malpractice Adjudication Act, the Federal act would be opened to all malpractice claims arising in the State, at the option of either party.

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A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH USE OF SELECTIVE CONTRACTING

Purpose of the Proposal

It is proposed to institute a system, under Medicare, whereby the program will reimburse a provider for the costs of performing a designated medical or surgical procedure—a procedure typified by its high cost to the program, such as a coronary artery bypass operation—only if Medicare has first approved the provider for the performance of that procedure. The proposal's objective is to channel patients for those procedures to facilities that provide cost-efficient, quality services.

Elements of the Proposal

Procedures Designated

The Secretary of Health and Human Services may designate a medical or surgical procedure the performance of which will be reimbursed by Medicare only if performed at an approved facility, if:

- the Secretary determines that the procedure is one that imposes high costs on the Medicare program, and

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- *the Office of Health Technology Assessment of the Public Health Service has assessed the procedure and found it to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.*

Qualification of Facility

Competitive bidding. The Secretary would be required to develop administrative arrangements under which criteria would be published for the selection of facilities to perform each procedure designated under the program, and bids from such facilities would be solicited and evaluated.

Fixed charge. All services delivered by a provider would be on the basis of a fixed charge per procedure for all hospital and physician services (including postoperative care) associated with the procedure, regardless of the actual cost of the procedure in a particular case.

Quality Assurance Standards

To be approved as a facility for the performance of a procedure under this proposal, the facility must meet the following criteria:

- **Patient selection.** It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

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- **Patient management.** It must have adequate patient management plans and protocols that include the following:

  - *Therapeutic and evaluative procedures.* Therapeutic and evaluative procedures for the acute and long-term management of a patient, including commonly encountered complications.

  - *Patient management and evaluation.* Patient management and evaluation during the waiting and immediate postdischarge period as well as in-hospital phases of the program for performing the procedure.

  - *Long-term management and evaluation.* Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least 5 years.

- **Commitment.** A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:

  - *Commitment at all levels.* Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.

  - *Adequate expertise.* The facility is expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.

- **Facility plans.** The facility must have overall facility plans, commitments, and resources for a program that will ensure a

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reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which it is indicated. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

- **Experience and survival rates.** The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

- **Maintenance of data.** The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.

- **Laboratory services.** The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in a laboratory facility approved for participation in the Medicare program.

Reimbursement of Beneficiary

In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a designated facility if the beneficiary resides more than 50 miles from the facility.

Patient Information

Health Care Financing Administration, in consultation with the Social Security Administration, would design and adopt procedures:

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- to inform individuals eligible for Medicare of the existence of facilities that provide cost-efficient, quality services; and

- to assist those individuals to tap into existing provider networks, such as PPO plans, from which they can obtain information as to the availability of services from such facilities.

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A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE

Purpose of the Proposal

It is proposed to reimburse health care providers, under Medicare, for the costs of performing designated major surgical procedures, only if those procedures are performed in facilities—termed "Centers of Excellence"—meeting rigorous criteria of quality. The procedures would be those that are not frequently performed by most institutions because of infrequent occurrences in terms of incidence and prevalence. Such procedures normally require the use of highly specialized techniques employed by a skilled and highly trained team of physicians and nurses and are necessary for life-threatening or seriously disabling conditions. Examples include heart, liver, or lung transplants.

Because the number of procedures performed has a direct bearing on the success rate, the proposal's objective is twofold: to encourage patients to seek procedures at facilities most successful in performing them and to discourage the performance of these procedures at facilities less successful in performing them.

Because a consequence of the proposal would be to reduce the number of facilities at which the designated procedures could be performed, a major feature would be to reimburse the Medicare beneficiary for the cost of travel between the facility and the residence.

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Elements of the Proposal

Procedures Designated

In order to be designated as a procedure the performance of which will be reimbursed by Medicare only if performed at a Center of Excellence, a procedure must meet these criteria:

- It is not frequently performed by most institutions.
- It requires the use of highly specialized techniques employed, in most cases, by a skilled and highly trained team of physicians and nurses.
- It is critically necessary for life-threatening or seriously disabling conditions.

Procedure Designation Process

The Secretary of Health and Human Services would establish an initial list of such procedures and would be authorized to add procedures as appropriate. Each procedure on the list must first be assessed by the Office of Health Technology Assessment of the Public Health Service and found to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.

Criteria for Designation as Center of Excellence

To be designated as a Center of Excellence for a designated procedure, the facility must meet the following criteria:

- Patient selection. It must have written patient selection criteria that it would follow in determining suitable candidates for the procedure.

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Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

- Patient management. It must have adequate patient management plans and protocols that include the following:

  - *Therapeutic and evaluative procedures.* Therapeutic and evaluative procedures for the acute and long-term management of a patient, including commonly encountered complications.

  - *Patient management and evaluation.* Patient management and evaluation during the waiting and immediate postdischarge period as well as in-hospital phases of the program for performing the procedure.

  - *Long-term management and evaluation.* Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least 5 years.

- Commitment. A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application, including a significant referral pattern.* Indications of this commitment should include the following:

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- *Commitment at all levels.* Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments in order to provide a full spectrum of supportive care.

- *Adequate expertise.* The facility is expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.

  - Integration of teams. The component teams must be integrated into a comprehensive team with clearly defined leadership and corresponding responsibility.

  - Anesthesia. The anesthesia service must identify a team for performance of the procedure that is available at all times.

  - Infectious disease. The infectious disease service must have both the professional skills and laboratory resources needed to discover, identify, and manage the complications from a whole range of organisms, many of which are uncommonly encountered.

  - Nursing service. The nursing service must identify a team or teams trained in the special problems of managing patients who undergo the procedure.

  - Pathology resources. Pathology resources must be available fo studying and reporting promptly any pathological responses to the procedure.

  - Social services. Adequate social services resources must be available.

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- Patient selection. Mechanisms must be in place to ensure that:

  - patient selection criteria are consistent with those set forth in the facility's written patient selection criteria, and

  - the facility is responsible for the ethical and medical considerations involved in the patient selection process and application of patient selection criteria.

- Plans for organ transplantation. If the procedure involves organ transplantation, that adequate plans exist for organ procurement meeting legal and ethical criteria, as well as yielding viable transplantable organs in reasonable numbers.

- **Facility plans.** The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which it is indicated. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

- **Experience and survival rates.** The facility must demonstrate experience and success with the procedure and be in the forefront of medicine for the specific specialty. Survival rates must meet criteria established by the Secretary. The facility should be evaluated periodically.

- **Maintenance of data.** The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo

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the procedure, not only those for whom payment under medicare is sought.

- **Laboratory services.** The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in a laboratory facility approved for participation in the Medicare program.

Reimbursement of Beneficiary

In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a Center of Excellence if the beneficiary resides more than 50 miles from the Center.

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PROMOTING HEALTHY LIFESTYLES

The Problem

A substantial amount of research has been done that demonstrates the impact of certain lifestyle behaviors, such as smoking, alcohol and drug abuse, improper nutrition, lack of exercise and physical activity, and stressful occupations, on longevity and quality of life. Substantial efforts have also been made by the government and public and private agencies to disseminate this information to the public in order to encourage changes in lifestyle behaviors that impact health status. As a result of these efforts, many Americans have made substantial changes in their lifestyle behaviors. For example, the national campaign against cholesterol has resulted in many Americans changing their eating behaviors.

Despite these successes, more needs to be done to increase the awareness of Americans as to the impact on health of making correct lifestyle choices. A grassroots level campaign is needed to educate Americans through activities with schools, clubs, community groups, voluntary organizations, businesses, labor organizations, government, and societies of health professionals.

The Proposal

Measures to Discourage the Use of Tobacco

Advertising ban. The proposal would ban all forms of advertising tobacco and tobacco products.

Vending machine ban. The proposal would ban the sale of cigarettes from vending machines.

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Termination of tobacco subsidy. The proposal would phase out tobacco subsidies under a program that would offer farmers loans and other short-term assistance to facilitate conversion to other crops.

Encouraging Healthy Lifestyles

The proposal[31] would establish a statutory foundation for the development and implementation of programs to encourage healthy lifestyle choices, such as:

- avoiding illegal drugs;
- avoiding excessive alcohol consumption;
- avoiding the use of tobacco products;
- choosing proper foods as components of a healthy, balanced diet;
- developing effective ways to manage stress; and
- engaging in regular exercise.

[31] One approach might be to reconstitute the President's Council on Physical Fitness and Sports as a statutory body and expand its functions.

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Use of Current Programs and Activities

The administering agency would promote this new concept of physical fitness by:

- enlisting the active support of private citizens, civic groups, business enterprises, foundations, and other entities in efforts to promote healthy lifestyle choices by all Americans;
- initiating activities to inform the general public of the importance of healthy lifestyle choices and the link between appropriate lifestyle behaviors and good health and productivity;
- encouraging State and local governments to emphasize to their citizens the importance of making healthy lifestyle choices;
- advancing the concept of physical fitness through healthy lifestyle choices by systematically encouraging the development of community programs;
- developing cooperative programs with societies of health professionals to encourage Americans to make healthy lifestyle choices;
- assisting educational agencies at all levels to develop high-quality, innovative health and physical education programs that emphasize the importance of making the right lifestyle choices for good health; and
- helping business, industry, government, and labor organizations by encouraging public/private ventures to establish programs to promote healthy lifestyle choices among their employees and to reduce the

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financial and human costs resulting from inappropriate lifestyle choices.[32]

[32] The new program would assume the current activities of the President's Council on Physical Fitness and Sports are directed only toward exercise and sports, i.e., promotion of research in sports medicine, physical fitness, and sports performance, and coordinating Federal agency activities relating to physical fitness and sports. This would be accomplished by expanding the mission of the Council to enable it to administer the proposal, transferring the Council to the agency administering the proposal, or abolishing the Council altogether.

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PRESIDENT'S COUNCIL ON FITNESS FOR THE SECOND FIFTY YEARS

The Problem

In its report, "The Second Fifty Years: Promoting Health and Preventing Disability," the Institute of Medicine wrote:

> Health research, education, and service policies are often written as though our older generations are beyond help. Although there is sufficient evidence of the benefits of health promotion and disability prevention among older individuals, many of them are not advised to stop smoking, to begin exercising, to be screened for various forms of cancer, or to be immunized against infectious diseases. . . . To accommodate the changing needs of an increasingly older society we must add several imperatives: we must promote health throughout life, and we must also prevent the ill from becoming disabled and help the disabled to prevent further disability.

These observations gain an added significance when it is appreciated that the first baby boomers will turn 50 in 1997.

Yet, as the American Medical Association observes:

> . . . most middle-aged adults do very little in the way of physical exercise. . . . In part, this widespread inactivity stems from the mythology that surrounds the issues of exercise and aging. As people grow older, they tend to believe that their need for physical activity

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> diminishes and they tend to exaggerate the risks involved in vigorous exercise after middle age.[33]

Predictably, most people enter their middle and senior years with a needlessly limited ability to carry out, with alertness and vigor, the critical tasks of daily living.

> Medical experts agree that many of the physical changes that people attribute to normal aging actually are a result of inactivity and could be diminished by a continuing program of physical exercise.[34]

Studies have found that people who exercise regularly have a lower incidence of cardiovascular disease.[35]

Although the President's Council on Physical Fitness and Sports has not neglected this age group, that Council's excellent programs appeal primarily to the young.

The Proposal

In General

It is proposed that there be established, as a companion body to the President's Council on Physical Fitness and Sports, a President's Council on Fitness for the Middle and Senior Years, which shall be within the Department of Health and Human Services. The Council shall focus on the

[33] The American Medical Association, *Health and Well-Being After 50*, 1984, p. 149.
[34] Dartmouth Institute for Better Health, *Medical and Health Guide*, 1986, p. 51.
[35] The Columbia University School of Public Health, *Complete Guide to Health and Well-Being After 50*, 1988, p. 154.

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development of programs especially suited to an individual's middle and later years.

Appointment

The President shall appoint 20 members to the Council and shall designate a Chairman and Vice Chairman.

National Program

The Council shall:

- enlist the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve the fitness of all Americans over age 50 through regular participation in suitable programs of physical fitness;
- initiate programs to inform the general public of the importance of exercise and the link that exists between regular physical activity and good health and effective performance;
- strengthen coordination of Federal services and programs relating to physical fitness of individuals over age 50;
- encourage State and local governments to emphasize the importance of regular physical fitness for older citizens;
- encourage research in physical fitness for older individuals; and
- assist business, industry, government, and labor organizations to establish sound physical fitness programs to reduce the financial and human costs of physical inactivity.

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Coordination

The Council shall seek to coordinate its activities with those of the President's Council on Physical Fitness and Sports.

Other Functions

The Council shall advise the President and the Secretary of Health and Human Services as to its activities in devising and promoting programs to improve the fitness of older Americans and evaluate the effectiveness of those programs.

Service of Members

The members of the Council shall serve without compensation for their work on the Council but will be entitled to travel and subsistence expenses for meetings.

Staff

The Secretary of Health and Human Services shall provide the Council with a suitable staff and facilities.

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RESEARCH TO FOSTER INDEPENDENT LIVING

The Problem

Many diseases or other conditions lead to chronic disability: dementia, arthritis, vascular diseases, hip and other fractures, hypertension, diabetes, cancer, and emphysema among them. Most of these diseases do not generally lead to high mortality.[36] Instead, they leave in their wake individuals unable to perform many of the activities of daily living and therefore in need of long-term care.

One generally needs long-term care, regardless of its setting, if one experiences limitations in one or more of five activities necessary for daily living: eating, continence, mobility, bathing, or dressing. Those not suffering severely from these limitations may nevertheless need help in performing instrumental tasks for daily living: shopping, cooking, and performing chores.[37]

Much research is being done into the underlying causes of the diseases that lead to these disabilities, but insufficient research has been done either to correct the disability and return the individual to normal functioning or to assist the afflicted individual in dealing with the disability. As a result, nursing home care remains the leading cause of uninsured catastrophic expenditures paid by the elderly.[38]

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[36] Technical Work Group on Private Financing of Long-Term Care for the Elderly, "Report to the Secretary on Private Financing of Long-Term Care for the Elderly," Department of HHS, November 1986, p. vi.

[37] *Ibid.*, p. 2-5 & 2-6.

[38] *Op. cit.* n.1, p.i.

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Although the majority of those unable to perform some the activities of daily living do not become institutionalized, for many a problem such as incontinence will require nursing home placement. The elderly nursing home population—persons age 65 and older—is expected to grow to 2.1 million by the year 2000, and to 4.4 million by the year 2040.[39] In part, this reflects increasing lifespan. "In [the decades] 1990 to 2010, the group age 85 and over will increase three to four times as fast as the general population."[40] Of those over the age of 85, almost one-quarter is institutionalized.[41] More than 20 percent of elderly persons will stay in a nursing home at least 1 year, at an average annual cost in excess of $30,000 a year.

Permanent institutionalization severs a person's ties to the community, contributing to the depression and demoralization that may afflict one's declining years. Although nursing home care is for most people the least desirable alternative to providing for themselves in old age, increasing numbers of the population will be compelled in the coming years to avail themselves of it.

The Home- and Community-Based Option

Today, most long-term care—71 percent—is provided in the home or community, much of it by family and friends at no cost to others.[42] It is the least disruptive to patterns of living built up over a lifetime.[43] In

[39] Manton, K.G. and Liu, K., "The future growth of the long-term care population," paper presented at Hillhaven Foundation's *Third National Leadership Conference on Long-Term Care Issues*, Washington, DC, March 7-9, 1984.

[40] *Ibid.*

[41] *Op. cit.* n. 1, p. 1-2.

[42] *Op. cit.* n.1, p. iii.

[43] Home and community-based long-term care encompasses the following services: service-enriched sheltered housing; home-delivered professional nursing and therapy services; nonprofessional home health aide and personal care services; homemaker/chore services; daycare for the elderly or mentally ill; habilitation services for the mentally retarded or developmentally disabled; home-delivered and congregate

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general, it is the option of choice. But it is an option denied to many whose disabilities or lack of family or friends prevent them from electing it.

Because the Federal Government possesses a unique resource in the National Institute on Aging, it can contribute to State, local, and private efforts to reduce institutionalizing the elderly. At present, the Institute, organizationally part of the National Institutes of Health, primarily engages in basic research, and the support of basic research, into the aging mechanism and problems associated with aging. But unlike the other institutes, the NIA's mission has enabled it to perform research outside of the biomedical field.

The Proposal

Establishment of Center

The proposal would expand the focus of the National Institute on Aging (NIA) by establishing within it a *Center for Fostering* Independent Living. The Director of the Center would report directly to the NIA director.

Mission, in General

The Center would conduct and support applied research into means, social and scientific, to foster independent living among persons suffering an impairment in their ability to perform activities of daily living. Given its organizational placement, the Center would have ready access to the scientific findings of NIA as well as the other NIH institutes.

Functional Assessment and Evaluation of Therapies

meals; case management, assessment, and referral services; home adaptations; transportation; friendly visiting; and surveillance services. *Op. cit.*, n.1, pp. 2-16 & 2-17.

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The Center would encourage the development of improved methods of assessing the ability of impaired individuals to function in a noninstitutional setting and would undertake an evaluation of the effectiveness of existing rehabilitative therapies.

Alleviation of Disabling Conditions

Continuing technological advances provide a means for dealing with the disabilities often associated with aging and which frequently lead to the need for long-term care.[44] The Center, in cooperation and consultation with the Food and Drug Administration, would support the development and availability of drugs and devices such as those to:

- eliminate falls or reduce their effect,
- alleviate severe hearing or vision losses,
- treat or correct urinary incontinence,
- aid memory so as to combat wandering behavior and other severe consequences of memory deficits, and
- compensate for losses in mobility.

Living Arrangements

The Center would:

- survey various living arrangements that would permit an individual employing them to live independently,

[44] Op. cit. n.1, p. 2-58.

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- develop or support ways to optimize those living arrangements, and
- conduct, or support the conduct of, one or more demonstrations of various living arrangements (except that no such demonstration may subsidize the living arrangements or care of any individual).

Guide to Independent Living

The Center would publish a Guide to Independent Living. The Guide would be widely distributed to the elderly and would provide them with information about medical and technological developments, home- and community-based services, and improved living arrangements, pertinent to aiding them, particularly the impaired elderly, to remain within the community.

Technical Assistance

The Center would be authorized to provide technical assistance to States, local communities, and nonprofit organizations in the development or implementation of improved arrangements to enable the elderly, particularly the impaired elderly, to live independently.

Appropriations Authorization

In order to ensure that the applied research and demonstrations conducted by the Center do not lose out to basic scientific research in the competition for limited funds, the Center would have its own appropriations authorization. Nevertheless, the Director of the National Institutes of Health would be authorized to supplement appropriations under this authorization from other NIH appropriations, subject to such limitations as annual appropriations acts may impose.

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PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT FOR PRESCHOOL AND ELEMENTARY SCHOOL CHILDREN

The Problem

Alcohol and drug abuse are serious problems in the United States today. Approximately 18 million Americans have problems resulting from alcohol abuse, and about 7 percent of drinkers experience dependence symptoms. Nine of 10 high school seniors report having used alcohol at least once.

Although the overall use of drugs has declined in recent years, the use of certain drugs—particularly crack cocaine—has increased. According to a 1988 survey conducted by the National Institute on Drug Abuse, 21 million Americans have used cocaine at least once, and 21 million also used marijuana during the preceding year. At least 263,000 drug abusers were treated in facilities in 1987.

Alcohol and drug abuse are becoming increasingly prevalent among youth. According to the 1987 National Adolescent School Health Survey, 77 percent of eighth grade students have tried alcohol and of these, 55 percent report trying it by sixth grade. Fifteen percent of eighth graders report having tried marijuana, and 44 percent of these report their first use was by sixth grade. Twenty-one percent of eighth grade students report having tried inhalants (glues, gases, and sprays), and, of these, 61 percent report their first use was by the sixth grade. Use of tobacco, which is a gateway drug to the use of alcohol and other drugs, is also a problem among youth. Fifty-one percent of

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eighth grade students report having tried cigarettes, and 72 percent of these report their first use by the sixth grade or before.

Peer pressure, as well as exposure to alcohol and drugs in the home, contribute to use of alcohol and drugs by youth. A survey by *Weekly Reader* found that 38 percent of the fourth graders surveyed report peer pressure to try wine coolers, 41 percent to smoke, and 24 percent to use crack or cocaine. To counteract these influences, early prevention, education, and treatment is needed, so that our youngest children learn not to abuse alcohol and/or use drugs. In the Advisory Council's national survey, 84 percent of respondents supported the provision by school-based health centers of education and counseling for elementary school children to prevent alcohol and drug abuse.

The Proposal

The Council recommends that the Surgeon General develop a program to provide prevention, education, and where appropriate, treatment, for alcohol abuse and drug abuse affecting preschool and elementary school children. The program should include the development of educational materials that parents and teachers can use to teach preschool and elementary school children to avoid alcohol and drug abuse, efforts to encourage producers of children's television programming to include antialcohol and drug abuse themes and messages in children programs, public service announcements, and other public education campaigns directed specifically at children.

In addition, the Council recommends that school-based health centers include programs such as Ala-Tot for preschool and elementary school children in the services offered at these centers and make referrals for alcohol and drug abuse treatment for parents of preschool and elementary school children.

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A PROPOSAL FOR A PUBLIC EDUCATION CAMPAIGN ON PREVENTION

The Problem

Many choices individuals make about their lifestyles—including choices about physical fitness, nutrition and diet, smoking, abuse of alcohol, abuse of drugs, and sexual behaviors—cause or place individuals at higher risk for illness or disease. Because of demands for treatment of these illnesses and diseases, health care costs increase, and there are burdens placed on the acute care delivery system. Many people make these choices without adequate knowledge of the consequences that these behaviors will have on their health.

There are many examples of how these behavioral choices result in illness and disease that are preventable. Americans generally choose a sedentary lifestyle, despite the contribution that physical activity can make in preventing and managing many illnesses and conditions, such as heart disease, hypertension, diabetes, osteoporosis, and depression, and in assisting with weight loss. Improper diet, particularly diets high in fat, are linked with coronary heart disease and atherosclerosis. Americans' diets are high in fat—currently 36 percent of calories for the average person.

Tobacco use is another behavior that results in preventable illnesses and diseases. It accounts for one out of every six deaths, or 390,000 deaths annually, and is a major risk factor for many diseases, including chronic bronchitis and emphysema, cancers of several organs, diseases of the heart and blood vessels, respiratory infections, and stomach ulcers. Cigarette smoking is responsible for an estimated 30 percent of all U.S. cancer deaths, 87 percent of lung cancer deaths, and 21 percent of all U.S. coronary health disease deaths. Smoking during pregnancy is estimated to cause 20 to

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30 percent of low birth weight babies, 14 percent of premature deliveries, and about 10 percent of infant deaths.

Use of alcohol and other drugs by Americans is another personal behavior choice that results in preventable illness and disease. Alcohol is linked to approximately one-half of all homicides, suicides, and automobile accidents. Fetal alcohol syndrome is the leading cause of birth defects which can be prevented and affects as many as 3 of 1,000 live births. The economic costs to the Nation resulting from alcohol abuse have been estimated to be $70 billion.

Drug abuse is widespread in the United States and has an increasingly serious impact on health status, and demands for treatment are increasing health care costs. Drug abuse increases risk of several problems, including injuries resulting from violence, the spread of the AIDS virus, and crack addiction and developmental problems in babies. From 1985 to 1989, the number of cocaine-related emergency room episodes increased from 10,231 to 41,602, with a high of 42,510 episodes in 1988. The costs of drug abuse problems to the Nation were estimated to be $44 billion in 1990.

Almost 12 million Americans are affected by sexually transmitted diseases annually, and 86 percent of these American are between the ages of 15 and 29. The most common sexually transmitted diseases are HIV, gonorrhea, syphilis, and genital herpes. The most serious complications of sexually transmitted diseases include AIDS, pelvic inflammatory disease, sterility, blindness, infant deaths, mental retardation, and birth defects. The total cost of sexually transmitted diseases to society exceeds $3.5 billion annually.

In addition, many Americans are unaware of the availability and benefits of preventive care, such as immunization, vision and eye tests, mammograms, and Pap smears, in reducing disease and saving lives. For example, there has been an increase in the number of cases of measles, a childhood disease that is preventable with a vaccine.

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Recent efforts, such as the campaign to educate the public about cholesterol, have been successful in raising the public's awareness of how changes in behavior and use of preventive care can reduce disease and illness. Increasing public awareness of the benefits of changing behavior and using this type of care can further reduce disease, and as a result, hold down health care costs.

The Proposal

It is proposed that the Surgeon General of the United States conduct a massive, 3-year public education campaign on the prevention of disease through changes in personal behaviors and use of preventive care and screening. The campaign would involve a coordinated effort using the broadcast and print media, including public service announcements, outreach to community groups, and cooperative ventures with businesses. The campaign would also involve schools through design of curricula for use in health education classes as well as presentations on preventive health issues.

The Council suggests that the Advertising Council adopt this public education campaign on prevention as its entire effort during this 3-year period and that the Surgeon General work with other groups, such as the National Association of Broadcasters, to implement this campaign.

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PROPOSAL TO DEVELOP MODEL SECONDARY SCHOOL COURSE UNITS FOR THE TEACHING OF FAMILY FINANCIAL MANAGEMENT AND LONG-TERM PLANNING

The Problem

Many Americans are not aware of the importance of early financial planning for health care costs, retirement, and other economic needs likely to arise in later life. There is a widespread misperception that when an individual reaches retirement age, the government, through Medicare and social security, will provide all necessary health care and income support. As a result, many Americans often do not learn about the limitations in the benefits provided by these two programs until retirement, at which point it is too late to undertake a program of savings and investment crucial to support during retirement years.

In particular, young people who graduate high school and enter college or employment tend to view their retirement years as a time so distant that they need not provide for it. Young people also see themselves as healthy, and, during their early working years, often do not appreciate the need to budget for, or insure against, predictable health care expenditures. For example, in hearings around the country, the Council heard numerous State and local employees express their regret at having declined Federal social security coverage when, in their twenties, they were asked to plan their retirement pensions.

Young people need to be taught the importance of budgeting and planning for these expenses if every American is to take responsibility to meet them adequately.

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The Proposal

Model Secondary School Course Units and Materials

The Secretary of Health and Human Services, in conjunction with the Secretary of Education, would develop and disseminate to States model secondary school course units and materials for teaching family financial management and long-term planning to meet major expenses, such as those associated with:

- health care, including major medical expenses;
- education;
- purchase of a home;
- child care;
- unemployment; and
- retirement.

Course units would include elements on credit card and checking account management, the availability of pertinent Federal and state programs (e.g., Federal student loan guaranties, State unemployment insurance benefits), and tax planning (e.g., IRA and Keogh plans).

The course units would also contrast the American social welfare system with those of other countries in order to provide the student with some historical perspective.

Suggested Course Unit Content

The course units could be designed to cover the following topics:

- **Retirement planning.** A unit on retirement planning could cover these topics:

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- *Determination of income needs.* How to determine the amount of income an individual would require to support his or her needs at retirement; how to plan savings or other investments to meet those needs; and how to plan for a retirement dependent upon multiple income sources, such as social security, pension plans, and savings.

- *Social security.* The purpose of social security as a supplement to other retirement savings; the eligibility rules for social security; and the level of benefits an individual would expect to receive under social security based on the number of years worked and income levels.

- *Pension plans.* The types of pension plans offered by private employers; how to evaluate plans and compute benefits; and the impact of changing jobs during one's lifetime on the vesting of retirement plans.

- *Savings.* The types of other private financial products, such as IRAs and annuities, available to individuals to enable them to meet their retirement income needs and how to evaluate and make decisions about these types of products.

- **Health care expense planning.** A unit on planning for health care expenses could cover these topics:

  - *Health expense education.* The types of health care expenditures that an individual may incur during his or her lifetime, including expenses for primary and preventive care, hospital care, physician care, long-term care, prenatal and well-baby care, prescription drugs, and other types of care.

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- *Availability and role of health insurance.* The types of health insurance available in the United States, including employer-based insurance, individually purchased coverage, and coverage from groups such as unions and professional associations; the types of costs that will be incurred by the individual, such as premiums, coinsurance, copayments, deductibles, and out-of-pocket costs for noncovered items; options for different types of plans, such as indemnity plans, HMOs, PPOs, and other types of managed care plans; long-term care insurance and medigap plans; the importance of being covered by health insurance throughout one's lifetime, especially for unexpected catastrophic expenses; and how to choose the proper health insurance plan based on one's age, income, health status, and family status.

- *Medicare and Medicaid.* The purpose of the Medicare and Medicaid programs; eligibility rules; types of services covered; and payment levels.

- **Disability insurance.** A unit on the role and importance of disability insurance could cover:

  - the types of events that may cause an individual to become disabled;

  - the role of social security and employer-based insurance in providing income protection if an individual becomes totally or partially disabled;

  - ways to determine the income that a wage earner and his or her family will need if the wage earner becomes disabled; and

  - the appropriate type and levels of insurance that will be needed to provide disability income.

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- **Life insurance.** A unit on the role of life insurance in planning to meet the income needs of the family after the death of a wage earner could include information on the types of life insurance products offered by employers and insurance companies and skills needed to select the appropriate types of life insurance based on one's age, income, health status, and family status.

- **Budget planning.** A unit on budget planning could teach students:

  - how to make choices about retirement planning, health expense planning, and life insurance planning in the context of their overall budgets starting when they enter the work force, and

  - how to re-evaluate their choices periodically in light of changes in their income, health status, or family status.

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Appendix B:
Recommendation Specifications
Reform of Health Care Institutions

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A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS

Background

In order to simplify the process through which health care providers submit bills to intermediaries and to the Health Care Financing Administration, a series of meetings, known as the "UB 82" exercise, was held among representatives of HCFA, health care insurers, and intermediaries that culminated in the adoption of a single billing form. Despite agreement on this form, the UB 82 form has become merely one of a number of billing forms currently in use. Often, a payer will require the submission of the UB 82 form and a number of other forms in addition. Consequently, the savings anticipated from UB 82 have not materialized. Today, it is estimated that 20 percent of Medicare expenditures, and a significant amount for other health care expenditures, are for paperwork.

Also, the information provided by the UB 82 form is insufficient for use by HCFA in evaluating the quality of care provided. HCFA has therefore directed peer review organizations to abstract clinical information on patients using a uniform clinical data set and provide it to HCFA for all patients for which UB 82 forms have been submitted.

The Proposal

The Objective

Legislation can support a forthcoming UB 92 process in three ways:

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- providing a framework to facilitate discussions;
- clearly defining their objective; and
- establishing an alternative process if the discussions were unsuccessful.

Advisory Council

The proposal would direct the Secretary to convene an Advisory Council on Health Claim Standardization to consist of 15 individuals, including representatives of the American Hospital Association, the American Medical Association, the Health Insurance Association of America, Blue Cross and Blue Shield, consumer groups, individual hospitals and health care insurers, and the Health Care Financing Administration. At least five members of the Council would be required to be currently employed as hospital administrators.

Responsibility of the Council

The proposal would direct the Council, to recommend to the Secretary, within 2 years of its appointment, a uniform health claim reimbursement form for hospital services that would include all charges—hospital and physician's services, x rays, tests, etc.—arising from an individual's hospitalization. The form would also include information needed to determine a patient's health insurance coverage and eligibility to participate in State, Federal, or private health care programs. When promulgated by the Secretary's regulations, the form would be the sole form required by the Health Care Financing Administration or any private health care insurer in

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the United States as the sole basis for making payment on a claim for reimbursement for hospital inpatient services or physician's services.[45]

Contents of a Uniform Reimbursement Form

The uniform reimbursement form, as recommended by the Council, shall include:

- **Uniform Clinical Data Set.** A diagnosis of the patient is based on a uniform clinical data set.[46]

- **Procedures Employed.** A uniform coding of medical procedures is used to treat the patient.

- **Billing Information.** Reimbursement is requested for each procedure employed with respect to the patient, including hospital services, physician's services, x rays, tests, rehabilitative services, and so forth, as may be required to ensure that the form is comprehensive.

[45] *The Omnibus Budget Reconciliation Act of 1990* (section 4112) created a Practicing Physicians Advisory Council to look into what is usually referred to as the "hassle factor" (i.e., the problems with physician billing under Medicare). In addition, the Standard Claim Form (OMB 1500), developed by HCFA in conjunction with the AMA, is now used by HCFA, Blue Shield, HIAA members, the Department of Defense, the Department of Labor, and many other public agencies and private payers as the basis for paying for physicians' services. Given recent congressional action in the area of physicians' claims under Medicare and the virtually universal acceptance of the Standard Claim Form, the proposal does not attempt to replow this ground.

[46] The Institute of Medicine has recently recommended development of an electronic medical record, with all patient information going into the record. The proposal, under development as "Quality 2000" in conjunction with congressional legislative staff, would mandate electronic data collection for hospitals by the year 2000.

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Report on Computerization of Billing

The Council would also report on the computerization of health claim billing, i.e., the use of electronic means to transmit billing information from hospitals and physicians to insurers and HCFA. The report would include:

- a survey of the current state of electronic billing;
- a discussion of the impediments to more extensive use of electronic billing;
- an analysis of the probable costs of increasing the volume and standardization of such billing in relation to the savings to the health care system that could reasonably be anticipated; and
- the Council's recommendations for action that would facilitate the further extension of electronic billing in a cost-effective manner.

Administration

The Council would meet at the call of the chair. Members would be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary under Medicare.

Development of Form by HCFA Upon Failure of the Council to Agree

If, at the end of 2 years after the Secretary has appointed the members of the Council under the proposal, the Council fails to recommend a uniform reimbursement form, the Secretary shall direct the Health Care Financing Administration to develop and promulgate such a form for the purpose within 6 months.

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TECHNOLOGY ASSESSMENT AND DATA POOLING

The Problem

There is need for an adequate data base from which to develop improved methods of technology assessment and medical evaluation. In addition, hospitals and insurance companies, in consultation with the medical profession, need to compare and pool data. Currently no institutional machinery exists to ensure that this data base will be assembled, and the current state of antitrust enforcement would deter private organizations from pooling such data.

The Proposal

Advisory Group on Technology Assessment Data

The Council recommends that the Secretary of Health and Human Services establish an Advisory Group on Technology Assessment Data.

Membership. The Group shall consist of representatives from the Agency for Health Care Policy and Research, the Health Care Financing Administration, the Public Health Service, the Department of Defense, the Veterans' Administration, the Institute of Medicine of the National Academy of Science, and private members representing consumer groups, medical device manufacturers, health care insurers, health care providers, employers, and recognized experts in health policy research.

Mission. In order to promote assessment of technology through the use of a wider base of information that can be linked together, the Group shall

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develop standards to be used in the collection and maintenance of such information. The Group shall also develop uniform definitions of information to be collected and used in describing a patient's clinical and functional status, common reporting formats for such information, and standards to ensure the security, accuracy, and appropriate maintenance of such information.

Report. Within 1 year after it is established, the Group shall report to the Secretary on the feasibility of linking such assessment-related information of the Department of Health and Human Services with such information collected or maintained by other Federal departments and agencies and by private organizations.

Staffing. The Agency for Health Care Policy and Research shall provide the Group with necessary technical, administrative, and clerical staff and with other facilities.

Amendment of the Antitrust Laws

The Council recommends that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws to permit hospitals and insurance companies, in consultation with the medical profession, to compare and pool data for the purpose of developing improved methods of technology assessment and medical evaluation.

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THE MEDICAL DIRECTIVE AND PROXY ACT

The Problem

Medical advances continue to heighten the quandary of society's response to *life-prolonging* procedures which do not maintain the patient's quality of life. Fifty years ago, the majority of Americans died at home, receiving comfort and care in their final hours; today, 80 percent die in institutions, often tied to a spider web of tubes and wires that marshal a sophisticated technology to prolong the process of dying.

In general, individuals who retain mental competence may refuse unwanted medical care. But often persons *in extremis* are no longer competent. Then they may be subjected to medical procedures that they would have refused, that offer them no hope of recovery, and that waste their remaining resources.

Forty-one States and the District of Columbia have responded by enacting statutes enabling individuals to execute, in advance of need, a document usually called a "living will." The living will directs the withholding of extraordinary, life-prolonging care, generally after a patient has become terminally ill without prospect of real improvement or cure. But these statutes have failed to solve the problems that gave rise to them. Only 9 percent of Americans have made a living will, and even these documents do not always reach the providers of care.

In some States the living will is ineffective to govern care in the case of irreversible coma or persistent vegetative state not coupled with a terminal illness. In all cases, its language is vague ("no reasonable expectation of recovery from extreme physical or mental disability," "artificial means and heroic measures," and so forth) and open to differing interpretations as to the

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conditions covered and the interventions that the patient, if competent, would accept.

The "durable" power of attorney, i.e., a power of attorney that comes into effect, or remains effective, when the individual who has executed it becomes incompetent, can serve as an alternative or supplement to the living will. However, although all States permit the use of the durable power, in many States it is unclear whether it may be used to designate a proxy to make health care decisions. Moreover, many individuals may be reluctant to vest such an unconstrained authority in the hands of another. Finally, even if an individual chooses to do so, the designated proxy may be uncertain as to how to exercise the power, particularly one executed many years before the event.

The Proposal, in General

Legislation, to be cited as the "Medical Directive and Proxy Act," would be proposed to require that a Registry be established within the Department of Health and Human Services. The Registry would provide a "Medical Directive and Proxy Designation" form[47] to all physicians who treat Medicare patients, and to any other physician who requests the form. The Registry would also inform each individual eligible for Medicare of the availability of the form at the office of the individual's physician and would encourage the individual to ask the physician to interpret the form and explain how it is to be executed. No physician would be required to assist an individual in interpreting or executing a form; however, if the physician accepts Medicare patients, the physician would be required to refer the individual to some other physician for the requested guidance.

[47] The form contemplated would be based on the form developed by Linda L. Emanuel, M.D., Ph.D., and Ezekiel J. Emanuel, M.D., Ph.D., and described in their article, "The Medical Directive, A New Comprehensive Advance Care Document," 261 JAMA 3288, June 9, 1989.

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An individual who chooses to execute the form would file with the Registry the form signed by the individual and the individual's designated proxy.[48]

The form would accomplish two purposes:

- It would allow an individual to designate the acceptability of specified life-prolonging medical procedures in the event of any of a small number of medical situations in which the patient has little or no competence to act for himself.

- It would appoint a proxy with the authority to make decisions regarding the cessation of life-sustaining treatments upon the individual's incompetence.

The proxy would be bound by the patient's choices evidenced in the medical directive portion of the form unless the patient specifies otherwise and would in any event be guided by that portion in making decisions not covered by it.

At the request of the patient or the patient's proxy, the Registry would supply a copy of the executed form to any physician of the patient or an appropriate licensed health care provider.

The bill would contain provisions, described below, to ensure the effectiveness of the form and to enable the individual who has executed it to revise or revoke it (if competent). From time to time, as new life-sustaining treatments become available, the Registry would promulgate amended forms, provide them to physicians, and advise registrants of their availability.

[48] In the case of minors eligible for Medicare by reason of disability, the parent or guardian would in any event be required to make the decision as to what care to authorize at the time that care is required. However, the proposal would allow the minor (through the minor's parent or guardian) to execute a Medical Directive and Proxy Designation form so as to take advantage of the provisions of the proposed law that override State limitations discussed earlier.

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The Proposal's Scope

Federal Preemption of State Law With Respect to Medicare Beneficiaries

Living will legislation has been the exclusive domain of the States. Proposals for Federal involvement have generally confined themselves to suggestions for model State living will statutes, or for Federal laws limited to requiring Medicare and Medicaid beneficiaries to be informed of their rights to execute advance medical directives under State law.[49] The instant proposal would encroach on that dominance by overriding State law in a few marginal situations: most notably in allowing an individual, regardless of the law of the State in which health care is received, to direct the withdrawal of that care (including the withholding of artificial nutrition and hydration) in the event of irreversible coma or persistent vegetative state.

The provisions of the instant proposal that override State law would apply only to Medicare beneficiaries. The health care of a Medicare beneficiary is largely paid for by the Federal Government. There is therefore a strong Federal interest in the medical care of Medicare beneficiaries: what care is to be provided and when it is to be provided. Preemption of State law, even when quite limited, is most defensible on constitutional and policy grounds when necessary to accomplish a legitimate Federal objective: in this case, ensuring the economical use of Medicare trust funds in providing care to those beneficiaries.

[49] This was the approach taken in 1982 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. See, also, the "Patient Self Determination Act of 1989," S. 1766, 101st Cong. (Danforth); "An Act To Provide for the Creation of a Durable Power of Attorney for Health Care," proposed as a model State law by the American Medical Association in October 1986; and sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, which amended the Social Security Act to require health care providers to inform Medicare and Medicaid beneficiaries of their rights under State law to accept or refuse medical care, including the right to make "an advance directive" concerning that care.

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Application to Other Individuals

The Medicare population, consisting of persons who are aged or seriously disabled, is the population group that appears to have the greatest need for an effective means of governing medical care in the event of mental incompetence. A proposal is most credible, generally speaking, when it evolves from a felt need. Nevertheless, although the proposal's State law override provisions would apply only to Medicare beneficiaries, any individual would be allowed to execute a Medical Directive and Proxy Designation and file it with the Registry.

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The Proposal, Major Features

Establishment of Registry

The Secretary of Health and Human Services would be directed to establish a Registry for the purpose of developing and disseminating a Medical Directive and Proxy Designation form, registering an official copy of each executed form, and providing certified copies of the form to appropriate physicians and other licensed health care providers.

Location in DHHS

The Registry would be located, organizationally, within an agency of the Department of Health and Human Services designated by the Secretary.

Development of Form. The Registry would develop, within 4 months after its establishment and after consultation with interested individuals and organizations, a Medical Directive and Proxy Designation form that meets the requirements described below.

Notification of Physicians and Medicare Eligibles. Upon completion of the form, the Registry would take the necessary steps:

- to inform primary care physicians of the availability of the form and who may execute it,
- to inform all Medicare eligibles of the nature of the form and how it may be executed, and
- to conduct outreach activities through public and private organizations, agencies, and institutions to inform the public about the form.

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Thereafter, the Registry would inform individuals of the form and how it may be executed upon their first becoming eligible for Medicare.

Maintenance and Release of Records. The Registry would establish a procedure for recording the existence of, and retaining, all executed forms, revised forms, and revocations of executed forms. The procedure for revising or revoking an executed form is described below.

Medical Directive and Proxy Designation

Terms. The Medical Directive and Proxy Designation (the "MD&PD") would be in two parts: a medical directive and a designation of proxy.[50]

Medical Directive. The medical directive portion would specify the procedures covered, paradigmatic cases in which a physician might reasonably direct the use of one or more of such procedures, and the patient's wishes with respect to those procedures in the context of the paradigmatic cases.

Procedures Covered. The Secretary's regulation would specify the procedures covered and would be amended from time to time (with appropriate notice to registrants) to reflect new procedures. Initially it would be expected that the procedures covered would include:

- cardiopulmonary resuscitation,
- mechanical breathing,
- artificial nutrition and hydration,
- major surgery,

[50] The form described is essentially the form proposed by the Drs. Emmanual, *op. cit.* note 51.

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- minor surgery,
- kidney dialysis,
- chemotherapy,
- invasive diagnostic tests,
- simple diagnostic tests,
- transfusion of blood or blood products,
- use of antibiotics, and
- pain medication that may dull consciousness or indirectly shorten life.

Paradigmatic Cases. The form would contain a small number of cases with respect to which the individual would express his wishes (as described in the next paragraph) as to the procedures listed in the preceding paragraph. These cases would, at least, include the following:

- A coma or persistent vegetative state, where there is no known hope of regaining consciousness;
- Brain damage or disease that cannot be reversed and which makes the individual unable to recognize people or speak intelligibly, with little or no likelihood of regaining significant higher functions;
- Brain damage, as previously described, coupled with a terminal illness.

Expression of Individual's Wishes. The form would contain a small number of multiple choices through which the individual would express his wishes,

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e.g., "I want the procedure," "I do not want the procedure," "I will leave the judgment to my proxy," "I want a trial of the procedure, but suspension of treatment if no clear improvement."

Proxy Designation

Who May Serve. The proxy decisionmaker may not be a person, or an employee of a person, who, at the time of making a health care decision under the designation, is responsible for providing health care to the individual executing the proxy or is an employee of a company that has issued to that individual a policy of life or health insurance.

Withdrawal of Proxy. An individual may change the designation of a proxy in such manner as the Secretary's regulations may provide, except that any such change must be in writing unless it is determined that the individual, although competent, is physically unable to execute a written document.

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Explanation of Revision and Revocation. The form would contain a clear explanation of:

- the manner in which an individual may revise or revoke the form (as described below) and
- the effect of an individual's choice to allow, or not allow, the designated proxy to override the choices expressed in the Medical Directive portion of the MD&PD.

Execution of Form.

Signature of Individual. The individual executing the form would sign it and provide his home and business addresses.

Designated Proxy to Co-Sign. The designated proxy would co-sign the form and provide his home or business address.

Effectiveness. Notwithstanding the law of any State to the contrary, a properly executed MD&PD would be effective at least with respect to the paradigmatic conditions described therein. Nevertheless, the MD&PD could not authorize the administration of any medication for the purpose of shortening the life of the subject or the refusal to provide normal feeding or hydration.

Filing with the Registry

Who May File. Any person may file with the Registry a properly executed MD&PD.

Copies. If the MD&PD is filed by any person other than the individual who has executed it, the person filing it would be instructed by the form to attest on it that a copy has been provided to such individual and to the co-signers.

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Notification. The Registry would make a permanent record of the receipt of a properly executed MD&PD and would send a notice to the signer and co-signers concerning the Registry's receipt of it. The Registry would subsequently make the form available to a physician or other licensed health care provider upon receiving evidence that the physician or provider is engaged in providing care to the signer.

Payment of Fee. The Registry may establish a fee to defray its administrative costs. The Registry would refuse to file an MD&PD unless accompanied by the prescribed fee.

Revision and Revocation. An individual for whom an MD&PD is on file would be enabled to revise or revoke it in accordance with the Secretary's regulations, subject to the following restrictions:

Writing Required. A revision or revocation would be required to be signed by the individual or accompanied by an attestation of two witnesses that the individual, although mentally competent, is physically unable to sign the document.

Witnesses. If the individual is capable of signing the document, the signature must be attested to by a notary public.

Mental Incompetence. Notwithstanding the law of any State to the contrary, an MD&PD could not be revised or revoked on behalf of a mentally incompetent individual by a guardian appointed to act in his behalf or by any other person.

Participation of Physician

Payment of Fee. If a physician agrees to interpret the MD&PD to a patient, or assist a patient to execute it, Medicare will reimburse the physician for an office visit.

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Referral of Patient. If a physician declines to interpret the MD&PD to a patient, or assist a patient to execute it, the physician, if he accepts Medicare patients, will be required to refer the patient to another physician who will provide the requested guidance.

Immunity of Physician and Other Licensed Health Care Providers. A physician or other licensed health care provider would be immune from any liability that might attach to advice given in connection with the form or the physician's failure to comply with any provision.

Not a Condition for Providing Services. No physician or other licensed health care provider would be permitted to condition the provision of treatment on the existence or execution of an MD&PD.

Effect on Policies of Life Insurance

No policy of life insurance would be permitted to deem compliance with an MD&PD a suicide under the policy. The bill would declare any such provision invalid.

State Participation

As indicated above, the Registry would be available for all citizens who choose to file a Medical Directive and Proxy Designation form and pay the required fee. However, at the discretion of the Secretary, a State could enter into an arrangement with the Registry under which the State would pay the Registry fees for its citizens, reimburse the Registry for special arrangements, e.g., notifying physicians and citizens of the State of the availability of the form, making a statewide distribution of the form to physicians, and providing the State with computer access to the Registry data base (subject to appropriate safeguards of individual privacy).

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HOSPITAL MERGERS AND JOINT VENTURES

The Problem

Since the adoption of DRGs in the early 1980s, hospital admissions and occupancy rates have declined, particularly in small communities. It has become very costly for communities with two or more hospitals, each with low occupancy rates, to maintain multiple hospitals. However, communities develop a strong sense of identity with their local hospitals and are reluctant to see one facility close in favor of another. Many local communities have proposed mergers of two hospitals in order to maintain their sense of community identity while pooling services, personnel, and expensive equipment. However, current antitrust laws prevent such mergers because of the anticompetitive impact. Alternatively, other communities have proposed joint ventures using two hospital facilities for a hospital and a different purpose, such as a nursing home, but their proposals have been inhibited because of antitrust laws as well as Medicare fraud and abuse considerations.

The Proposals

Hospital Mergers

The Council would propose that the Attorney General develop proposals for legislation to amend the antitrust laws to permit mergers of two hospitals in the same community in limited cases. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rates and relative financial condition of each hospital, and the willingness of each hospital to engage in the merger.

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Joint Ventures

The Council would propose that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws to permit two hospitals in the same community, in a limited case, to enter into a joint venture for the provision of hospital services at one facility and health-related services (such as long-term care or outpatient care) at the other hospital facility. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rates and relative financial condition of each hospital, the types of services to be provided by the joint venture, and whether the new services to be provided meet an unmet need in the community.

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FACILITATING THE DISSEMINATION AND USE BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND MEDICAL PRACTICE GUIDELINES

The Problem

The Department of Health and Human Services, through the Agency for Health Care Policy and Research, is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. They would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

While there is a wealth of scientific information available to physicians to assist them in making professional judgments, mechanisms need to be developed to train physicians, during their undergraduate educations, to have the substantive background and skill level to enable them to use, and be comfortable in using, effectiveness research results and medical practice guidelines as an integral and regular part of their practice. Also, since there are, and will continue to be, more information and guidelines available to assist physicians in residency and practice, continuing medical education courses and new technologies need to be developed to enable residents and practicing physicians to use this information and apply it in the cases of specific patients.

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In the educational courses proposed below, emphasis would be placed on assisting the medical profession to reach consensus on different sets of guidelines and on methods of dissemination of the information.

The Proposals

Enhancement of Medical Education

The Council recommends three proposals to facilitate the dissemination to, and use by, students, residents, and physicians of effectiveness research and medical practice guidelines. One proposal is directed at undergraduate medical education; the second is directed at continuing education for physicians; and the third is directed at new technologies to assist graduate medical education and physician practice.

Undergraduate Medical Education Course in Subjects Relating to Effectiveness Research

Model Curriculum. The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curriculum and materials for a course to be given to fourth-year medical students. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give students a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines in order that, as practicing physicians, they would have the skills to use the scientific information available to them and appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies. The Secretary would work with medical schools, medical societies, and professional associations in developing the model curriculum and to ensure

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that the curricula and materials are incorporated by medical schools around the country.

Continuing Medical Education

Model Curriculum. The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curriculum and materials for a continuing medical education course for practicing physicians. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give practicing physicians a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines and to provide them with the skills needed to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies. The Secretary would work with hospitals, medical schools, medical societies, and professional associations in developing the model continuing medical education course and to ensure that the curricula and materials are made widely available around the country.

Technologies to Train Residents and Assist Practicing Physicians

Development of Computer-Assisted Models. The Council would recommend that a grant program be established at HHS to support the development of computer-assisted models to enable residents and practicing physicians to have access to the vast range of textbooks, literature, effectiveness research results, and practice guidelines developed by public and private research institutions, medical societies, and the public. The models would contain teaching units that would help physicians determine the most efficient and effective methods of diagnosis, treatment, and management of patients

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presenting different symptoms and would help to minimize unnecessary tests, treatments, and associated costs.

Use in Residency Programs. DHHS would work with residency programs across the United States to encourage the incorporation of computer-assisted models in residency training. The purpose of this would be twofold: to expand the information and practice guideline base available to residents during their training in addition to that provided by residency program faculty and to encourage graduates of residency programs to use these computer-assisted models when they enter practice.

Study and Evaluation

The Secretary of Health and Human Services would commission a broad-ranging, long-term study of medical education in order to:

- develop and recommend additional means of enhancing medical education so as to improve the ability of physicians to incorporate information on the outcome of medical procedures into their own treatment modalities and

- undertake longitudinal studies to evaluate the effectiveness of the training proposed above in improving the quality of medical care provided by physicians who have received it.

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MERGING MEDICARE PARTS A AND B

The Issue

When Medicare was established in 1965, the hospital played the critical role in the provision of health care services. Most procedures and tests were performed in the hospital, and patients recuperated there until they were ready to be sent home. Because of the central role of the hospital in 1965, Medicare Part A was established as a hospital insurance program. Part B was established as a voluntary supplemental insurance program, and each part had its own funding sources.

Several factors have occurred since 1965 which reduce the need for the separation of the two parts of the program. Many types of procedures once provided in the hospital are now provided in outpatient settings, and many services incident to a hospital stay (such as preadmission testing) are now performed on an outpatient basis.

Furthermore, the percentage of Medicare expenses for Part A has been steadily decreasing, while expenses for Part B have been increasing. The separation between the Part A trust fund and the premiums and general revenues for Part B inhibits evaluation of total program expenditures and goals.

The distinction between Parts A and B is becoming less important to consumers of services. Also, HCFA is increasing its capacity for integrating Part A and B files so that it can study overall use of health care services. It is time to consider whether administrative efficiencies, both for the program and consumers, can be achieved by the merging of Parts A and B.

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The Proposal

The Advisory Council recommends that the Medicare law be amended to combine the administration of Parts A and B into one program. Eligibility and financing would not change. The three separate funding sources—payroll taxes, general revenues, and premiums for Part B would remain, and a method would be developed by HCFA to maintain the integrity of the relative share of program costs for purposes of determining the part B premium.

Combining Parts A and B has several advantages. The Medicare program would be viewed as a single unified program with common administrative and management goals. The impact of program expenditures could be evaluated and analyzed in terms of their total impact on the economy, and a unified portrayal of the long-range obligations of the program could be accomplished. Administrative efficiencies would result in savings for the program and easier interaction with the program for beneficiaries.

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Appendix C: Cost Estimates

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Estimates of Savings and Costs To the Federal Government of Selected Health Care System Reform Proposals and Demonstration Projects

December 17, 1991

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Preface

This paper contains estimates of twenty six proposals for reform of the health care system and demonstrations made by the Advisory Council on Social Security. The estimates are organized into:

- A statement of the proposal,
- The basis of the estimate and key assumptions, and
- The estimate itself.

Unless otherwise noted, the estimates are calibrated to the Congressional Budget Office (CBO) August 1991 baseline.

It is important to note that the proposals have been estimated as a package. Removal or modification of a proposal can cause the cost or savings from other proposals to increase or decrease. For example, eliminating the infant mortality proposal would increase the cost of the school-based clinic proposal.

Coordination of Estimates and Council Proposals

The descriptions of the Advisory Council's proposals are not precisely the same as those contained in the final report of the Council printed elsewhere. The press of printing and other deadlines prevented precise coordination of detailed proposal descriptions between this report and the main Council report. However, the estimates contained in this report are, to the best information available to the author, essentially the same from a cost estimator's point of view, to those contained in the Council's final report.

Acknowledgements

The author is indebted to the numerous persons who provided information used in the preparation of the estimates and the assistance of Advisory Council staff. Without their assistance and the editorial and secretarial support of Ms. Elizabeth Salomon, this report would not have been possible.

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SUMMARY TABLE OF COSTS AND SAVINGS ASSOCIATED WITH REFORM AND DEMONSTRATION PROPOSALS

Numbers in millions of Dollars By Fiscal Year

		1993	1994	1995	TOTAL
A.	**PROPOSALS TO INCREASE THE ROLE OF SCHOOLS IN THE HEALTH CARE SYSTEM**				
	1. A PROPOSAL TO ASSIST STATE DEPARTMENT OF HEALTH TO ESTABLISH SCHOOL-BASED HEALTH CLINICS TO PROVIDE PRIMARY HEALTH CARE	681	1423	1453	3557
	2. A PROPOSAL TO ASSIST THE STATES TO PROVIDE SCHOOL-BASED MAJOR MEDICAL INSURANCE	50	500	500	1050
	3. A PROPOSAL TO DEVELOP MODEL SECONDARY-SCHOOL COURSE UNITS FOR THE TEACHING OF FAMILY FINANCIAL MANAGEMENT AND LONG-TERM PLANNING	1.5	1.5	.5	3.5
	4. A PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT FOR PRESCHOOL CHILDREN	0	0	0	0
B.	**PROPOSALS TO REFORM THE HEALTH CARE SYSTEM**				
	5. THE MEDICAL DIRECTIVE AND PROXY ACT	0	0	0	0
	6. RESEARCH TO FOSTER INDEPENDENT LIVING	5	109	110	224
	7. FACILITATING THE DISSEMINATION AND USE BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND MEDICAL PRACTICE GUIDELINES	5	3	2	10

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		1993	1994	1995	TOTA
8.	ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS	10	35	-330	-285
9.	INCREASING ACCESS TO PRIMARY CARE	210	400	390	1000
10.	A PROPOSAL TO REDUCE INFANT MORTALITY	124	370	470	964
11.	A PROPOSAL TO PROMOTE EMPLOYER-BASED HEALTH INSURANCE	0	0	0	0
12.	HEALTH INSURANCE FOR THE SELF-EMPLOYED	0	0	0	0
C.	PROPOSALS TO INCREASE THE EFFICIENCY OF MEDICARE				
13.	A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS	1	1	50	52
14.	HOSPITAL MERGERS AND JOINT VENTURES	0	0	0	0
15.	A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE	0	-5	-10	-15
16.	A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH USE OF SELECTIVE CONTRACTING[1]	0	-60	-170	-230
17.	MERGING MEDICARE PARTS A AND B	0	0	0	0
D.	TASK FORCE AND OTHER INITIATIVES				
18.	TASK FORCE ON INVESTMENT IN HUMAN RESOURCES	0	0	0	0
19.	PROMOTING HEALTHY LIFESTYLES THROUGH THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS	.2	.2	.3	.7

[1] This is a conservative estimate. Depending on Secretari actions, this proposal could save $640 million over the thr years. See write up for detail.

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		1993	1994	1995	TOTAL
20.	POOLING OF DATA AND TECHNOLOGY ASSESSMENT	0	0	0	0
21.	ESTABLISH PRESIDENTS COUNCIL ON FITNESS FOR THE SECOND FIFTY YEARS	2	5	5	12
22.	DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES	0	0	0	0
23.	PUBLIC EDUCATION CAMPAIGN ON PREVENTION	10	20	20	50
	SUBTOTAL REFORMS[2]	1100	2803	2491	6393
E.	MEDICAID DEMONSTRATIONS				
IMPROVING ACCESS TO MEDICAID SERVICES		203	403	403	1009
OUTREACH DEMONSTRATIONS		203	403	403	1009
INCREASING MEDICAID COVERAGE OF UNINSURED		103	203	203	509
	SUBTOTAL MEDICAID DEMONSTRATIONS	509	1009	1009	2527
F.	PROTOTYPE COMPREHENSIVE REFORM DEMONSTRATIONS[3]				
PROTOTYPE COMPREHENSIVE DEMONSTRATIONS		500	3000	3000	6500
	SUBTOTAL COMPREHENSIVE DEMONSTRATIONS	500	3000	3000	6500
	GRAND TOTAL	2109	6812	6500	15421

[2] Totals may not add due to rounding.

[3] descriptions of these demonstrations can be found in the Council's main report. The cost of these demonstrations was determined by the Council and is included here for convenience only.

87764016

PROPOSAL 1
A PROPOSAL TO ASSIST STATE DEPARTMENTS OF HEALTH
TO ESTABLISH SCHOOL-BASED HEALTH CLINICS
TO PROVIDE PRIMARY HEALTH CARE

The Proposal

It is proposed to support the establishment of a nationwide system of health clinics located primarily in or adjacent to elementary schools of the state. State departments of health would operate the clinics--directly or through arrangements with health care providers--so as to offer wider and more regular access to primary health and dental care, including routine and preventive services, for all children of elementary-school age, and for pre-schoolers.

The programs will not, themselves, provide for health care services. These would be paid for from multiple sources: services provided to children from Medicaid-eligible families would be paid for by Medicaid (including the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program); services provided to children eligible for such services from other programs, for example the Maternal and Child Health Block Grant or the State General Medical Assistance Program, would be paid for by those programs; and services to children from families not entitled to public or medical assistance would be paid for by those families or their insurers except for the subsidy program. Like the school lunch program, the source of payment for any child will not be evident to other participants in the program.

The program would incorporate features of managed care. A health care provider, selected under competitive bidding procedures, would deliver services to federal beneficiaries on a per capita basis, and would, at a minimum, pay for a substantial portion of a child's hospital costs.

Elements of the Proposal

A. Federal-State Program. A "School-Based Clinic Act" would be proposed as a federal formula grant program: (1) administered by the Secretary of Health and Human Services, to reimburse states, in the manner described below, for a portion of their administrative expenditures in establishing and operating health clinics in public elementary schools of the state, or in locations reasonably adjacent to public or private elementary schools within the state.

B. Services Provided. A clinic established under the Act would be required to make available to children of elementary school age, and children of pre-school age, the following services:

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1. Preventive health care services, including immunizations, periodic well-child visits, and hearing and vision testing.

2. Primary health care.

3. Dental care.

C. Eligibility for Services. Any child of pre-school or elementary school age would be eligible to receive services at a clinic.

D. Provision of Services. Services may be provided by health care practitioners employed by the state Department of Health (the "Department"), or engaged under contract (but see G, below). Insofar as practicable, considering the location of the clinic and the patient population, the Department would endeavor to provide a physician who would be on duty at the clinic for all or part of each school day or alternate day, depending upon the number of children to be serviced.

E. Payment for Services.

1. Medicaid Eligibles. In the case of services to a child from a Medicaid-eligible family, Medicaid (including EPSDT) would pay for the services.

2. Others. In the case of services to other children, payment may be on such basis as the state (in the case of a state-operated school) or local educational agency may provide. A participant in the program would not be aware of the source of payment for other participants.

F. Location of Clinic. It is the objective of the program to encourage the establishment of a school-based clinic easily accessible to every child of elementary school age.

1. Public Elementary Schools. Insofar as practicable, the Department would be required to establish a clinic on-site in existing public elementary school space.

2. Other Locations. Where existing public elementary school space is inadequate, and it is necessary to establish a clinic to make health care services readily accessible to students at that school, the Department may establish the clinic in commercial or other space.

3. Private School. Clinics must be established to provide services to children attending private elementary schools.

G. Management of Clinic. The Department would operate each clinic directly or through arrangements with providers. However, where considerations of economy and efficiency dictate, the Department could contract for outside management services. In such case the Department would be required to follow these procedures:

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1. Quality Assurance. Each provider would be required, as a condition of the contract with the Department, to undertake to perform services for contract beneficiaries of the same quantity and quality provided to the provider's other patients. A failure to perform would be a breach of contract that would make the provider liable for appropriate liquidated damages established under the contract (subject to the Secretary's regulations), and termination of the contract.

H. Administration

1. Matching Rate. The federal matching rate under the program would be 75 percent and 25 percent state. Funds would be allocated among the states on the basis of elementary-school-aged population in each state, as estimated in advance of each program year by the Bureau of the Census. In addition, the federal government would provide a $600 million annual subsidy for health care in the clinics extended to non-medicaid eligibles subject to sliding scale fee payments. Funds would be allocated among the states on the basis of elementary-school-age population in each state, as estimated in advance of each program year by the Bureau of the Census.

2. Payment of Funds. The state would administer the funds through the Department.

3. Use of Program Funds. The Department could use program funds for the following activities:

a. Remodeling and Renovation. Remodeling or renovating existing public schools' facilities or other space so as to create a site suitable for the provision of health care services.

b. State Administrative Expenses. Department administrative expenses required to establish and inspect regularly the clinics.

c. Equipment. Purchase or rental of medical equipment reasonably necessary to provide the health care services described in III.B, above.

d. Furnishings. Necessary furnishings of the clinic, exclusive of medical equipment.

I. Use of Child Support Enforcement System. The child support enforcement provisions of the Social Security Act would be amended to clarify the authority of the courts to include, in a child support order, a requirement for the payment of the premiums to enable a child to enroll in the insurance program offered under the preceding paragraph.

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Basis of Estimate and Key Assumptions

From a cost estimator's viewpoint, this proposal has two dimensions. First, there are certain overall and timing assumptions that must be made in order to price all components of the proposal. And secondly, the proposal requires several separate but interrelated estimates. It should be noted that this proposal has been estimated as part of the Advisory Council's overall package. If this proposal is implemented without the rest of the package it is more expensive than is estimated below.

Overall Assumption

First, this proposal has been priced as part of a package of proposals. Should certain other proposals be modified or deleted the costs of this proposal might increase or decrease.

A second key assumption of this estimate is that the programs would be self-funding as specified in the proposal. Specifically, this estimate assumes that once a program is established in a particular school district, the rates charged to "clients" would approximate the costs of running the program. Obviously, some school districts will "lose" money on the program and some will "make" money on the clinics.

Timing Assumptions

This estimate assumes that the Secretary of Health and Human Services(HHS) will design and implement the program in FY 1993. This is obviously an optimistic assumption. This assumption is being made so that readers may have some estimate of the costs of implementing this proposal. In reality, should this proposal become law, it would be several years before the costs and savings from such a proposal would be realized.

Individual Estimates

From a cost estimators viewpoint this proposal is five separate but interrelated estimates. Each estimate is discussed below.

Start-Up Costs

The program will require elementary schools to have (1) a room in which health services can be delivered and (2) sufficient equipment and furnishings in that room to deliver the services. However, the proposal also allows school systems to make arrangements to deliver the services in an area adjacent to the school.

Extensive discussion with school system personnel, representatives of national educational and health organizations indicated that almost all elementary schools currently have a space, usually a room, dedicated to health. This is primarily due to state and federal accreditation

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requirements. In some instances, this space/room is currently being used for other purposes. As one respondent indicated, "The program might make allot of schools have to find another place to put the xerox machine. In the small number of schools who do not have adequate space, some of the school systems in which they are located will have existing full time school maintenance personnel that can remodel the will be capable of altering existing space to make it suitable for the program. Hence, the estimate assumes that less than five percent of all elementary schools will require remodeling or renovation for this new program. Based on discussions with school system personnel in charge of such projects, this should average approximately $10,000 per school.

Discussions with a wide spectrum of school health personnel yielded a finding for the equipment and furnishings similar to that for remodeling. The vast majority of schools already have simple medical equipment necessary to deliver the care. However, most respondents indicated that the number of schools needing new equipment or to add to existing equipment would be higher than the number of school that would require remodeling. Hence, the estimate assumes that 10 percent of schools will require a complete new package of medical equipment and an additional 15 percent of school will be required to purchase at least some new equipment. Based on conversations with member companies of the Health Industry Dealers Association (HIDA), it appears that the average cost of a new equipment package is approximately $1500. It was assumed that a school in need of a partial package would spend $500.

It should ne noted that since the remodeling and equipment purchase will be borne by the federal government, it can be expected that school systems and states will be somewhat aggressive in claiming these funds. This estimate assumes that the federal government will secede in identifying schools that really need such remodeling and supplies.

State Administrative Expenses

State activities will include oversight and certification of the program. Based on similar activities now being conducted by state educational agencies, it would appear that approximately one million dollars per year will be adequate for an average state (plus the District of Columbia). An additional $2 million per year will be needed the federal level for program oversight. This means that the program will require $53 million per year for program administration.

Increased Services to Medicaid Beneficiaries

The school clinic program will have two effects on the Medicaid program.

More Services to Existing Beneficiaries

First, it will increase services to existing Medicaid eligibles. Specifically, the clinics will identify and refer for treatment children who are currently on Medicaid for treatment of

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conditions that would have previously gone untreated. It will also increase the proportion of children who actually receive EPSDT services.

It is clear that data on the magnitude of these effects is not available. However, conversations with staff of the existing Florida, New York and California school based clinic programs yielded relatively uniform opinions that approximately 15 percent of Medicaid children seen by the clinics would need at least one additional service and that the clinics would increase the current EPSDT completion rate by a 20 percent. Using current per capita's as reported to HCFA by the states this result in $510 million in additional new services to existing Medicaid beneficiaries by 1995.

Costs of Services to New Medicaid Beneficiaries

The second effect that the school based clinic program will have on Medicaid is that it will increase the number of children with Medicaid coverage. Specifically, children and their families who are Medicaid eligible will be identities through the clinics attempt to assist families in gaining access to needed health care services. Staff in existing school based clinic programs reported this ass a significant consequence of the programs activities. Based on conversations with these staff and the limited data available on the number of persons eligible but not currently enrolled on Medicaid program, it would appear that approximately 420,000 new children and adults will be enrolled on the Medicaid program as a consequence of this proposal.

Subsidy of Nearly Poor Children

The proposal calls for a $600 million per year appropriation to subsidize the cost of the school based program for nearly poor children not eligible for Medicaid. This amount is assumed to be 100 percent expended within the fiscal year as Medicaid is an appropriated entitlement.

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Estimate

Table 1

COSTS OF A PROPOSAL TO ASSIST STATE DEPARTMENTS OF HEALTH TO ESTABLISH SCHOOL-BASED HEALTH CLINICS TO PROVIDE PRIMARY HEALTH CARE
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
A. Start-Up Costs				
Remodeling and Renovation	75	30	0	105
Equipment and Furnishings	60	30	0	90
B. Ongoing Administration				
State Administrative Expenses	26	53	53	132
C. Increase in Services to Medicaid Beneficiaries				
Costs of Providing More Services For Existing Medicaid Beneficiaries	290	460	510	1260
Costs of Providing Services to Previously Unserved Medicaid Eligibles	130	250	290	670
D. Subsidy of Nearly Poor Children	100	600	600	1300
Total	681	1423	1453	3557

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PROPOSAL 2
A PROPOSAL TO ASSIST THE STATES TO PROVIDE
SCHOOL-BASED MAJOR MEDICAL INSURANCE

THE PROPOSAL

The school system is an ideal locus for assisting parents to meet the major health needs of children through the purchase of economical group policies of major medical insurance negotiated by the school system.

A program is proposed to assist the states, through their school districts, to offer a voluntary supplemental low-cost insurance product, limited to paying the costs of major medical expenses, to all pre-school and elementary school children registered at schools of the state. The insurance would remain available until a participant attained age 22, regardless of whether the participant remained in school.

The federal government would reimburse the states, within an annual aggregate federal program cost of $500 million, for 75 percent of their expenses in providing subsidized insurance to students from families with family incomes up to 185 of poverty.

A state that participated in the proposed school-based clinics program would also be reimbursed, under both programs, for its annually program administrative expenses.

Basis of Estimate and Key Assumptions

The proposal calls for a $500 million per year appropriation to subsidize the insurance of nearly poor children through age 22 who are not eligible for Medicaid. The estimate assumes that it would be 100 percent expended within the fiscal year.

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Estimate

Table 2
ESTIMATE OF THE COST OF
A PROPOSAL TO ASSIST THE STATES TO PROVIDE
SCHOOL-BASED MAJOR MEDICAL INSURANCE
Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts	50	500	500	1050

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PROPOSAL 3
A PROPOSAL TO DEVELOP MODEL SECONDARY-SCHOOL COURSE UNITS FOR THE TEACHING OF FAMILY FINANCIAL MANAGEMENT AND LONG-TERM PLANNING

The Proposal

Model Curricula and Materials

The Secretary of Health and Human Services, in conjunction with the Secretary of Education, would develop and disseminate to states model secondary-school course units and materials for teaching family financial management and long-term planning to meet major expenses, such as those associated with:

1. health care, including major medical expenses;
2. education;
3. purchase of a home;
4. child care;
5. vacations;
6. unemployment; and
7. retirement.

Course units would include elements on credit card management, checking account management, the availability of pertinent federal and state programs (e.g., federal student loan guaranties, state unemployment insurance benefits), and tax planning (e.g., IRA and Keogh plans).

The course units would also contrast the American social welfare system with those of other countries, in order to provide the student with some historical perspective.

B. Suggested Course Unit Content. The course units could be designed to cover the following topics:

1. Retirement Planning. A unit on retirement planning could cover these topics:

a. Determination of Income Needs. How to determine the amount of income an individual would need to support the individual's needs at retirement; how to plan savings or other investments to meet those needs and how to plan for a retirement dependent upon multiple income sources, such as social security, pension plans, and savings.

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b. Social Security. The purpose of social security as a supplement to retirement savings; the eligibility rules for social security and the level of benefits an individual would expect to receive under social security based on the number of years worked and income levels.

c. Pension Plans. The types of pension plans offered by private employers; how to evaluate plans and compute benefits and the impact of changing jobs during ones lifetime on the vesting of retirement plans.

d. Savings. The types of other private financial products, such as IRAs and annuities, available to individuals to enable them to meet their retirement income needs and how to evaluate and make decisions about these types of products.

2. Health Care Expense Planning. A unit on planning for health care expenses could cover these topics:

a. Health Care Expense Education. The types of health care expenditures that an individual may incur during his or her lifetime, including expenses for primary and preventive care, hospital care, physician care, long-term care, prenatal and well-baby care, prescription drugs, and other types of care.

b. Availability and Roles of Health Insurance. The types of health insurance available in the U.S., including employer-based insurance, individually purchased coverage and coverage from groups such as teachers.

Basis of Estimate and Key Assumptions

Staff in the Office of Management and Budget within the Department of Education indicated that their Department has implemented numerous similar mandates over the last ten years. They indicated that it would cost approximately $3 million for the development over a two-year period and then approximately $500,000 per year for continued dissemination and updating of the materials.

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Estimate

Table 3

ESTIMATE OF THE COST OF
A PROPOSAL TO DEVELOP MODEL SECONDARY SCHOOL COURSE
UNITS FOR THE TEACHING OF FAMILY FINANCIAL
MANAGEMENT AND LONG-TERM PLANNING
Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts	1.5	1.5	.5	3.5

8776027

PROPOSAL 4
A PROPOSAL TO PROVIDE DRUG AND ALCOHOL ABUSE PREVENTION, EDUCATION, AND TREATMENT FOR PRESCHOOL CHILDREN

The Proposal

The Council recommends that the Surgeon General develop a program to provide prevention, education, and where appropriate, treatment, for alcohol abuse and drug abuse affecting preschool children. The program should include the development of educational materials that parents and teachers can use to teach preschool children to avoid alcohol and drug abuse, efforts to encourage producers of children's television programming to include anti-alcohol and drug abuse themes and messages in children programs, public service announcements and other public education campaigns directed specifically at children.

In addition, the Council recommends that school based health centers include programs such as Ala-Tot for preschool children in the services offered at these centers, and make referrals for alcohol and drug abuse treatment for parents of preschool and school-aged children.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

Estimate

Table 4

DRUG AND ALCOHOL PREVENTION FOR PRESCHOOL CHILDREN:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

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PROPOSAL 5
THE MEDICAL DIRECTIVE AND PROXY ACT

The Proposal

The Council recommends;

A. Establishment of Registry: The Secretary of Health and Human Services (HHS) would be directed to establish a Registry for the purpose of developing and disseminating a Medical Directive and Proxy Designation form, registering an official copy of each executed form, and providing certified copies of the form to appropriate physicians and other licensed health care providers.

B. Location in HCFA Form: The Registry would be located, organizationally, within HHS.

1. Development of Form: The Registry would develop, within four months after its establishment, and after consultation with interested individuals and organizations, a Medical Directive and Proxy Designation form that meets the requirements outlined elsewhere.

2. Notification of Physicians and Medicare Eligibles: Upon completion of the form, the Registry would take the necessary steps--

a. to inform primary care physicians of the availability of the form, who may execute it, and of the responsibility of the physicians toward a patient who elects to execute it; and

b. to inform all Medicare eligibles of the nature of the form, and how it may be executed.

HCFA would maintain the registry and a toll free telephone line for hospital and beneficiary access to the data.

3. Payment of Fee: HCFA may establish a fee to defray its administrative costs in operating the Registry. The Registry would refuse to file an MD&PD unless accompanied by the prescribed fee. Physicians who assist the elderly would be paid some fee for assisting them to be determined by the Secretary.

4. Notification of Physicians and Medicare Eligibles: Upon completion of the form, the Registry would take the necessary steps--

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a. to inform primary care physicians of the availability of the form, and who may execute it,

b. to inform all Medicare eligibles of the nature of the form, and how it may be executed, and

c. to conduct outreach activities through public and private organizations, agencies, and institutions, to inform the public about the form.

Thereafter, the Registry would inform individuals of the form, and how it may be executed, upon their first becoming eligible for medicare.

Basis of Estimate and Key Assumptions

This proposal would increase administrative costs of the program by (1) the development and information requirements of the bill and (2) increased ongoing operating cost for maintaining the Registry and toll free telephone line. Based on the costs of similar registries and lines operated by HHS and the Department, it would appear that the Registry would cost approximately $2 million per year. However, since the Secretary and/or the states may recover these costs by a user fee, this provision would have no budget impact even if states expand it to cover non-Medicare citizens by charging them a user fee. It was not possible to estimate tyhe cost of the physician fee for assisting the elderly in completion of the form since Secretartial discretion is indicated in ther proposal.

This proposal would also save Medicare money through reduced lengths of stays. A shorter stay results in reduced costs for physician visits under Part B. This estimator was unable to locate any data on the number of life-sustaining situations encountered by the elderly. Hence, no estimate of savings to Part B was possible. However, the fact that this proposal would save Medicare, and to some extent other federal programs, is not questionable in the opinion of this estimator.

Estimate

Table 5

ESTIMATE OF COSTS OF MEDICAL DIRECTIVE AND PROXY ACT:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Costs of Development and Administration of Registry	0	0	0	0

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PROPOSAL 6
RESEARCH TO FOSTER INDEPENDENT LIVING

The Proposal

The Advisory Council recommends the establishment of a Center for Fostering Independent Living, and the funding of research oriented toward increasing independent living in America's elderly population. Specifically, the Council propose:

A. Establishment of a Center. The proposal would expand the focus of the National Institute on Aging by establishing within it a Center for Fostering Independent Living. The Director of the Center would report directly to the NIA director.

B. Mission in General. The Center would conduct and support applied research into means, social and scientific, to foster independent living among persons suffering an impairment in their ability to perform activities of daily living. Given its organizational placement, the Center would have ready access to the scientific findings of NIA as well as the other NIH institutes.

C. Functional Assessment and Evaluation of Therapies. The Center would encourage the development of improved methods of assessing the ability of impaired individuals to function in a non-institutional setting, and would undertake an evaluation of the effectiveness of existing rehabilitative therapies.

D. Alleviation of Disabling Conditions. Continuing technological advances provide a means for dealing with the disabilities often associated with aging and which frequently lead to the need for long-term care. The Center, in cooperation and consultation with the Food and Drug Administration, would support the development and availability of drugs and devices such as those to:

1. eliminate falls or reduce their effect;

2. alleviate severe hearing or vision losses;

3. treat or correct urinary incontinence;

4. aid memory so as to combat wandering behavior and other severe consequences of memory deficits, and

5. compensate for losses in mobility.

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E. Living Arrangements. The Center would:

1. survey various living arrangements that would permit an individual employing them to live independently,

2. develop or support ways to optimize those living arrangements, and

3. conduct, or support the conduct of, one or more demonstrations of various living arrangements (except that no such demonstration may subsidize the living arrangements or care of any individual).

F. Guide to Independent Living. The Center would publish a Guide to Independent Living. The Guide would be widely distributed to the elderly, and would provide them with information of medical and technological developments, home- and community-based services, and improved living arrangements, pertinent to aiding them, particularly the impaired elderly, to remain within the community.

G. Technical Assistance. The Center would be authorized to provide technical assistance to states and local communities, and nonprofit organizations, in the development or implementation of improved arrangements to enable the elderly, particularly the impaired elderly, to live independently.

Basis of the Estimate and Key Assumptions

The costs of this proposal to the federal government would accrue in two ways: first, the costs of administering the program and maintaining the staff and overhead of the Center for Fostering Independent Research, and secondly, the costs of the research grants themselves. The costs of administering the program were developed by examination of the costs of operation of the current centers within the National Institute on Aging. Based on the size of existing NIA staffs relative to their grant and other responsibilities, it would appear that the new Center would need approximately 10 staff members to plan for, award, and monitor the research grants. An additional four staff members and a director would appear necessary to administer the center and carry out other functions. Based on current and projected NIA staff and administrative costs this would result in $9 million in costs for the Center in the first full year of operation, FY 1994. The research grants could be as large or as small as available funds. The $100 million per year level estimated below represents this estimator's opinion of the minimum level of funding suggested by the Center's mandate.

Technical Notes Concerning the Estimate

The estimate assumes that grants would be awarded in the second year of the Center's operation. Some experience of other new federal grant programs suggests that it takes several years to develop a specific research agenda and implement a new program.

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Estimate

Table 6

ESTIMATE OF COSTS OF RESEARCH TO
FOSTER INDEPENDENT LIVING:
Numbers in Millions of Dollars by Fiscal Year

Appropriated Amounts	1993	1994	1995	Total
1. Costs of Center for Fostering Independent Care Administration	5	9	10	24
2. Research Grants	0	100	100	200
Total	5	109	110	224

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PROPOSAL 7
FACILITATING THE DISSEMINATION AND USE BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND MEDICAL PRACTICE GUIDELINES

The Proposals

The Council would recommend three proposals to facilitate the dissemination to, and use by, medical students, residents, and physicians of effectiveness research and medical practice guidelines. One proposal is directed at undergraduate medical education; the second is directed at continuing education for physicians, and the third is directed at new technologies to assist graduate medical education and physician practice.

Undergraduate Medical Education Course in Subjects Relating to Effectiveness Research

Model Curricula The Secretary of HHS, through the Agency for Health Policy and Research, would develop a model curricula and materials for a course to be given to fourth-year medical students. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give students a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines, in order to give them the skills as practicing physicians to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies The Secretary would work with medical schools, medical societies, and professional associations in developing the model curricula and to ensure that the curricula and materials are incorporated by medical schools around the country.

Continuing Medical Education

Model Curricula The Secretary of HHS, through the Agency for Health Policy and Research, would develop model curricula and materials for a continuing medical education course for practicing physicians. The course would include training in epidemiology, biostatistics, research methodology, and technology. The purpose of the course would be to give practicing physicians a thorough grounding in subjects which are the foundation of effectiveness research and the development of practice guidelines, providing them with the skills needed to use the scientific information available to them and to appreciate the value of guidelines as a tool for patient diagnosis, treatment, and management.

Cooperation with Academic Institutions and Professional Societies The Secretary would work with hospitals, medical schools, medical societies, and professional associations in

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developing the model continuing medical education course and to ensure that the curricula and materials are made widely available around the country.

Technologies to Train Residents and Assist Practicing Physicians

Development of Computer-Assisted Models The Council would recommend that a grant program be established at HHS to support the development of computer-assisted models, enabling residents and practicing physicians to have access to the vast range of textbooks, literature, effectiveness research results, and practice guidelines developed by public and private research institutions, medical societies, and the public. The models would contain teaching units to help physicians: determine the most efficient and effective methods of diagnosis, treatment, and management of patients presenting different symptoms, and minimize unnecessary tests, treatments, and associated costs.

Use in Residency Programs HHS would work with residency programs across the United States to encourage the incorporation of computer-assisted models in residency training. The purpose of this would be twofold: to expand the information and practice guideline base available to residents during their training, in addition to that provided by residency program faculty, and to encourage graduates of residency programs to use these computer- assisted models when they enter practice.

Basis of Estimate and Key Assumptions

The American Association of Medical Colleges (AAMC) staff and members were a major source of information for this estimate. Based on their experience, the development and dissemination of model curricula would be approximately $2 million dollars in the first two years and approximately $1 million per year thereafter to update and disseminate. The computer model was very difficult for them to estimate given that very few of this type of model have been developed. Contracts with two firms that develop such models in the general education area, indicated the amount of effort and dollars to produce such a model could be anywhere from "a little to a lot". Based on these conversations, this estimator selected $3 million in the first year and $1 million thereafter. Such models could cost more or less.

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Estimate

Table 7

COSTS OF FACILITATING THE DISSEMINATION AND USE
BY PHYSICIANS OF EFFECTIVENESS RESEARCH AND
MEDICAL PRACTICE GUIDELINES
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts				
1. Model Curricula Development	2	2	1	5
2. Computer Models	3	1	1	5
Total	5	3	2	10

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PROPOSAL 8
ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS

The Proposal

The Advisory Council proposes a significant reform of malpractice procedures for Medicare beneficiaries. In general, the proposal removes the malpractice award process from the judiciary system into a new executive branch administrative structure. The proposal also limits the amount of the awards and attorney fees.

A. Administrative Structure. The administrative structure would be as follows:

1. Office of Malpractice Adjudication. The Act would establish, within the Department of Health and Human Services, an Office of Malpractice Adjudication (the "Office"). The Director of the Office would report to the Secretary or the Secretary's appointee.

2. Administrative Tribunal. Each malpractice claim would be heard by an administrative tribunal consisting of a presiding officer, who would be an administrative law judge meeting the qualifications for hearing examiners established by the Administrative Procedure Act, and two individuals determined by the Secretary to be expert in the field of health care or health care management. A decision of the tribunal would be by majority vote. Panels of the tribunal would be located in major population centers throughout the United States for the purpose of hearing malpractice claims against health professionals, and other health care providers, who provide health care wholly or partially paid for by a federal program.

3. Administrative Appeal. A party would be entitled to appeal a final determination of a tribunal to an administrative appeal council, a panel of which would be established within each region of the Department. The panel would be required to accept the tribunal's findings of fact, unless arbitrary, capricious, or unreasonable. The appeals council would be obligated to hear and decide the appeal within four months after the tribunal's decision.

4. Appeal to United States Court of Appeal. The judgment of the appeals council could be appealed, on matters of law, to the United States Court of Appeal for the circuit within which the malpractice claim arose. The court would be without jurisdiction to reexamine findings of fact affirmed on administrative appeal, although it could remand the case to the agency with instructions to find additional facts. The court would be required to affirm the judgment of the appeals council unless it were found to be arbitrary, capricious, or unreasonable.

B. Judgments. Judgements rendered by the system would be structured in the following ways:

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1. Economic Loss. A judgment for the claimant under the Act would be for the claimant's past, present, and future economic loss resulting from physical damage attributable to malpractice.

2. Collateral Source Reduction.

a. Amounts Not Deriving from a Federal Program. A judgment would be reduced by any insurance or other amount to which the claimant became entitled in compensation of illness or injury resulting from the claimed malpractice (except amounts deriving from a federal program).

b. Amounts Deriving from a Federal Program. A judgment would be reduced by one-half of any amount deriving from a federal program. In such case a supplementary judgment would be issued in favor of the United States for the balance of the payments. In the case of Medicare, this latter amount would, upon payment, be credited to the pertinent Medicare trust fund. In the case of a federal direct care program, the amount would be deposited in the general fund of the treasury. In the case of a federally assisted state program, the money would be divided, as appropriate, between the general fund of the treasury and the state.

3. Noneconomic Damages. Noneconomic damages, such as pain and suffering, would be limited to $2 million. Derivative damages, such as a wife's claim for pain and suffering, would be abolished.

4. Attorney's Fees. A judgement for the claimant would include an amount for attorney's fees, in accordance with a schedule established by regulator within a ceiling set by the statute. The proposed ceiling is 25 percent of the first $1 million, 15 percent of the next $200,000, and 10 percent of the remainder.

5. Costs of Proceeding. The tribunal could, in its discretion, assess either or all parties an amount, established by regulation and payable to the general fund of the Treasury, equivalent to all or part of the administrative costs of the proceeding.

6. Comparative Negligence. An award for the claimant would be reduced in proportion to the degree to which the tribunal found that the claimant's negligence had contributed to the injury.

7. Liability of Parties Defendant. If there are two or more parties defendant, they would not be jointly liable. A judgment against a party defendant would be limited to that party's proportionate share of the injury caused.

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8. Award for Future Economic Loss. An award for future economic loss would not require the payment within a calendar year of an amount that exceeded the loss anticipated for that year; but such award would not be subject to future adjustment.

9. Derivative Rights. No award could be made to any party based upon injury caused by malpractice in the medical treatment of some other person.

C. Exclusions. The Office would be without the power to adjudicate a malpractice claim alleging:

1. wrongful death, or

2. willful injury.

D. Exclusivity of Remedy. Except as otherwise provided by this Act, no court of any state, or of the United States, would have jurisdiction to adjudicate any claim arising from, or alleging, malpractice, if that claim were cognizable under this Act. In other words, the Act would be the exclusive avenue available to federal beneficiaries for pressing malpractice claims.

Model State Malpractice Act

Like the proposed federal act, the model state act would seek to restrain further growth in the cost of malpractice insurance, which has both inflated the cost of medical care and reduced the availability of health care in some medical specialties.

The proposal adopts an administrative alternative to the present system of tort liability. Administrative alternatives, either as a supplement to, or replacement of, the existing system have been proposed by the Health Care Provider Liability Reform bill, based on the 1987 report of the Department of Health and Human Services' Task Force on Medical Liability and Malpractice, the Ensuring Access Through Medical Liability Reform bill, introduced in the last Congress by Senator Hatch (S. 2934, 101st Cong.), the Medicare Malpractice Dispute Resolution bill of 1990, introduced in the last Congress by Mrs. Johnson of Connecticut. The American Medical Association's Medical Liability Project, in its January 1988 report entitled A" Fault-Based, Administrative System" also recommends adoption of an administrative model.

If a state adopts the Malpractice Adjudication Act before Congress enacts the Federal Beneficiary Malpractice Adjudication Act, the state statute would apply to all federal beneficiaries and health care professionals and other health care providers over whom the state has jurisdiction, until enactment of the federal act. If a state does not adopt the Malpractice Adjudication Act within five years after the Secretary promulgates it, and Congress has enacted the Federal Beneficiary Malpractice Adjudication Act, the federal act would be opened to all malpractice claims arising in the state, at the option of either party.

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Basis of Estimate and Key Assumptions

From a cost estimator's viewpoint, this proposal has two components: first, the additional costs associated with the administrative procedures put in place by the Act, and secondly, the savings that would accrue directly to Medicare, and indirectly to Medicaid and other federal programs from a reduction in malpractice awards caused by the Act.

The additional administrative costs were estimated from data on the costs of the administrative procedures currently in place for the disabilities determination process in the Social Security Administration. Based on that data and conversation with SSA budget staff, it would appear that approximately 800 additional federal staff would be required to administer the system. This would result in an additional cost of $50 million in FY 1995.

The savings from this proposal result from two sources. First, there would be a reduction in increases of Part A costs of due to a decrease in the DRG update factor. The DRG update factor is estimated annually by the Office of the Actuary in the Health Care Financing Administration (HCFA). As part of the calculation of the update factor, the estimated future cost of malpractice is estimated. Future Medicare Part A DRG update costs are therefore reduced by the degree to which future malpractice costs are reduced. It is absolutely clear that this proposal would decrease malpractice costs. Unfortunately, after an extensive effort to locate data on the distribution of malpractice claims by award amount, this estimator was unable to locate a reliable distribution upon which to base this estimate. Extensive anecdotal, local, and sporadic data exist to document that many malpractice awards exceed the limit contained in the proposal. However, reliable data on the dollar value of these awards could not be located. Given the fact that savings would occur but the unknown magnitude was, this estimator made the assumption that the HCFA actuaries would reduce their estimate of malpractice costs by 10 percent. This leads to savings of approximately $30 million in FY 1995.

The second source of savings from this proposal would be reductions in the "defensive medicine" behavior of physicians. A extensive literature exists on the costs to the health care system of defensive medicine. There is little doubt that this behavior exists and that it adds to the costs of federal health programs, such as Medicare. Unfortunately, estimates of the quantitative impact of the behavior are a small subset of the literature. This author reviewed over twenty such studies and contacted several of the authors. In spite of the wide range of estimates of savings found in the literature (from 5 percent to 25 percent of program costs), most experts and the literature agreed that the savings to the Medicare program would principally occur in two ways:

First, savings from an effective reduction in defensive medicine behavior by physicians would result in reduced laboratory tests under Part B. Interestingly, most experts said that these savings would be on the order of 5 percent to 15 percent, a much narrower range than

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that found in the literature. Based on all available evidence, this estimate assumes that laboratory tests ultimately would be reduced by 10 percent. It should be noted that these savings occur in both direct billings for laboratory procedures and indirect billings for office and clinic-based procedures under Part B.

Second, although the literature and the experts agreed that a considerable number of unnecessary tests and procedures are performed on Medicare beneficiaries in hospitals, savings to the federal government would primarily occur as a result of reduced admissions since Part A primarily reimburses on a per admission basis. Almost all experts agreed that hospitals would benefit extensively from a reduction in unnecessary admissions. How many unnecessary admissions would be avoided by an effective malpractice adjudication program? The literature and experts were in relative agreement that this would be less than 2 percent of all admissions. This estimate assumes that by the end of year three, approximately one-half of 1 percent of all admissions would be avoided.

A combination of the foregoing two factors results in a reduction of $330 million dollars in Medicare spending by FY 1995. This estimate can be criticized from several viewpoints. On the one hand, literature and expert opinion exists that could substantiate a much larger estimate of the effect of an effective malpractice reform package. On the other hand, this estimate can be criticized as optimistic over the ability of the federal government to implement a program successfully within three years and for physicians to alter their behavior in so short a period. Clearly, the estimate could be wrong on both counts. However, this estimator believes that on net, these two assumptions are reasonable.

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Estimate

Table 8

ESTIMATE OF COSTS ALTERNATIVE PROCEDURE TO ADJUDICATE MALPRACTICE CLAIMS:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays				
1. Costs of Administering Program[1]	10	40	50	100
2. Program Savings	0	5	-380	-375
Total	10	35	-330	-285

[1] Appropriated Amounts

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PROPOSAL 9
INCREASING ACCESS TO PRIMARY CARE

The Proposal

In order to improve access to primary care, the Council recommends that $250 million in new federal funding should be made available to establish 250 new community health centers, to be located in underserved areas or in areas with high concentrations of underserved target populations. The Secretary shall see that 20 of these new centers are targeted toward providing emergency care in areas without such services. An additional $290 million should then be provided in annual operating funds.

In other respects, the Council has concluded that the existing authorities of the Department of Health and Human Services, if properly employed and financed, are sufficient to address the problems described. It strongly recommends that the Secretary of Health and Human Services and the Assistant Secretary for Health instruct the National Health Service Corps to revise its priorities focusing more attention on demonstrated unmet need.

Specifically, NHSC should work within its authorities to increase the access of target populations to primary medical care, i.e., the urban and inner-city poor, especially infants and children; high-risk pregnant women; migrant workers and their families; drug and alcohol abusers, and the homeless. A $100 million grant for this purpose is proposed by the council.

The NHSC should encourage primary care physicians to serve in community and migrant health centers, or in related health programs, or in underserved rural areas, and offer them incentives for efficient private practice in the areas in which they locate.

To facilitate implementation of the proposed instructions, the Advisory Council also recommends that the Corps prepare a written plan describing the actions that it will take so as to refocus its activities as described. The plan should contain measures by which its success can be measured objectively, and, after approval by the Secretary, should be published in the Federal Register.

Basis of the Estimate and Key Assumptions

This proposal does not require an estimate since the appropriated amount is specified in the proposal. However, it should be noted that approximately 2.1 million new persons annually would be served by the new funds based on current per capitas for community health centers. The new centers themselves also would serve other clients funded by Medicaid and other payors. If the new centers' client mix were approximately the same as that of existing centers, these new centers would provide service to approximately 4 million persons.

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Technical Notes Concerning the Estimate

Considerable variation exists between migrant and community centers across the country in terms of per capita expenditures. This estimate assumes that the new centers approximate the average centers now in existence. To the degree to which the new centers differ in client population from the old centers, the estimate of the number of new people served would be in error.

Allocation between years is based on current CBO spendout rates.

Estimate

Table 9

ESTIMATE OF COSTS OF INCREASING ACCESS
TO PRIMARY CARE:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
1. Costs of Establishing Centers	160	90	0	250
2. Operating Expenses	0	210	290	500
3. Grant to *NHSC*	50	100	100	250
Total	210	400	390	1000

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PROPOSAL 10
A PROPOSAL TO REDUCE INFANT MORTALITY

The Proposal

The Council proposes a major initiative to reduce infant mortality:

A. General Approach to Reducing Infant Mortality. Although many programs seek to reduce infant mortality, its incidence is bound up in societal problems not readily solved. The challenge to government is not to devise further programs, but to use more effectively those that exist. Accordingly, the following proposal seeks to sharpen institutional weapons already deployed.

B. A Proposal in Outline. As part of a renewed attack on infant mortality, legislation should be proposed to:

1. Integrate the WIC program with the MCH Block Grant program. The restructured programs would be administered by the Department of Health and Human Services rather than the Department of Agriculture, but would continue to support activities now conducted under either program.

2. Require states to furnish locations at which an eligible woman could establish her entitlement, or that of her infant, both to MCH/WIC benefits and to Medicaid.

3. Introduce a simplified application form for MCH/WIC/Medicaid eligibility.

4. Use publicly financed providers for "one-stop shopping": i.e., a single location both for determining eligibility for all programs pertinent to infant mortality and for providing health services.

5. Support outreach activities to publicize the program's existence of the program to potential eligibles, and to make program funds available for transportation and child care to enable mothers to meet health care appointments.

6. Establish demonstration of incentives to encourage women to obtain prenatal and well-baby care.

7. Support a demonstration program of home visits.

8. Institute economies, such as managed care, in the provision of health services, and arrangements to ensure the quality of those services.

C. Additional Program Features.

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1. Use of Modified Block Grant Mechanism. The integrated MCH/WIC program, like the existing MCH program, would be structured as a block grant to the states, controllable by annual appropriations action. It would, nevertheless, require participating states to meet program objectives described in paragraph IV.B.

2. Availability of Program Benefits. Food and services under the program would be available to all pregnant women and infants, regardless of income, although the state would be allowed to charge for food or services provided to individuals other than low-income mothers or children. In such case, the state would be required to scale those charges in proportion to the income, resources, and family size of the (non-low-income) individual assisted.

3. Supplemental Grants for High Risk Populations. The program would reserve a proportion of total grant funds for grants, by the Secretary, to states, and counties, for innovative approaches to enhancing the program for high-risk populations. The Secretary would be required to develop a system of priorities for awarding such grants, with preference to be given to assisting children with special health care needs, chronically underserved populations, and other populations within which infant mortality is significantly higher than the national average.

4. National Health Service Corps Priority. The Public Health Service Act would be amended to establish a priority for the assignment of National Health Service Corps primary care physicians to areas (whether or not "underserved") that are shown to suffer annual rates of infant mortality exceeding, by 50 percent or more, the average annual rate of infant mortality among the white female population of the United States.

5. Maternal and Child Health Information Program. The program would generate maternal and child health information at two levels:

a. Written Information. Within the federal administering agency, there would be created an Office of Maternal and Child Health Information. The Office would be responsible for developing and disseminating written information to women of child-bearing age within the United States.

b. Classes. As a condition of federal financial participation, a state would be required to develop classes in prenatal care, child-care, and child-nurture, making them accessible to pregnant women, mothers, fathers, and (within the limit of program resources) all other women of child-bearing age. The Office of Maternal and Child Health

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Information would be authorized to cooperate with the states in preparing written course materials.

6. Prenatal Care Incentives Demonstration. In order to encourage women, particularly low-income women, to avail themselves of services intended to reduce infant mortality and improve the nutrition and health of mothers and children, the demonstration program would offer incentives, in the form of additional subsidization of prenatal, obstetrical, and well-baby care.

7. Quality Assurance. Each provider would be required, as a condition of the contract with the state, to undertake to perform services for contract beneficiaries of the same quantity and quality provided to the provider's other patients or clients. A failure to perform would be a breach of contract that would make the provider liable for appropriate liquidated damages established under the contract (subject to the Secretary's regulations), and termination of the contract.

Basis of Estimate and Key Assumptions

This is a complex estimate with a number of components. It should be noted that this proposal would be more expensive is other proposals, such as the school based clinics, were removed from the package of proposals.

Integrate WIC/MCH Block Grants

Integration of the WIC program with the MCH Block Grant program would have no budget impact. The few department staff freed by the administration most likely would be reassigned to the other activities required by this proposal. Hence, this portion of the proposal would have no costs or savings.

Simplification of Application Process

The proposal requires states to: (1) increase the number of intake sites, (2) simplify the application form, and (3) institute "one-stop shopping". Based on the experience of six states currently being analyzed by HCFA, such efforts increase Medicaid costs due to increased coverage during the verification phase of the application process. The estimate of these costs assumes that approximately 10 percent of applicants would benefit for an average of 60 days from the simplification process.

Outreach Activities

The proposal requires states to publicize the program's existence to potential eligibles, and to make program funds available for transportation and child care to enable mothers to meet health care appointments. Outreach activities for this group are assumed to cost $20 million per year. These outreach activities will yield an increased number of Medicaid eligibles.

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Using the limited experience of California in such activities for this particular group, it would appear that an additional 200,000 persons would be enrolled and services to an additional 500,000 children would increase. Per capita's for these groups were taken from Medicaid statistical data.

Demonstrations of Incentives

The proposal requires the Secretary to establish demonstrations of incentives to encourage women to obtain prenatal and well-baby care. The demonstrations are to be appropriated at $10 million per year and therefore do not require estimation.

Demonstrations of Home Visits

The proposal requires the Secretary to establish demonstration programs of home visits. The demonstrations are to be appropriated at $10 million per year and therefore do not require estimation.

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Estimate

Table 10

COSTS OF A PROPOSAL TO REDUCE INFANT MORTALITY
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Integrate WIC/MCH Block Grants				
	0	0	0	0
Simplification of Application Process				
	70	100	120	290
Outreach Activities				
	50	250	330	630
Demonstrations of Incentives				
	2	10	10	22
Demonstrations of Home Visits				
	2	10	10	22
Total	124	370	470	964

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PROPOSAL 11
PROMOTING EMPLOYER-BASED HEALTH INSURANCE

THE PROPOSAL

Model State Law. The Secretary of Health and Human Services would develop and promulgate a model law, for adoption by the several states, that would apply to a group health benefit plan covering employers of from 2 to 50 employees. Plans for small employers would be required to meet a number of conditions governing the exclusion of employees for pre-existing conditions, renewability, the use of medical underwriting, availability, denial because of risk, waiting periods for coverage, premium variations among groups, and annual premium increases.

All insurers within the state would agree on risk categories that would place employees of all or many small employers within the state into one or more statewide risk groups. Among possible sources of revenue to fund the risk pool, the state could enact legislation to assess all employers within the state for contributions.

If insurers within a state do not establish a pooling arrangement, the state would establish a reinsurance pool in which all insurers within the state would participate, and which would reinsure such policies so as to reduce their cost. All carriers and other organizations issuing health benefit plans would be members of the program, including Blue Cross and Blue Shield. Nevertheless, Blue Cross and Blue Shield would be permitted to manage their own reinsurance risk if they (jointly) choose to do so.

If a state does not adopt the model legislation within three years after the Secretary promulgates it, the standards for insurance policies under the model act shall go into effect as federal standards for all policies offered to small employers within the state.

Disallowance of State-Mandated Benefits for Small-Employer Core Health Benefit Plans. The proposal would relieve health care insurers, and other organizations that offer health benefit plans to employers, from state requirements that health insurance policies for small employers limited to core benefits contain specified additional benefits, and cover services by designated categories of health care providers.

Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans. The proposal would relieve health care insurers from state limitations on the use of managed care. In order to safeguard the patient from the erection of unreasonable barriers to adequate medical treatment that this supersedure might invite, the Secretary of Health and Human Services, through a formal rulemaking process to redefine the term "managed care," would establish standards for alternative limitations that a state could impose. State laws would cease to apply that currently inhibit carriers from contracting with providers, restrict carriers'

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ability to negotiate with providers regarding reimbursement, and restrict the inclusion of financial incentives to patients in managed care Plans.

Improving the Portability of Private Health Insurance. The proposal, through an amendment to the tax law, would induce health insurers to extend employer-based health plan coverage to new employees with a history of recent prior health coverage, without imposing restrictions relating to pre-existing health conditions, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

Basis of Estimate and Key Assumptions

This estimate has two parts from a cost estimator's viewpoint: first, the administrative costs associated with developing the new legislation, and secondly, the costs of operating the program. Developing the legislation is well within the resources available to the Secretary in the Assistant Secretary for Legislation's staff. Hence, development of the legislation and model law would not increase federal expenditures. Similarly, the proposal indicates that the costs of the program and its administration would be funded by the premiums. Again, there would be no cost to the federal government.

Estimate

Table 11

COSTS OF A PROPOSAL PROMOTE EMPLOYER-BASED HEALTH INSURANCE:
Numbers in Millions of Dollars by Fiscal Year

Appropriated Amounts	1993	1994	1995	Total
1. Costs of Development of Legislation	0	0	0	0
2. Program Operation	0	0	0	0
Total	0	0	0	0

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PROPOSAL 12
HEALTH INSURANCE FOR THE SELF-EMPLOYED

The Council recommends that the Treasury Department review the deductibility of health insurance premiums paid by the self-employed, with a view to proposing an amendment of the tax laws that would place the self-employed on the same footing, in regard to the tax treatment of premiums for health insurance coverage, as employees.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

Estimate

Table 12

HEALTH INSURANCE FOR THE SELF-EMPLOYED:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

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PROPOSAL 13
A PROPOSAL TO REDUCE THE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS

The Proposal

The Health Care Financing Administration will review its major hospital billing form in 1992. The council recommends that legislation be developed to give guidance to that process.

A. The Objective. Legislation guides the process in three ways:

1. By providing a framework to facilitate discussions.

2. By clearly defining its objective.

3. By establishing an alternative process if the discussions are unsuccessful.

B. Advisory Council. The proposal would direct the Secretary to convene the Advisory Council on Hospital Reimbursement Procedures, to consist of 15 individuals, including representatives of the American Hospital Association, the American Medical Association, the Health Insurance Association of America, individual hospitals and health care insurers, and the Health Care Financing Administration. At least five members of the Council would be required to be currently employed as hospital administrators.

C. Responsibility of the Council. The proposal would direct the Council, within three years of its appointment, to recommend to the Secretary, a uniform hospital reimbursement form, which, when promulgated by the Secretary's regulations, would be the sole form required by the Health Care Financing Administration or any private health care insurer in the United States as the sole basis for making payment on a claim for reimbursement for hospital in-patient services.

D. Contents of a Uniform Reimbursement Form. The uniform reimbursement form, as recommended by the Council, shall include:

1. Uniform Clinical Data Set. A diagnosis of the patient based on a uniform clinical data set.[2]

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[2] The Institute of Medicine has recently recommended development of electronic medical records, with all patient information going into the record. The proposal, under development

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2. Procedures Employed. A uniform coding of medical procedures used to treat the patient.

3. Billing Information. Reimbursement requested for each procedure employed with respect to the patient, including hospital services, physician's services, X-rays, tests, rehabilitative services, and so forth, as may be required to ensure that the form is comprehensive.

E. Report on Computerization of Billing. The Council would also report on the computerization of health claim billing, i.e., the use of electronic means to transmit billing information from hospitals and physicians to insurers and HCFA. The report would include:

1. a survey of the current state of electronic billing;

2. a discussion of the impediments to more extensive use of electronic billing;

3. an analysis of the probable costs of increasing the volume and standardization of such billing in relation to the savings to the health care system that could reasonably be anticipated, and

4. the Council's recommendations for action that would facilitate the further extension of electronic billing in a cost-effective manner.

F. Development of Form By HCFA if the Council Fails to Agree. If, at the end of two years after the Secretary has appointed the members of the Council under the proposal, the Council fails to recommend a uniform hospital reimbursement form, as required under paragraph II.C, the Secretary shall direct the Health Care Financing Administration to develop and promulgate such a form for the purpose within six months.

Basis of Estimate and Key Assumptions

This estimate has two parts from a cost estimator's viewpoint: first, the administrative costs associated with developing and changing the new uniform bill, and secondly, the potential savings from increased efficiencies. The costs of the Advisory Council were estimated from data supplied by the Department's management staff who indicated that several similar advisory groups cost approximately $1 million per year.

The major cost of changing the uniform bill would be the cost of reprogramming in the fiscal intermediaries and HCFA computers. Based on extensive conversations with current and

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as "Quality 2000" in conjunction with congressional legislative staff, would mandate electronic data collection for hospitals by the year 2000.

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former HCFA staff involved in the last major reform of the hospital billing form, it will cost approximately $50 million for HCFA and the intermediaries to revise the forms.

Savings from changing the form could not occur until after the form was implemented. Assuming the form was available at the end of 1994, based on the last revision of the bill, it would be at least two more years before HCFA, fiscal intermediaries, and hospitals were able to implement the form and realize savings. Although that is beyond the period being estimated, this estimator believes that some savings to the Medicare program would be realized by a streamlined billing process.

Estimate

Table 13

A PROPOSAL TO REDUCE PAPERWORK ASSOCIATED WITH HEALTH CLAIMS
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts				
1. Costs of Computer Conversion	1	1	50	52
2. Costs of Advisory Council	0	0	0	0
Total	1	1	50	52

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PROPOSAL 14
HOSPITAL MERGERS AND JOINT VENTURES

The Proposal

The Advisory Council recommends that certain antitrust and Medicare fraud and abuse laws and regulations be amended to permit certain types of hospital mergers and joint ventures. Specifically:

A. Hospital Mergers The Council would propose that the Attorney General develop proposals for legislation amending the antitrust laws to permit mergers of two hospitals in the same community in limited cases. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rate and relative financial condition of each hospital, and the willingness of each hospital to engage in the merger.

B. Joint Ventures The Council would propose that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation amending the antitrust laws to permit two hospitals in the same community, in limited cases to enter into a joint venture for the provision of hospital services at one facility and health-related services (such as long-term care or outpatient care) at the other hospital facility. The proposed legislation should include criteria relating to the length of time each hospital has served the community, the occupancy rate and relative financial condition of each hospital, the types of services to be provided by the joint venture, and whether the new services to be provided meet an unmet need in the community.

Basis of the Estimate and Key Assumptions

This proposal has two components from a cost estimator's point of view: first, possible costs associated with developing the legislative proposal, and secondly, potential secondary costs and savings associated with increased efficiencies when services are delivered in a coordinated manner in a particular community.

The development of the legislative proposals called for by the Council appears well within the resources allocated by the Departments to existing Offices charged with developing legislative proposals. Hence, the estimate for this portion of the Council's proposal is zero.

The second potential effect on federal outlays of this proposal would be increases and/or decreases in Medicare, Medicaid, and other program costs as a consequence of the new provider arrangements fostered by the eventual implementation of the legislation. For example, it can be argued that savings will occur due to the better coordination within communities of outpatient services between the existing hospitals. [illegible] can

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be argued that program outlays will increase due to unmet needs within the communities. Data directly relevant to estimate either the costs or savings is nonexistent. Even if such data did exist, a considerable number of assumptions concerning the behavior and timing of hospitals would be required to develop an estimate. Finally, such savings and costs would appear well outside the time frame being estimated, fiscal years 1993 to 1995, since development and passage of the legislation would take at least that long. For these and other reasons, costs and savings of this proposal are not estimable and a zero has been assigned. It should be noted that this position on estimates of this type is also the position taken by CBO and the HCFA Office of the Actuary on a number of similar proposals.

Estimate

Table 14

ESTIMATE OF COSTS OF HOSPITAL MERGERS
AND JOINT VENTURES:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays[3]				
1. Costs of Developing Legislation				
	0	0	0	0
2. Savings from Increased Efficiencies				
	0	0	0	0

[3] The costs of developing the proposals would be appropriated amounts. However, costs and savings to Medicare, Medicaid, and other federal programs would be outlays from the federal Treasury if they could be estimated.

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PROPOSAL 15
A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE

The Proposal

It is proposed to reimburse health care providers, under Medicare, for the costs of performing designated major medical or surgical procedures – procedures employed for certain life-threatening or seriously disabling conditions and typified by their high cost and low volume – only if those procedures are performed in facilities meeting rigorous criteria of quality.

The proposal would channel patients for those procedures to facilities most successful in performing them and discourage their performance at less successful facilities.

Because a consequence of the proposal would be to reduce the number of facilities at which the designated procedures could be performed, it is also proposed to reimburse a Medicare beneficiary for the cost of travel between the facility and the beneficiary's place of residence.

A. Procedures Designated. In order to be designated, by the Secretary of Health and Human Services, as a procedure the performance of which will be reimbursed by Medicare only if performed at a designated facility, the procedure must first be assessed by the Office of Health Technology Assessment of the Public Health Service and found to be:

1. safe,
2. effective,
3. necessary to alleviate a life-threatening or seriously disabling condition, and
4. a relatively low-volume procedure requiring a major case management effort.

B. Criteria to be Met by a Selected Facility. To be selected as a facility for the performance of a procedure designated under this proposal, the Secretary must find that the facility meets the following criteria:

1. Patient Selection. It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

2. Patient Management. It must have adequate patient management plans and protocols that include the following:

a. Therapeutic and Valuative Procedures.

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Therapeutic and valuative procedures for the acute and long-term management of a patient, including commonly encountered complications.

b. Patient Management and Evaluation.
Patient management and evaluation during the waiting and immediate post-discharge period, as well as in-hospital phase of the program for performing the procedure.

c. Long-term Management and Evaluation.
Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician and the maintenance of active patient records for at least five years

3. Commitment. A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:

a. Commitment at All Levels.
Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.

b. Adequate Expertise.
The facility must be expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board certified or otherwise approved by the Secretary.

(1) Integration of Teams.
The component teams must be integrated into a comprehensive team with clearly defined leadership and corresponding responsibility.

(2) Anesthesia.
The anesthesia service must identify a team for performance of the procedure that is available at all times.

(3) Infectious Disease.
The infectious disease service must have both the professional skills and laboratory resources needed to discover, identify, and manage the

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complications from a whole range of organisms, many of which are uncommonly encountered.

(4) Nursing Service.
The nursing service must identify a team or teams trained in the special problems of managing patients who undergo the procedure.

(5) Pathology Resources.
Pathology resources must be available for studying and reporting promptly any pathological responses to the procedure.

(6) Social Services.
Adequate social services resources must be available.

(7) Patient Selection.
Mechanisms must be in place to ensure that:

(a) patient selection criteria are consistent with those set forth in the facility's written patient selection criteria, and

(b) the facility is responsible for the ethical and medical considerations involved in the patient selection process and application of patient selection criteria.

(8) Plans for Organ Transplantation.
If the procedure involves organ transplantation, that adequate plans exist for organ procurement meeting legal and ethical criteria, as well as yielding viable transplantable organs in reasonable numbers.

4. Facility Plans. The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

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5. Experience and Survival Rates. The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

6. Maintenance of Data. The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.

7. Laboratory Services. The facility must make available, directly or under arrangements, laboratory services (including blood banking) to meet the needs of patients. Laboratory services must be performed in a laboratory facility approved for participation in the Medicare program.

C. Reimbursement of Beneficiary. In addition to such other reimbursement as the Medicare statute may provide, a beneficiary may be reimbursed for travel to and from a selected facility if the beneficiary resides more than 50 miles from the facility.

Basis of the Estimate and Key Assumptions

This estimate is based on information from two sources: first, data and conversations with individuals familiar with Medicare's heart transplant centers, and secondly, with State Medicaid agencies that have had experience with hospital contracting. The Medicare heart transplant centers use very similar types of approaches to those suggested by this proposal, with the exception that cost effectiveness was not an explicit goal in the selection of these centers. The State Medicaid agency staff were a primary source of information concerning what, realistically, one might consider obtaining through a contracting approach.

The data and conversations with persons knowledgeable with the heart transplant centers yielded a relative consensus that transportation of patients, which is often necessary, rarely exceeds 5 percent of the total cost of the hospitalization, with the rare exception being a very large air ambulance bill. In contrast, there was wide variation among these and Medicaid respondents on the level of savings that could be expected from a contracting approach. Of the eight persons interviewed, the low estimate was 5 percent and the high estimate was 25 percent. Given the wide variation and lack of hard data in this area, this estimate assumes that Medicare would save 15 percent per admission through a contracting approach, and that it would add 5 percent per admission for beneficiary travel, for a net savings of 10 percent per admission.

The most difficult part of this estimate is to make assumptions on how quickly the Secretary would move, and on how many procedures involving how many admissions. Clearly, the first year, FY 1993, would be required to develop the guidelines and begin the contracting process. Aside from that, what the Secretary might do is difficult to project. Given the

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intent of the proposal, liver and other high-cost procedures clearly would be immediate candidates for this selective contracting. By 1993, Medicare Part A and B expenditures for these patients would appear to be on the order of $80 million. Experts estimated that approximately 75 percent of all cases were of a non-emergency nature and would be amenable to a center of excellence approach. Hence, assuming that the Secretary was able to get 20 percent of the admissions under contract in 1994 and 40 percent in 1995, Medicare would save $10 million in FY 1995.

The above assumptions are conservative and could be characterized as a low estimate. If the Secretary were to include three other procedures and get 50 percent of the admissions under contract in 1994 and 70 percent in 1995, assumptions not outside the realm of possibility, the savings would rise to $30 million in 1995.

Estimate

Table 15

A PROPOSAL TO ESTABLISH CENTERS OF EXCELLENCE
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays				
Low Estimate	0	-5	-10	-15
High Estimate	0	-10	-30	-40

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PROPOSAL 16
A PROPOSAL TO CONTAIN MEDICARE COSTS THROUGH USE OF SELECTED CONTRACTING

The Proposal

The Council proposes to institute a system, under Medicare, whereby the program will reimburse a provider for the costs of performing a designated medical or surgical procedure -- a procedure typified by its high cost to the program -- only if Medicare has first approved the provider for the performance of that procedure.

The proposal's objective is to channel patients for those procedures to facilities that have qualified as cost-efficient.

ELEMENTS OF THE PROPOSAL

A. Procedures Designated. The Secretary of Health and Human Services may designate a medical or surgical procedure as reimbursable by Medicare, only if performed at an approved facility, and if:

1. the Secretary determines that the procedure is one that imposes high costs on the Medicare program, and

2. the Office of Health Technology Assessment of the Public Health Service has assessed the procedure and found it to be safe, effective, and necessary to alleviate a life-threatening or seriously disabling condition.

B. Qualification of Facility.

1. Competitive Bidding. The Secretary would be required to develop administrative arrangements under which criteria would be published for the selection of facilities to perform each procedure designated under the program, and bids from such facilities would be solicited and evaluated.

2. Fixed Charge. All services delivered by a provider would be on the basis of a fixed charge per procedure for all hospital and physician services (including post-operative care) associated with the procedure, regardless of the actual cost of the procedure in a particular case.

C. Quality Assurance Standards. To be approved as a facility for the performance of a procedure under this proposal, the facility must meet the following criteria:

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1. Patient Selection. It must have written patient selection criteria which it would follow in determining suitable candidates for the procedure. Patient selection criteria must be based upon both a critical medical need for the procedure and a maximum likelihood of successful clinical outcome.

2. Patient Management. It must have adequate patient management plans and protocols that include the following:

a. Therapeutic and Valuative Procedures. Therapeutic and valuative procedures for the acute and long-term management of a patient, including commonly encountered complications.

b. Patient Management and Evaluation. Patient management and evaluation during the waiting and immediate post-discharge period, as well as in-hospital phases of the program for performing the procedure.

c. Long-Term Management and Evaluation. Long-term management and evaluation, including education of the patient, liaison with the patient's attending physician, and the maintenance of active patient records for at least five years.

3. Commitment. A facility must make a sufficient commitment of resources and planning to the program for performing the procedure to carry through its application. Indications of this commitment should include the following:

a. Commitment at All Levels. Commitment of the facility to the program at all levels, including, as necessary, other departments of the facility as well as the principal sponsoring departments.

b. Adequate Expertise. The facility must be expert in medical, surgical, and other relevant areas, including an identifiable and stable team for performing the procedure, the responsible members of which are board-certified or otherwise approved by the Secretary.

4. Facility Plans. The facility must have overall facility plans, commitments, and resources for a program that will ensure a reasonable concentration of experience. The Secretary of Health and Human Services would establish the frequency with which the facility must perform the procedure for the conditions for which the facility must perform the procedure. This level of activity must be shown feasible and likely on the basis of plans, commitments, and resources.

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5. Experience and Survival Rates. The facility must demonstrate experience and success with the procedure. Survival rates must meet criteria established by the Secretary.

6. Maintenance of Data. The facility must agree to maintain and, when requested, periodically submit data to the Secretary, in standard format, about patients selected (including patient identifiers), protocols used, and short- and long-term outcome on all patients who undergo the procedure, not only those for whom payment under Medicare is sought.

Basis of the Estimate and Key Assumptions

This estimate is based on information from two sources: First, data from the Medicare Part A and Part B bill files, and secondly, conversations with State Medicaid agencies that have had experience with hospital contracting. The Medicare bill file provided estimates of the costs of the procedure in question. The State Medicaid agency staff were a primary source of information concerning what, realistically, one might consider obtaining through a contracting approach.

The first part of this estimate involves assumptions on how many procedures involving how many admissions the Secretary would move to place under contracting, and how quickly the Secretary would move. Clearly, the first year, FY 1993, would be required to develop the guidelines and begin the contracting process. It appears reasonable to assume that the Secretary might also initially select a major cost procedure for contracting. Based on conversations with senior health policy and advisory council staff, the leading candidate for early inclusion would be cataract surgery. This procedure is undergoing a contracting demonstration currently and, despite congressional reimbursement reductions, is still viewed as a prime candidate for further reductions. By FY 1993, Medicare Part A and B expenditures for these patients would appear to be more than $3.6 billion. Hence, assuming that the Secretary was able to get 20 percent of the admissions under contract in FY 1994 and 40 percent in FY 1995, combined with the proposal's other assumptions, a contracting approach would save $170 million in FY 1995.

The above assumptions are conservative and could be characterized as a low estimate. If the Secretary were to include three other procedures and get 50 percent of the admissions under contract in FY 1994 and 70 percent in FY 1995, assumptions not outside the realm of possibility, the savings would rise to $530 million in FY 1995.

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Estimate

Table 16

A PROPOSAL TO CONTAIN MEDICARE COSTS
THROUGH THE USE OF SELECTED CONTRACTING
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays				
Low Estimate	0	-60	-170	-230
High Estimate	0	-110	-530	-640

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PROPOSAL 17
MERGING MEDICARE PARTS A AND B

The Proposal

The Advisory Council would recommend that the Medicare law be amended to combine Parts A and B into one program. The three separate funding sources – payroll taxes, general revenues, and premiums for Part B – would remain, and a method would be developed by HCFA to maintain the integrity of the relative share of program costs for purposes of determining the Part B premium.

Combining Parts A and B has several advantages. The Medicare program would be viewed as a single unified program, with common administrative and management goals. The impact of program expenditures could be evaluated and analyzed in terms of their total impact on the economy, and a unified portrayal of the long-range obligations of the program could be accomplished.

Estimate and Key Assumptions

Combining Parts A and B of Medicare has been proposed by members of Congress on several occasions in the last several years. The Congressional Budget Office (CBO) has estimated that there would be no savings or costs from such legislation. They have rejected the argument that administrative efficiencies would occur on the grounds that the nature of such efficiencies is unclear, and in any event it would take years before the Health Care Financing Administration (HCFA) would implement such programs' economies. This estimator concurs with CBO's estimate.

Estimate

Table 17

MERGING MEDICARE PARTS A AND B:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

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PROPOSAL 18
TASK FORCE ON INVESTMENT IN HUMAN RESOURCES

The Proposal

The Council would recommend that the President establish an Interagency Task Force on Investment in Human Resources.

Composition. The Task Force would be chaired by the Secretary of Health and Human Services and would include:

(1) the Secretary of Agriculture;
(2) the Secretary of Education;
(3) the Secretary of Housing and Urban Development;
(4) the Secretary of Labor; and
(5) the heads of such other Federal agencies as the President considers appropriate.

Mission. The Task Force would be charged with developing a comprehensive interagency strategy to improve investment in American human resources and society, and thereby improve productivity and competitiveness. Areas to be considered by the Task Force would include:

(1) the identification of problems in education, housing, nutrition, and alcohol and drug abuse which have an effect on health status, as well as the resulting effects on productivity and competitiveness;

(2) the development of a comprehensive five-year strategy detailing how Federal agencies can address the problems identified, including:

(A) the development of a plan that includes a process so that Federal agencies can work together to minimize duplication in programs addressing these problems and maximize the use of existing resources;

(B) a list of actions that can be taken by Federal agencies, without changes in law, to implement the strategy, and

(C) a timetable for implementation of the strategy and a plan for evaluating and ensuring that the timetable is met.

(3) recommendations for changes in law that would be necessary to further the strategy.

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Report. The Task Force would prepare semiannual reports to the President containing updates on the implementation of the strategy and recommendations for legislation.

Staffing. Staff for the Task Force would be drawn from personnel of the agencies represented.

Estimate and Key Assumptions

This proposal specifies that the staff of the Task Force would be drawn from the agencies represented, hence, no estimate of this proposal is necessary. It would not increase federal expenditures.

Estimate

Table 18

TASK FORCE ON INVESTMENT IN HUMAN RESOURCES:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

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PROPOSAL 19
PROMOTING HEALTHY LIFESTYLES

The Proposal

The Council recommends that the President's Council on Physical Fitness undertake a program to:

A. Develop Measures to Discourage The Use of Tobacco.

1. Advertising Ban. The proposal would ban all forms of advertising tobacco and tobacco products.

2. Vending Machine Ban. The proposal would ban the sale of cigarettes from vending machines.

3. Termination of Tobacco Subsidy. The proposal would phase out tobacco subsidies, under a program that would offer loans and other short-term assistance to farmers in order to facilitate conversion to other crops.

B. Encourage Healthy Lifestyles. The proposal[4] would establish a statutory foundation for the development and implementation of programs to encourage healthy lifestyle choices, such as:

- avoiding illegal drugs;
- avoiding excessive alcohol consumption;
- avoiding the use of tobacco products;
- choosing proper foods as components of a healthy, balanced diet;
- developing effective ways to manage stress; and
- engaging in regular exercise.

C. Use Current Programs and Activities. The administering agency would promote this new concept of physical fitness by:

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[4]. One approach might be to reconstitute the President's Council on Physical Fitness and Sports as a statutory body and expand its functions.

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- enlisting the active support of private citizens, civic groups, business enterprises, foundations, and other entities in efforts to promote healthy lifestyle choices by all Americans;

- initiating activities to inform the general public of the importance of healthy lifestyle choices, and of the link between appropriate lifestyle behaviors and good health and productivity;

- encouraging state and local governments to emphasize to their citizens the importance of making healthy lifestyle choices;

- advancing the concept of physical fitness through healthy lifestyle choices, systematically encouraging the development of community programs;

- developing cooperative programs with societies of health professionals to encourage Americans to make healthy lifestyle choices;

- assisting educational agencies at all levels to develop high quality, innovative health and physical education programs that emphasize the importance of making the right lifestyle choices for good health, and

- helping business, industry, government, and labor organizations, encouraging public/private ventures which establish programs to promote healthy lifestyle choices by their employees and to reduce the financial and human costs resulting from inappropriate lifestyle choices.[5]

Basis of the Estimate and Key Assumptions

The estimate assumes that existing Council on Physical Fitness and Sports staff would redirect part of their efforts to include the themes recommended by the Advisory Council in existing publication and activities. For example, the proposal does not mandate an overall increase in the presidential Council's publication budget. The estimate assumes small additional costs to modify the publications based on examination of the Presidential Council's budget and conversations with the Council's staff on publication costs.

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[5]. The new program would assume only those current activities of the President's Council on Physical Fitness and Sports directed towards exercise and sports; i.e., promotion of research in sports medicine, physical fitness, and sports performance, and coordinating Federal agency activities related to physical fitness and sports. This would be accomplished either by expanding the mission of the Council to enable it to administer the proposal, by transferring the Council to the agency administering the proposal, or by abolishing the Council altogether.

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Estimate

Table 19

ESTIMATE OF COSTS OF PROMOTING HEALTHY LIFESTYLES THROUGH THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts	.2	.2	.3	.7

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PROPOSAL 20
POOLING OF DATA FOR TECHNOLOGY ASSESSMENT

The Proposal

The Council would recommend that the Attorney General and the Secretary of Health and Human Services jointly develop proposals for legislation to amend the antitrust laws, permitting hospitals and insurance companies to compare and pool data for the purpose of developing improved methods of technology assessment and medical evaluation.

Basis of the Estimate and Key Assumptions

Both the Attorney General and the Secretary of Health and Human Services have existing staffs charged with development of legislation. Hence, this proposal has no cost implications.

Estimate

Table 20

POOLING OF DATA FOR TECHNOLOGY ASSESSMENT:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

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PROPOSAL 21

PRESIDENT'S COUNCIL ON FITNESS FOR THE MIDDLE AND SENIOR YEARS

THE PROPOSAL

In General. It is proposed that there be established, as a companion body to the President's Council on Physical Fitness and Sports, a President's Council on Senior Fitness, which shall be within the Department of Health and Human Services. The Council shall focus on the development of programs especially suited to an individual's middle and later years.

Appointment. The President shall appoint 20 members to the Council, and shall designate a Chairman and Vice Chairman.

National Program. The Council shall—

1. enlist the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve the fitness of all Americans over the age of 50 through regular participation in suitable programs of physical fitness;

2. initiate programs to inform the general public of the importance of exercise and the link that exists between regular physical activity and good health and effective performance;

3. strengthen coordination of federal services and programs relating to physical fitness of individuals over age 50;

4. encourage State and local governments to emphasize the importance of regular physical fitness for older citizens,

5. encourage research in physical fitness for older individuals;

6. assist business, industry, government, and labor organizations to establish sound physical fitness programs to reduce the financial and human costs of physical inactivity.

Coordination. The Council shall seek to coordinate its activities with those of the President's Council on Physical Fitness and Sports.

Other Functions. The Council shall advise the President and the Secretary of Health and Human Services as to its activities in devising and promoting programs to improve the fitness of older Americans.

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Service of Members. The members of the Council shall serve without compensation for their work on the Council, but will be entitled to travel and subsistence expenses for meetings.

Staff. The Secretary of Health and Human Services shall provide the Council with a suitable staff and facilities.

Estimate and Key Assumptions

The estimate for the cost of the council was based on costs of similar councils. Obviously, the scope of the councils activities would depend on the funding level.

Estimate

Table 21

PRESIDENT'S COUNCIL FITNESS FOR THE MIDDLE AND SENIOR YEARS:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Appropriated Amounts	2	5	5	12

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PROPOSAL 22
A PROPOSAL TO DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES

The Proposal

The Department of Health and Human Services, through the Agency for Health Care Policy and Research (AHCPR), is supporting research on the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of a variety of acute and chronic conditions, and along with other entities is developing medical practice guidelines for use by health care providers. Practice parameters, the development of which by the medical profession is strongly advocated by the American Medical Association, will encourage and enhance the delivery of the most appropriate care to each patient. they would supplement the physician's judgment in reducing unnecessary and inappropriate variation in the use of health care services and procedures.

The Advisory Council recommends that AHCPR focus its efforts on developing a system that would produce comprehensive reports on the performance of local and regional health care markets. The reports could be used to repair flaws in three critical policy areas: information, finance, and manpower. As proposed by Dr. Weinberg, reports would include the following information:

- the location of local and regional market areas,
- the per capita allocation of hospital beds, physician, and other manpower in each market;
- Utilization rates; and
- certain outcomes.

The reports would be invaluable for supporting alternative strategies for containing capacity. Information on outcomes of alternative treatment modalities standing alone, would make a serious contribution to reducing supplier-induced demand.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures.

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Estimate

Table 22

DEVELOP INFORMATION ON MEDICAL TREATMENT OUTCOMES:
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	0	0	0	0

87764077

PROPOSAL 23
A PROPOSAL FOR A PUBLIC EDUCATION CAMPAIGN ON PREVENTION

The Proposal

It is proposed that the Surgeon General of the United States conduct a massive three year public education campaign on the prevention of disease through changes in personal behaviors and use of preventive care and screening. The campaign would involve a coordinated effort using the broadcast and print media, including public service announcements, outreach to community groups, and cooperative ventures with businesses. The campaign would also involve schools through design of curricula for use in health education classes as well as presentations on preventive health issues.

The Council suggests that the Advertising Council adopt this public education campaign on prevention as its entire effort during this three year period, and that the Surgeon General work with other groups, such as the National Association of Broadcasters, to implement this campaign.

Estimate and Key Assumptions

The staff necessary for these activities would be drawn from the agency staff. It would not increase federal expenditures. The public education activities would be funded by both the government and the organizations involved in the campaigns. The $20 million contained in this estimate for the federal portion was supplied by Advisory Council staff.

Estimate

Table 23

PUBLIC EDUCATION CAMPAIGN ON PREVENTION
Numbers in Millions of Dollars by Fiscal Year

	1993	1994	1995	Total
Outlays	10	20	20	50

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Appendix D:
Prototype Comprehensive Plans

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THE INSURANCE MARKET REFORM PROPOSAL: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Submitted By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764080

THE INSURANCE MARKET REFORM PROPOSAL

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OVERVIEW OF PLAN

- *SMALL GROUP INSURANCE MARKET REFORM AND OTHER REFORMS TO MAKE INSURANCE MORE WIDELY AVAILABLE*
- *MEDICAID EXPANSION FOR ALL PERSONS LIVING BELOW POVERTY REGARDLESS OF CATEGORICAL ELIGIBILITY*
- *MEDICAID BUY-IN FOR PERSONS BETWEEN 100 AND 150 PERCENT OF POVERTY*

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EMPLOYER BASED INSURANCE

- *EMPLOYER BASED COVERAGE IS ENCOURAGED AND FACILITATED RATHER THAN MANDATED*
- *THE SELF-EMPLOYED WOULD BE ABLE TO DEDUCT 100 PERCENT OF THE COST OF HEALTH INSURANCE*
  - *The deduction for self-employed persons is currently limited to 25 percent of benefit costs.*
  - *The self employed are already permitted to deduct the full cost of benefits for workers.*
- *SMALL EMPLOYERS (FEWER THAN 25 EMPLOYEES) WILL BE PROVIDED A REFUNDABLE TAX CREDIT FOR EMPLOYEE HEALTH BENEFITS COSTS IN EXCESS OF FIVE PERCENT OF GROSS REVENUES*

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Lewis/ICF

SMALL GROUP INSURANCE MARKET REFORMS

- *GUARANTEED ISSUE AND RENEWABILITY*
  - *Insurers are required to offer coverage to all applicants regardless of health status*
  - *Insurers must renew coverage for all groups regardless of health status*
  - *Failure to pay premiums is the only grounds an insurer may use to terminate coverage*
- *ONCE A WORKER HAS SATISFIED PRE-EXISTING CONDITION REQUIREMENTS ON ONE PLAN, THOSE REQUIREMENTS ARE WAIVED IF THE INDIVIDUAL CHANGES JOBS OR THE EMPLOYER CHANGES INSURERS*
- *STATE MINIMUM BENEFITS LAWS ARE ELIMINATED TO PERMIT CREATION OF LOW COST INSURANCE PLANS*
- *PREMIUM SETTING LIMITATIONS*
  - *Premiums may not vary among groups by more than a specified percentage (e.g., 50 percent) of the average premium charged by the insurer for groups with similar age, sex, industry and geographic characteristics*
  - *Year-to-year premium increases for any group could not be more than a specified percentage (e.g., 15 percent) above the carriers general cost trend*
- *A REINSURANCE MECHANISM IS ESTABLISHED*
  - *Spreads risk for high risk groups across all insurers*
  - *Reinsurance funded by an assessment on all small group insurance policies*

87764084

MEDICAID EXPANSION

- *ALL PERSONS BELOW POVERTY ARE COVERED UNDER MEDICAID REGARDLESS OF CATEGORICAL ELIGIBILITY STATUS*
- *PROVIDER REIMBURSEMENT LEVELS ARE INCREASED TO LEVELS COMPARABLE TO THE MEDICARE PROGRAM*
- *A UNIFORM NATIONWIDE MINIMUM STANDARD BENEFITS PACKAGE (SHOWN ON NEXT PAGE) IS ESTABLISHED (COMPARABLE TO THE MEDIAN BENEFITS PACKAGE CURRENTLY OFFERED BY THE STATES)*
- *THE CURRENT FEDERAL/STATE MATCH IS USED FOR THE MEDICAID EXPANSION*

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STANDARD MEDICAID BENEFITS PACKAGE

BENEFITS	PLAN PROVISIONS
Inpatient Hospital Services	100%
Outpatient Hospital Services	100%
Rural Health Clinic Services	100%
Laboratory & X-ray Services	100%
Early and Periodic Screening, Diagnosis and Treatment Services for Individuals Under Age 21	100%
Physician Services	100%
Home Health Services	100%
Private Duty Nursing	100%
Preventive Dental Care	100%
Clinic Services	100%
Physical Therapy	100%
Occupational Therapy	100%
Speech, Hearing and Language Disorders	100%
Prosthetic Devices	100%
Diagnostic Tests	100%
Preventive Services	100%
Rehabilitative Services	100%
Case Management	100%
Podiatrist and Optometrist	100%

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MEDICAID BUY-IN

- *A MEDICAID BUY-IN PROGRAM IS CREATED FOR PERSONS BETWEEN POVERTY AND 150 PERCENT OF POVERTY*
- *COVERED SERVICES*
  - *Inpatient and outpatient hospital care*
  - *Physicians services*
  - *Prescription drugs*
  - *Laboratory and diagnostic tests*
  - *Mental health and substance abuse*
  - *Prenatal/well-baby/child care*
- *COST SHARING*
  - *$250 deductible ($500 family)*
  - *80 percent coinsurance (50 percent mental health)*
  - *No cost sharing for prenatal and well child care*
  - *Out-of-pocket limit of $3,000 per family*
- *PREMIUMS PHASED-IN BETWEEN 100 AND 150 PERCENT OF PREMIUM*
  - *Individual premium of $86*
  - *Family premium of $172*
- *THE CURRENT FEDERAL/STATE MEDICAID MATCH IS MAINTAINED FOR THE BUY-IN PROGRAM*

8776408?

TABLE 1

CHANGE IN THE NUMBER OF UNINSURED PERSONS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Thousands)

	Number Who Obtain Insurance	Reduction In Number Of Uninsured	Percent Of Uninsured
Extend Medicaid to Cover All Below Poverty	12,158	5,834	18.3%
Medicaid Buy-In Through 150 Percent of Poverty	11,877	4,937	15.5
Insurance Market Reforms[a]	921	515	1.6
Eliminate State Mandated Benefits[a]	2,314	1,214	3.8
Increase Self-Employment Deduction[a]	181	91	0.3
Combined Impact	27,451	12,591	39.6%

a Assumes each percentage reduction in premium costs is associated with a 0.4 percent increase in the number of employers offering insurance.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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TABLE 2

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)

Household Payments			**$19.2**
Tax Payments	33.4		
Premium Payments	(3.0)		
Out-of-Pocket Spending	(11.2)		
Private Employers			**(4.8)**
Currently Provide Insurance		(5.9)	
Currently Do Not Insure		1.1	
State Governments (Program Fully Funded)[a]			**0.0**
Federal Government (Program Fully Funded)[a]			**0.0**
Local Governments			**(3.0)**
Change in National Health Spending			**$11.4**
Utilization Increase for Newly Insured		6.9	
Net Increase in Provider Reimbursement[b]		4.2	
Net Change in Administrative Costs		0.3	

a *We assume that state and federal governments raise the revenues needed to fully fund the program so that the proposal has no net impact on government spending.*

b *Increases in Medicaid reimbursement for hospital services are assumed to be passed-on to employers in the form of cost-shift savings. Increases in physician reimbursement are assumed to be retained as income.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 3

SOURCES AND USES OF FEDERAL FUNDS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)

Sources of Funds		*Uses of Funds*	
Personal Income Tax Increase[a]	*$19.5*	*Federal Share of Medicaid Expansion*	*$20.2*
		Tax Credit for Small Employer Costs Over 5 Percent of Revenues[b]	*0.2*
		Self Employed Deductions[c]	*0.4*
		Change in Corporate Tax Revenues[d]	*(1.3)*
Total Program Revenues	*$19.5*	*Total Program Costs*	*$19.5*

a The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (5 percent).
b Employers with 25 or fewer employees will receive a refundable tax credit for health expenditures in excess of 15 percent of revenues.
c Self employed persons are permitted to deduct the full amount of their health benefits expenditures.
d Employers are assumed to absorb changes in employer costs as changes in profits resulting in changes in corporate income tax deductions for health benefits and tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

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Table 4

CHANGE IN MEDICAID PROGRAM COSTS FOR ACUTE CARE ONLY UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991 (In Billions)[a]

	Total Program	Federal Cost	State Cost
Current Medicaid Program (Acute Care Only)	$45.3	$25.3	$20.0
Offsets to Existing Program			
Cover Persons Up To Poverty Level	10.7	6.3	4.4
Minimum Benefits Standard	6.4	3.7	2.7
Improved Provider Reimbursement	12.6	7.4	5.2
Net Cost of Medicaid Buy-In Benefit Costs $9.0 Premium Receipts (4.2)	4.8	2.8	2.0
Net Change in Medicaid Costs			
Net Change	$34.5	$20.2	$14.3

[a] Included benefits and administration for acute care only. Excludes long-term care.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764091

Table 5

SOURCES AND USES OF STATE FUNDS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991

(In Billions)

Sources of Funds		*Uses of Funds*	
Increase in State Taxes to Fund Program	*$13.9*	*State Share of Medicaid Expansion (see Table 4)*	*$14.3*
		State Corporate Income Taxes	*(0.2)*
		Savings to Indigent Care Programs	*(0.2)*
Total Sources of Funds	*$13.9*	*Total Uses of Funds*	*$13.9*

a Premium payments are subsidized for persons with incomes between the poverty line and 150 percent of poverty.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

87764092

Table 6

IMPACT OF THE INSURANCE MARKET REFORM PROPOSAL ON PRIVATE EMPLOYERS
(In Billions, 1990)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance[a]	$115.5	—	$115.5
Changes in Employer Costs			
Cost of Insuring Workers and Dependents Not Now Covered	0.8	1.7	2.5
Tax Credit to Small Employers	0.0	(0.2)	(0.2)
Cost Shift Savings	(8.6)	—	(7.6)
Total Employer Costs	107.7	1.5	109.2
Net Change in Employer Cost	(7.8)	1.5	(6.3)
Change in Corporate Income Tax	1.9	(0.4)	1.5
Net After-Tax Change in Employer Costs	(5.9)	1.1	(4.8)

a *Includes employer share of premium for workers, dependents, and retirees.*

b *The plan provides a refundable tax credit which limits employer expenditures for health benefits in small firms not to exceed 5 percent of revenues.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

8776093

Table 7

IMPACT OF THE INSURANCE MARKET REFORM PROPOSAL ON HOUSEHOLD HEALTH RELATED EXPENDITURES IN 1991

(In Billions)

	Change From Current Policy
Funding for Public Program	
Premium Payments For Medicaid Buy-In	*4.2*
Federal Taxes[a]	*19.5*
State Taxes[a]	*13.9*
Offsets to Tax Payments	
Employee Share of Employer Plan Premiums	*(2.4)*
Non-Group Plan Premium Payments	*(4.8)*
Household Out-of-Pocket Expenditures	*(11.2)*
Total Net Change	*$19.2*

a New state and federal expenditures under the program are assumed to be fully funded through increases in personal taxes.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764094

THE UNIVERSAL MEDICAL EXPENSE PROPOSAL

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764035

THE UNIVERSAL MEDICAL EXPENSE PROPOSAL

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87764096

OVERVIEW OF PLAN

- *PROTECT ALL AMERICANS AGAINST THE COST OF CATASTROPHIC MEDICAL EXPENSES THROUGH THE CREATION OF THE UNIVERSAL MEDICAL EXPENSE PROTECTION PLAN (UMEPP).*
- *UMEPP WOULD OFFER MEDICARE BENEFITS AND PROVIDE STOP-LOSS PROTECTION TO MEDICARE AND MEDICAID BENEFICIARIES AND TO OTHER INDIVIDUALS AND FAMILIES NOT COVERED BY "QUALIFIED" EMPLOYER PLANS.*
- *UMEPP WOULD CERTIFY EMPLOYER PLANS AS "QUALIFIED" IF THEY MEET CERTAIN CRITERIA.*
- *LIMIT EMPLOYER TAX DEDUCTIONS FOR HEALTH INSURANCE TO QUALIFIED PLANS.*
- *INDIVIDUALS WOULD BE PERMITTED TO DEDUCT 50 PERCENT OF ANNUAL HEALTH INSURANCE PREMIUMS UP TO $250.*
- *THE INDIVIDUAL TAX DEDUCTION FOR UNREIMBURSED MEDICAL EXPENSES WOULD BE REDUCED TO 2 PERCENT.*

87764097

UMEPP DEDUCTIBLES/CO-PAYMENTS AND STOP-LOSS

If a Family's Income is:	The Deductible is:	Coinsurance is:	The Stop-Loss Limit is:
Below Federal Poverty Level* ($13,400)	$1,050	10%	$1,750
Between 100% and 200% of the Federal poverty level ($13,400 - 26,800)	$1,050 plus 13 percent of income over Federal poverty level	15%	$1,750 plus 15% of income over Federal poverty level
Over 200% of Federal poverty level (over $26,800)	$3,130 plus 20% of income over 200% of Federal poverty level	20%	$4,150 plus 25% of income over 200% of Federal poverty level

* The Federal poverty level is $13,400 for a family of four in 1991.

87764098

87794099

EMPLOYER RESPONSIBILITY

- EMPLOYER HEALTH INSURANCE PLANS MAY BE CONSIDERED QUALIFIED PLANS IF THEY INCLUDE:
  - No waiting period or exclusions for pre-existing conditions
  - Continuation of coverage
  - Annual open enrollment
  - Payment for the entire cost for services for which UMEPP would have covered
  - Employer premium contribution of 50 percent of the cost of the least expensive qualified plan
- ONLY QUALIFIED PLANS CAN RECEIVE A TAX DEDUCTION FOR THE COST OF HEALTH INSURANCE.

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PUBLIC RESPONSIBILITY

- *COVERAGE FOR THE UNINSURED*
  - *UMEPP would cover the costs for all covered medical expenses above a deductible based on family income and all expenses above a stop-loss limit*
- *COVERAGE FOR MEDICARE BENEFICIARIES*
  - *Medicare Part A deductibles would be repealed except for the initial inpatient hospital deductible. Part A coinsurance would be repealed.*
  - *UMEPP will pay for all Medicare services after the stop-loss limit provided the individual has paid the deductible and cost-sharing requirements.*
  - *Medicare Part A and Part B deductible and co-insurance payments count toward UMEPP's cost-sharing requirements.*
- *COVERAGE OF MEDICAID BENEFICIARIES*
  - *UMEPP will pay for all Medicaid services after the stop-loss limit provided the individual has paid the deductible and cost-sharing requirements.*
  - *States would be prohibited from reducing the amount, scope, or duration of Medicaid benefits, where the net effect is to shift costs onto UMEPP.*
- *COVERAGE OF PERSONS INSURED BY EMPLOYER PLANS*
  - *If a plan results in greater cost-sharing than UMEPP, UMEPP would pay the difference up to the stop-loss amount.*

87764100

INDIVIDUAL RESPONSIBILITY

- *INDIVIDUALS WOULD BE RESPONSIBLE FOR PAYING FOR MEDICAL EXPENSES UP TO THE UMEPP STOP-LOSS LIMIT.*
- *NO INDIVIDUAL WOULD BE REQUIRED TO PAY DEDUCTIBLES AND COINSURANCE UNDER A QUALIFIED PLAN THAT RESULTS IN A GREATER COST TO THE INDIVIDUAL THAN UNDER UMEPP.*
- *IF AN EMPLOYEE FAILS TO ENROLL IN A QUALIFIED EMPLOYER PLAN, HE/SHE MAY PARTICIPATE IN UMEPP AFTER PAYMENT OF 1 1/2 TIMES THE UMEPP DEDUCTIBLE.*
- *INDIVIDUALS WOULD BE PERMITTED TO DEDUCT 50 PERCENT OF THE ANNUAL COST OF INSURANCE UP TO $250.*
- *THE INDIVIDUAL TAX DEDUCTION FOR UNREIMBURSED MEDICAL EXPENSES WOULD BE REDUCED TO 2 PERCENT.*

87764101

TABLE 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE UNIVERSAL MEDICAL EXPENSE PROPOSAL IN 1991
(In Billions)

Household Payments		*9.0*
Tax Payments	*$43.1*	
Premium Payments	*(8.3)*	
Out-of-Pocket Spending	*(25.8)*	
Private Employers		*1.5*
State and Local Governments		*(6.0)*
Federal Government (Program Fully Funded)[a]		*0.0*
Change in National Health Spending		*$4.5*
Utilization Increase for Newly Insured	*3.6*	
Net Change in Administrative Costs	*0.9*	

[a] *We assume that the federal government raises the revenues needed to fully fund the program so that the proposal has no net impact on government spending.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764102

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE UNIVERSAL MEDICAL EXPENSE PROPOSAL

Sources of Funds		Uses of Funds	
Unspecified General Revenues[a]	$51.2	Eliminate Medicare Part A Coinsurance[b]	$ 5.7
		Catastrophic Coverage[c]	
		Medicare Recipients	15.3
		Other Individuals	20.5
		Administrative Cost[d]	1.1
		Tax Incentive to Enroll in Employer Plan[e]	3.9
		Net Change in Medical Expense Deduction[f]	4.3
		Change in Corporate Income Tax[g]	0.5
Total Sources of Funds	$51.2	Total Uses of Funds	$51.2

Footnotes to follow on next page

87764103

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Footnotes to Table 2

[a] *We assume that the full amount of federal costs under the proposal will be funded by a proportional increase in personal income taxes (12.1 percent).*

[b] *The proposal eliminates Part B patient cost sharing.*

[c] *The catastrophic coverage program covers coinsurance and deductibles under Medicare and persons without private insurance. Catastrophic coverage also applies to Medicaid recipients but would involve minimal cost because Medicaid does not impose deductibles or coinsurance. Some costs would be incurred for Medicaid recipients in states with benefits limitations (inpatient days, etc.)*

[d] *Administrative costs are assumed to be equal to 2.7 percent of claims.*

[e] *The plan permits individuals to deduct half of the employee share of employer plan premiums up to $250 as an incentive to participate in the employers plan. We assume that this deduction is provided over and above the exclusion of employee contributions for health insurance permitted under current law.*

[f] *The plan permits tax deductions for medical expenses in excess of two percent of AGI (deductions are currently limited to costs over 7.5 percent of AGI). The increase in deductions and subsequent tax loss would be offset by reductions in out-of-pocket spending resulting under the catastrophic coverage program.*

[g] *Employers are assumed to absorb the cost of expansions in coverage in the form of reduced profits resulting in changes in corporate income tax deductions for health benefits and tax payments.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764104

TABLE 3

IMPACT OF THE UNIVERSAL MEDICAL EXPENSE PROPOSAL ON PRIVATE EMPLOYERS IN 1991
(In Billions)

Current Employer Expenditures for Health Insurance	*$115.5*
Changes in Employer Costs	
Workers and Dependents Induced to Take Employer Coverage	*3.5*
Minimum Benefit and Premium Standards	*2.1*
Cost Shift Savings	*(3.5)*
Net Change in Employer Costs	*2.1*
Change in Corporate Income Tax	*(0.6)*
Net After-Tax Change in Employer Costs	*$1.5*

[a] *Includes employer share of premium for workers, dependents, and retirees.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764105

TABLE 4

IMPACT OF THE UNIVERSAL MEDICAL EXPENDITURES PROPOSAL ON STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)

	Change in Expenditures
Changes in Employee Benefit Costs	*$0.4*
Savings to Public Hospitals and Other Programs[a]	*(6.6)*
Loss of Corporate Income Taxes	*0.2*
Net Impact on State and Local Governments	*($6.0)*

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[a] *Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program resulting in savings to local governments.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764106

TABLE 5

IMPACT OF THE UNIVERSAL MEDICAL EXPENDITURES PROPOSAL ON HOUSEHOLD HEALTH EXPENDITURES IN 1991
(In Billions)

		Change from Current Policy
Federal Taxes		*$43.1*
Tax Deduction for Employee Premiums	*(3.9)*	
Change in Medical Expense Deduction	*(4.2)*	
Federal Income Tax Payments	*51.2*	
Employee Share of Employer Plan Premiums		*(1.2)*
Non-Group Plan Premium Payments		*(7.1)*
Household Out-of-Pocket Expenditures		*(25.8)*
Total Net Change		*$9.0*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764107

THE INDIVIDUAL TAX CREDIT PROPOSAL: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764108

THE INDIVIDUAL TAX CREDIT PROPOSAL

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87764109

OVERVIEW OF PLAN

- *ALL PERSONS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE.*
- *EMPLOYER BASED INSURANCE IS ELIMINATED. INSTEAD, EMPLOYER CONTRIBUTIONS FOR HEALTH BENEFITS ARE CONVERTED TO INCOME.*
- *MEDICAID IS ELIMINATED FOR ACUTE CARE. INSTEAD, A REFUNDABLE TAX CREDIT IS PROVIDED TO LOW INCOME PERSONS TO COVER THE COST OF INSURANCE.*
- *INDIVIDUALS MAY DEDUCT THE COST OF AN AVERAGE STANDARD INSURANCE PLAN IN DETERMINING PERSONAL INCOME TAXES. PREMIUMS FOR BENEFITS IN EXCESS OF THE STANDARD PACKAGE ARE NOT TAX DEDUCTIBLE.*
- *THE PRIVATE INSURANCE MARKET WOULD BE REFORMED TO MAKE THE STANDARD BENEFITS PACKAGE AVAILABLE TO ALL.*
- *STATE MANDATED BENEFITS WOULD BE PREEMPTED AND RESTRICTIONS ON MANAGED CARE PLANS WOULD BE ELIMINATED.*

87764110

INDIVIDUAL RESPONSIBILITY

- *ALL PERSONS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE*
- *MEDICARE IS RETAINED FOR PERSONS AGE 65 AND OLDER*
- *MEDICAID IS ELIMINATED FOR PERSONS UNDER AGE 65 FOR ACUTE CARE AND REPLACED WITH A REFUNDABLE TAX CREDIT. MEDICAID IS RETAINED FOR:*
  - *PERSONS AGE 65 AND OLDER*
  - *LONG-TERM CARE*
- *INDIVIDUALS MAY DEDUCT THE COST OF THE STANDARD BENEFITS PACKAGE IN DETERMINING PERSONAL INCOME TAXES*
- *INDIVIDUALS MAY PURCHASE SUPPLEMENTAL COVERAGE BUT PREMIUMS ARE NOT TAX DEDUCTIBLE*

87764111

BENEFITS PACKAGE

- *BASIC COVERAGE FOR ALL AMERICANS*
  - *$250 deductible ($500 per family)*
  - *$3,000 cost-sharing maximum*

BENEFIT	COINSURANCE
Inpatient Hospital Services (365-day per stay maximum)	*80%*
Outpatient Hospital Services	*80%*
Hospital Alternatives (extended or home health care)	*Yes*
Physician Services	*75%*
Prenatal/Well-Baby/Well-Child Care	*75%*
Diagnostic Tests	*75%*
Prescription Drugs	*75%*
Emergency Services	*100%*
Mental Health Care	*Not Covered*
Dental Care	*Not Covered*

87764112

BENEFITS PACKAGE (Continued)

- *COMPREHENSIVE COVERAGE FOR PERSONS BELOW POVERTY.*

BENEFITS	PLAN PROVISIONS
Rural Health Clinic Services	100%
Early and Periodic Screening, Diagnosis and Treatment Services for Individuals Under Age 21	100%
Home Health Services	100%
Private Duty Nursing	100%
Dental Care	100%
Clinic Services	100%
Physical Therapy	100%
Occupational Therapy	100%
Speech, Hearing and Language Disorders	100%
Dentures	100%
Prosthetic Devices	100%
Eyeglasses	100%
Preventive Services	100%
Rehabilitative Services	100%
Inpatient Psychiatric Care for Individuals Under Age 21	100%
Hospice Services	100%
Transportation	100%
Case Management	100%
Podiatrist, Optometrist, and Chiropractor Services	100%

87764113

INSURANCE MARKET REFORMS

- *GUARANTEED ISSUE AND RENEWABILITY*
  - *Insurers are required to offer coverage to all applicants regardless of health status*
  - *Insurers must renew coverage for all groups regardless of health status*
  - *Failure to pay premiums is the only grounds an insurer may use to terminate coverage*
- *PRE-EXISTING CONDITION LIMITATIONS ARE ELIMINATED*
- *STATE MINIMUM BENEFITS LAWS ARE PREEMPTED*
- *PREMIUMS WILL BE SET ON A REGIONAL BASIS USING AN ADJUSTED COMMUNITY RATE*
  - *Age and sex premium variation permitted*
  - *Rates could not vary with medical history or condition*
- *A REINSURANCE MECHANISM IS ESTABLISHED*
  - *Spreads risk for high risk groups across all insurers*
  - *Reinsurance funded by an assessment on all small group insurance policies*

87764114

EMPLOYER RESPONSIBILITY

- *EMPLOYERS WOULD NO LONGER PROVIDE HEALTH INSURANCE DIRECTLY TO EMPLOYEES*
- *EMPLOYERS WOULD BE REQUIRED TO MAINTAIN THEIR CURRENT LEVEL OF EFFORT BY CONVERTING HEALTH BENEFIT PAYMENTS TO INCOME*
- *EMPLOYERS WOULD SERVE THE ADMINISTRATIVE FUNCTION OF DEDUCTING PREMIUMS FROM WORKER PAYCHECKS AND SUBMITTING PAYMENTS TO INSURERS*

87464115

FEDERAL TAX CREDIT

- *A REFUNDABLE TAX CREDIT IS ESTABLISHED TO COVER PREMIUMS AND COST SHARING UNDER THE STANDARD BENEFITS PACKAGE FOR PERSONS BELOW 200 PERCENT OF POVERTY*
- *TAX CREDIT PHASED OUT BETWEEN 100 AND 200 PERCENT OF POVERTY*

Income as a Percent of Poverty	Percent of Premiums and Cost Sharing Refunded
<100	100%
101-110	90%
111-120	80%
121-130	70%
131-140	60%
141-150	50%
151-160	40%
161-170	30%
171-180	20%
181-190	10%
191-200	5%
200+	0%

- *MEDICAID IS ELIMINATED FOR ACUTE CARE*
  - *State and Federal funding used to fund the tax credit*
  - *Medicaid is maintained for long-term care*

87764116

FINANCING

- *STATE AND FEDERAL FUNDING FOR THE ACUTE CARE PORTION OF MEDICAID IS TRANSFERRED TO THE PUBLIC PROGRAM*
- *INCREASED TAX REVENUES DUE TO ELIMINATION OF TAX DEDUCTIONS FOR BENEFITS IN EXCESS OF THE FEDERAL STANDARD*
- *ANY ADDITIONAL FEDERAL FUNDING REQUIREMENTS ARE ASSUMED TO BE FINANCED BY AN ACROSS THE BOARD INCREASE IN FEDERAL PERSONAL INCOME TAXES*
  - *Personal income tax increase: $24.0 billion*
  - *Personal income tax rates are increased by 4.9 percent*

COST CONTAINMENT

- *STATE LAWS IMPEDING SELECTIVE CONTRACTING, UTILIZATION REVIEW AND OTHER MANAGED CARE MECHANISMS ARE ELIMINATED*
- *ELIMINATION OF TAX BENEFITS FOR COVERAGE IN EXCESS OF THE FEDERAL STANDARD WILL ENCOURAGE INDIVIDUALS TO REDUCE HEALTH CARE CONSUMPTION*

ASSUMPTION

- *ALL INDIVIDUALS IN PLANS WHICH EXCEED THE MINIMUM BENEFITS STANDARDS ARE ASSUMED TO SHIFT TO SOME FORM OF MANAGED CARE PLAN IN WHICH HEALTH SPENDING IS REDUCED TO THE POINT WHERE THE EMPLOYEE AFTER TAX PREMIUM CONTRIBUTION IS THE SAME AS UNDER CURRENT POLICY*

87764118

Table 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE INDIVIDUAL TAX CREDIT MODEL IN 1991 (In Billions)

Household Payments		$ 20.3
Private Employers		0.0
Employer Insurance Payments	(105.7)	
Employer FICA Taxes	2.7	
Employee Wages and Salaries	103.0	
State and Local Governments		(18.8)
Federal Government (Program Fully Funded)		0.0
Change in National Health Spending		$(1.5)
Utilization Increase for Newly Insured	12.2	
Net Increase in Provider Reimbursement	4.2	
Tax Induced Reduction in Utilization	(20.8)	
Net Change in Administrative Costs	2.9	

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE INDIVIDUAL TAX CREDIT PROPOSAL IN 1991
(In Billions)

Sources of Funds			Uses of Fund		
Taxes on Benefits Converted to Income [a]		$18.4	Tax Credit [d]		$67.1
Personal Income Taxes	12.9				
OASDI and HI Payroll Taxes	5.5		Premium Subsidy	52.4	
			Cost Sharing Subsidy	14.7	
			Administrative Costs		1.1
State Contribution to Public Plan [b]		12.9	Net Change in Tax Revenues Due to Tax Deduction for Federal Benefit Standard [e]		8.1
Personal Income Tax Increase [c]		24.0	Offsets to Medicaid [f]		(16.8)
			Elimination of Health Care Deduction [g]		(4.2)
TOTAL SOURCES OF FUNDS		$55.3	TOTAL USES OF FUNDS		$55.1

87764120

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE INDIVIDUAL TAX CREDIT PROPOSAL IN 1991 (Cont.)

a Employer contributions to health benefits are converted to wages and salaries resulting in an increase in OASDI and HI payroll tax payments.

b States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care for persons under age 65. Medicaid is assumed to be retained for long-term care.

c The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (4.8 percent).

d A refundable tax credit is provided to subsidize premium payments and cost sharing for low income persons.

e A tax credit is provided for purchase of the Federal standard benefits package.

f Medicaid is eliminated for acute care for persons under age 65 resulting in savings to the Federal government.

g The current deduction for health benefits expenses in excess of 7.5 percent of adjusted gross income is eliminated.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764121

Table 3

CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE INDIVIDUAL TAX CREDIT MODEL IN 1991 (In Billions)

Current Employer Expenditures for Health Care	*$115.5*
Coverage Eliminated for Persons Under Age 65	*(105.7)*
Employer Contribution Converted To Wages[a]	*103.0*
OASDI and HI Tax on Wages	*2.7*
Net Change in Employer Costs	*0.0*

a Employers are assumed to convert their contribution for health benefits to wages and salaries adjusted for increases in employer OASDI and HI tax payments on these wages and salaries.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87769122

Table 4

IMPACT OF THE INDIVIDUAL TAX CREDIT MODEL ON STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)

		CHANGE IN EXPENDITURES
Changes in Employee Benefit Costs[a]		$0.0
Change in Medicaid Spending[b]		0.0
Contribution to Public Plan	12.9	
Medicaid Spending	(12.9)	
Savings to Public Hospitals and Other Programs[c]		(16.5)
Increase in State Income Taxes Due to Changes in Wages and Salaries[d] *(Counted as an offset)*		(2.3)
Net Impact on State and Local Governments		$(18.8)

a *Employers are assumed to convert their contribution for health benefits to wages and salaries adjusted for increases in employer OASDI and HI tax payments on these wages and salaries.*

b *All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.*

c *Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program.*

d *In about two thirds of all states, state personal income taxes are based upon Federal taxable income. In these states, the deduction for insurance benefits would automatically be conveyed in computing state personal income taxes. In other states the tax credit is not automatically conveyed resulting in a revenue windfall in these states.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764123

Table 5

CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER THE INDIVIDUAL TAX CREDIT MODEL IN 1991 (In Billions)

NEW EXPENDITURES UNDER PROGRAM	
Individual Premium Payments for Insurance	$206.4
Estimated Purchase of Supplemental Coverage	39.6
Federal Personal Income Tax Increase to Fund Tax Credit Program	24.0
Increase in State Personal Income Taxes	2.3
OFFSETS TO HOUSEHOLD SPENDING	
Net Increase in Disposable Income[a]	(110.0)
Premium Subsidy to Low Income Persons	(52.4)
Cost Sharing Subsidy to Low Income Persons	(14.7)
Premium Payments for Non-Group Coverage	(15.8)
Employee Share of Premium Payments	(43.3)
Out of Pocket Expenses	(15.8)
Net Change in Household Spending	$20.3

a Change in personal income less changes in tax payments for that income under the proposal.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87761124

ALTERNATIVE TAX CREDIT OPTIONS

Presented To:

The Social Security Advisory Council

Presented By:

Lewin/ICF
a division of Health & Sciences International

December 19, 1991

87764125

TAX CREDIT PROPOSAL

- ALL INDIVIDUALS UNDER AGE 65 ARE REQUIRED TO PURCHASE INSURANCE
- MEDICARE IS RETAINED FOR PERSONS UNDER AGE 65 FOR ACUTE CARE AND REPLACED WITH A REFUNDABLE TAX CREDIT. MEDICAID IS RETAINED FOR:
  - -- Persons age 65 and older
  - -- Long-term care
- INDIVIDUALS RECEIVE A TAX CREDIT FOR THE COST OF A BASIC HEALTH INSURANCE PACKAGE
- EXISTING HEALTH TAX EXPENDITURES ELIMINATED ($63.7 BILLION)
  - -- Employer health benefits exclusion: $59.4 billion
  - -- Tax deduction for health expenses: $4.3 billion

87764126

INSURANCE RATING UNDER TAX CREDIT PLAN

- ASSUMED PREMIUM VARIATION BY AGE, SEX, HEALTH STATUS AND REGION
- PREMIUM VARIATION AS A PERCENT OF STANDARD RISK

REGIONAL VARIATION	
Northeast	95.0%
Midwest	104.8
South	92.7
West	108.9%

HEALTH STATUS VARIATION	
Poor Health	240.2%
Fair Health	150.4
Good Health	99.2
Excellent Health	89.3

AGE VARIATION	
Less Than 18	37.3%
18-24	70.5
25-34	74.0
35-44	64.7
45-54	82.3
55-64	131.7%

SEX VARIATION	
Male	89.9%
Female	108.9%

87764127

TAX CREDIT AMOUNTS

- MAXIMUM TAX CREDIT VARIES BY AGE BASED UPON COST OF BASIC HEALTH PLAN FOR LOW-INCOME PERSONS

Age of Individual	Annual Tax Credit Amount at or Below Poverty
Less Than 18	$ 677
18-24	1,281
25-34	1,344
35-44	1,176
45-54	1,496
55-64	2,393
Average Annual	$1,817

- ADD-ON TO TAX CREDIT FOR HIGH RISK INDIVIDUALS (PREMIUMS OVER 150 PERCENT OF STANDARD RISK)
  - -- Option A: $1,000
  - -- Option B: $2,000
  - -- Option C: $5,000

- TAX CREDIT PHASED OUT FOR INCOMES ABOVE POVERTY WITH FULL PHASE-OUT AT
  - -- Option 1: 200 percent of poverty
  - -- Option 2: 300 percent of poverty
  - -- Option 3: 400 percent of poverty
  - -- Option 4: 600 percent of poverty

87764128

TAX CREDIT IMPACTS

- TAX CREDIT EXPENDITURE (IN BILLIONS)

	HIGH RISK ADD-ON		
Income Phase-Out Amount	$1,000	$2,000	$5,000
200 Percent of Poverty	$35.5	$39.1	$ 46.6
300 Percent of Poverty	51.4	56.0	64.0
400 Percent of Poverty	66.8	71.8	79.5
600 Percent of Poverty	$90.4	$95.6	$102.4

- NET CHANGE IN TAX EXPENDITURE (IN BILLIONS)

	HIGH RISK ADD-ON		
Income Phase-Out Amount	$1,000	$2,000	$5,000
200 Percent of Poverty	$(28.2)	$(24.6)	$(17.1)
300 Percent of Poverty	(12.3)	(7.7)	0.3
400 Percent of Poverty	3.1	8.1	15.8
600 Percent of Poverty	$26.7	$31.9	$ 38.7

87764129

TABLE 1-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF $1000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1443.51	4263.	125.46	1285.48	152.	889.40	539.87	7238.	1555.67
10,000-14,999	5541.	182.85	1104.57	2633.	211.75	1395.97	1019.	447.27	235.85	1890.	1401.76
15,000-19,999	6602.	321.59	746.40	1868.	310.25	1639.50	3179.	485.50	96.14	1555.	1003.15
20,000-29,999	10400.	527.12	391.64	1770.	516.71	1822.63	7293.	626.28	61.48	1337.	297.85
30,000-39,999	9901.	813.46	78.33	371.	662.53	1425.09	6931.	873.40	18.28	598.	138.55
40,000-49,999	8529.	874.71	21.33	46.	1373.63	2137.67	8151.	907.03	6.05	329.	87.99
50,000-74,999	15034.	1173.81	3.13	39.	797.01	1217.40	14370.	1225.92	0.00	626.	0.00
75,000 +	10648.	1257.44	0.00	0.	0.00	0.00	10218.	1310.70	0.00	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10
100% - 149%	6156.	250.66	1525.14	3638.	320.54	1607.34	301.	1253.60	931.04	2218.	1470.98
150% - 199%	6405.	491.56	807.47	3013.	383.32	1084.60	2090.	953.64	398.98	1301.	821.95
200% - 299%	13198.	687.80	17.06	160.	87.95	559.28	11544.	785.31	8.30	1493.	26.49
300% +	41458.	997.18	0.00	0.	0.00	0.00	39235.	1053.69	0.00	2224.	0.00
TOTAL	78309.	713.07	426.40	10993.	267.23	1466.83	53312.	992.32	24.18	14004.	1140.96

87764130

TABLE 1-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: *HIGH RISK ADD-ON OF $1000*

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	15.0	38.7
15,000-19,999	6602.	1.8	8.6	24.4	8.8	6.6	9.6	1.6	1.9	5.7	8.3	24.7
20,000-29,999	10400.	9.3	21.0	28.2	4.3	7.3	9.6	1.0	1.4	3.2	4.4	10.3
30,000-39,999	9901.	29.9	33.1	13.4	3.7	10.1	5.4	0.6	0.5	0.7	1.3	1.3
40,000-49,999	8529.	35.8	36.5	12.2	2.1	8.9	3.7	0.2	0.0	0.0	0.3	0.3
50,000-74,999	15034.	57.7	22.5	7.6	1.3	6.5	4.2	0.1	0.1	0.0	0.1	0.0
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.2	1.1	1.0	1.3	1.3	0.2	2.6	3.7	15.4	20.7	52.6
150% - 199%	6405.	3.8	9.2	7.9	6.6	5.2	0.0	6.1	8.0	19.3	16.6	17.4
200% - 299%	13198.	26.6	23.8	20.2	5.3	11.6	10.6	0.4	0.3	0.2	1.0	0.0
300% +	41458.	45.0	26.4	13.5	1.7	8.0	5.4	0.0	0.0	0.0	0.0	0.0
TOTAL	78309.	28.6	18.9	11.3	2.5	6.8	4.6	0.9	1.4	4.9	6.6	13.5

87764131

TABLE 2-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF $1000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1449.73	4263.	125.46	1293.29	152.	889.40	539.87	7238.	1561.09
10,000-14,999	5541.	182.85	1371.19	3279.	235.23	1334.33	373.	649.25	442.73	1890.	1618.34
15,000-19,999	6602.	321.59	1368.41	3717.	317.82	1298.12	1330.	708.00	438.18	1555.	1483.23
20,000-29,999	10400.	527.12	819.04	3625.	582.23	1759.13	5438.	620.00	198.68	1337.	793.62
30,000-39,999	9901.	813.46	477.09	1956.	652.71	1543.68	7347.	922.54	190.63	598.	507.16
40,000-49,999	8529.	874.71	236.02	973.	715.75	1410.73	7226.	935.94	64.83	329.	520.39
50,000-74,999	15034.	1173.81	41.86	231.	765.36	1639.16	14177.	1232.27	14.09	626.	6.22
75,000 +	10648.	1257.44	2.01	0.	0.00	0.00	10216.	1310.70	2.09	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10
100% - 149%	6156.	250.66	1616.60	3638.	320.54	1697.88	301.	1253.60	958.57	2218.	1572.64
150% - 199%	6405.	491.56	1412.88	4458.	522.77	1497.12	646.	1266.96	809.53	1301.	1423.77
200% - 299%	13198.	687.80	774.21	5646.	461.11	1068.42	6059.	1068.65	487.87	1493.	824.11
300% +	41458.	997.10	6.90	123.	380.79	875.97	39112.	1055.80	3.94	2224.	10.91
TOTAL	78309.	713.07	614.38	18045.	374.00	1435.81	46259.	1061.23	86.48	14004.	1299.77

87764132

TABLE 2-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF $1000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11659.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.6	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0
15,000-19,999	6602.	0.7	2.1	4.2	7.6	5.3	0.6	8.3	9.8	14.2	12.3	34.8
20,000-29,999	10400.	2.1	12.2	26.5	6.8	4.8	5.1	2.8	4.2	5.6	9.6	20.4
30,000-39,999	9901.	17.3	28.2	16.5	4.3	7.8	3.6	1.6	2.6	4.0	5.5	8.4
40,000-49,999	8529.	29.1	33.3	12.4	2.9	6.9	2.9	0.6	2.5	2.2	3.3	3.8
50,000-74,999	15034.	56.3	23.0	7.6	1.3	6.1	4.1	0.1	0.4	0.3	0.2	0.7
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.3	1.5	0.2	2.1	4.2	15.2	18.6	54.8
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.3	25.5	36.2
200% - 299%	13198.	6.9	12.4	12.8	9.3	5.1	0.3	6.7	10.4	12.4	11.7	12.7
300% +	41458.	44.8	26.3	13.6	1.7	8.0	5.3	0.0	0.0	0.2	0.2	0.0
TOTAL	78309.	25.0	16.3	9.5	2.8	5.5	2.9	1.9	3.0	6.8	9.0	17.4

87764133

TABLE 3-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $1000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1451.81	4263.	425.46	1295.90	152.	889.40	539.87	7238.	1562.90
10,000-14,999	5541.	182.85	1401.41	3279.	235.23	1362.48	373.	649.25	445.68	1890.	1657.54
15,000-19,999	6602.	321.59	1290.56	4312.	331.03	1294.22	735.	946.47	622.57	1555.	1596.42
20,000-29,999	10400.	527.12	1120.73	5734.	549.47	1516.99	3330.	700.31	423.82	1337.	1157.35
30,000-39,999	9901.	813.46	861.88	3705.	687.21	1561.65	5518.	988.33	419.27	598.	848.71
40,000-49,999	8529.	874.71	612.05	2276.	733.41	1599.08	5924.	977.59	224.43	329.	764.43
50,000-74,999	15034.	1173.81	234.51	1122.	747.58	1575.83	13287.	1265.07	127.96	626.	91.74
75,000 +	10648.	1257.44	88.51	66.	1255.53	1549.97	10150.	1311.05	8.60	433.	17.86
INC AS % OF POV											
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10
100% - 149%	6156.	250.66	1645.70	3638.	320.54	1726.13	301.	1253.60	968.95	2218.	1605.92
150% - 199%	6405.	491.56	1473.90	4481.	528.54	1556.32	623.	1252.51	789.69	1301.	1517.79
200% - 299%	13198.	687.80	1279.20	8983.	585.59	1380.39	2722.	1402.65	980.32	1493.	1215.64
300% +	41458.	997.18	180.28	3554.	472.29	877.58	35682.	1111.56	112.58	2224.	152.21
TOTAL	78309.	713.07	798.56	24836.	445.94	1437.04	39468.	1134.21	191.23	14004.	1377.97

8776134

TABLE 3-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $1000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7
15,000-19,999	6602.	0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	18.6	15.1	37.1
20,000-29,999	10400.	0.1	4.9	9.5	6.8	8.5	0.5	9.8	7.5	11.6	13.2	25.6
30,000-39,999	9901.	7.3	19.7	15.8	6.7	6.3	2.7	3.2	5.7	5.7	12.6	14.3
40,000-49,999	8529.	16.8	28.3	12.9	4.6	6.8	2.7	2.3	3.5	5.4	6.4	10.3
50,000-74,999	15034.	48.2	22.5	9.5	2.5	5.7	3.6	0.4	1.5	2.0	1.8	2.3
75,000 +	10648.	61.5	20.2	4.7	0.2	6.7	4.0	0.2	0.3	0.0	0.2	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	55.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.7	0.2	2.1	4.0	15.5	18.6	54.8
150% - 199%	6405.	0.9	2.1	1.8	2.2	2.4	0.3	5.8	6.1	15.2	24.0	39.2
200% - 299%	13198.	2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.8	25.0
300% +	41458.	37.7	24.0	12.2	4.2	7.9	3.7	2.1	2.4	2.9	2.1	0.8
TOTAL	78309.	20.4	13.6	7.4	3.4	5.6	2.0	3.2	4.3	8.8	11.3	20.1

87764135

TABLE 4-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $1000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1453.47	4263.	125.46	1297.98	152.	869.40	539.87	7238.	1564.35
10,000-14,999	5541.	182.85	1425.13	3279.	235.23	1384.32	373.	649.25	448.03	1890.	1688.74
15,000-19,999	6602.	321.59	1340.76	4326.	332.40	1343.79	721.	950.49	627.94	1555.	1662.90
20,000-29,999	10400.	527.12	1302.55	7061.	541.10	1481.98	2003.	829.76	620.99	1337.	1376.28
30,000-39,999	9901.	813.46	1313.41	8083.	698.11	1606.23	3220.	1182.65	772.42	598.	1248.75
40,000-49,999	8529.	874.71	1156.65	4444.	753.78	1627.24	3756.	1094.47	587.29	329.	1301.60
50,000-74,999	15034.	1173.81	808.11	4237.	881.70	1709.10	10171.	1367.72	452.24	626.	492.24
75,000 +	10648.	1257.44	255.49	756.	907.38	1778.91	9460.	1342.92	135.91	433.	209.76
INC AS % OF POV											
< POVERTY	11080.	65.68	1679.14	4181.	144.05	1654.89	132.	953.37	603.02	6768.	1715.10
100% - 149%	6158.	250.66	1668.97	3650.	331.09	1754.67	288.	1159.99	865.37	2218.	1632.54
150% - 199%	6405.	491.56	1518.15	4481.	528.54	1598.48	623.	1252.51	793.93	1301.	1588.37
200% - 299%	13198.	687.80	1441.13	9349.	622.79	1577.35	2356.	1381.93	946.89	1493.	1368.36
300% +	41458.	997.18	659.63	12788.	670.93	1306.24	26453.	1238.50	357.96	2224.	528.04
TOTAL	78309.	713.07	1085.08	34448.	539.43	1507.69	29856.	1247.96	419.49	14004.	1464.73

87764136

TABLE 4-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $1000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.8	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.6	17.0	22.0	44.3
15,000-19,999	6602.	0.3	2.4	2.1	2.3	3.9	0.0	5.8	8.6	20.2	16.8	37.9
20,000-29,999	10400.	0.1	1.9	3.0	6.0	8.2	0.0	9.7	8.0	16.4	17.2	29.4
30,000-39,999	9901.	3.1	5.0	8.4	10.2	6.0	0.1	5.1	9.3	11.7	17.8	23.5
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	0.7	4.2	7.2	9.2	15.8	18.9
50,000-74,999	15034.	27.0	19.7	11.7	5.1	4.3	1.7	2.4	4.5	5.7	8.8	9.3
75,000 +	10648.	53.0	21.1	4.9	1.7	8.1	3.6	0.2	1.0	2.0	1.8	2.5
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.8	1.5	0.2	2.3	4.0	15.3	18.2	55.4
150% - 199%	6405.	0.9	2.1	1.8	2.0	2.6	0.3	5.8	5.9	14.8	23.5	40.3
200% - 299%	13198.	2.0	3.3	3.8	4.5	4.3	0.1	6.2	8.9	16.4	19.4	31.1
300% +	41458.	24.2	15.9	10.4	6.1	7.2	1.7	3.9	5.6	8.4	9.5	7.1
TOTAL	78309.	13.2	9.3	6.4	4.3	4.9	1.0	3.9	5.6	11.7	15.1	24.6

87764137

TABLE 5-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF $2000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1578.47	4263.	125.46	1367.33	152.	889.40	539.87	7238.	1724.74
10,000-14,999	5541.	102.85	1262.97	2633.	211.75	1481.33	1019.	447.27	235.85	1890.	1512.80
15,000-19,999	6602.	321.59	819.70	1883.	315.45	1789.17	3164.	483.23	92.77	1555.	1125.36
20,000-29,999	10400.	527.12	443.35	1904.	560.02	1923.13	7159.	616.82	61.70	1337.	379.80
30,000-39,999	9901.	813.46	103.12	421.	663.85	1665.13	8882.	874.39	22.32	598.	204.78
40,000-49,999	8529.	874.71	28.38	84.	948.77	1588.10	8116.	909.39	9.86	329.	87.99
50,000-74,999	15034.	1173.81	5.67	39.	797.01	1609.45	14370.	1225.92	1.59	626.	0.00
75,000 +	10648.	1257.44	0.00	0.	0.00	0.00	10218.	1310.70	0.00	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1886.86
100% - 149%	6158.	250.66	1620.72	3650.	331.09	1696.02	288.	1159.99	844.52	2218.	1597.85
150% - 199%	6405.	491.56	889.18	3013.	383.32	1188.53	2090.	953.64	403.90	1301.	975.55
200% - 299%	13198.	687.80	63.10	357.	497.53	1490.40	11348.	784.31	13.63	1493.	97.57
300% +	41458.	997.18	1.45	24.	283.95	566.26	39211.	1054.15	0.95	2224.	8.22
TOTAL	78309.	713.07	469.47	11225.	280.65	1572.72	53079.	992.66	25.60	14004.	1267.54

87764138

TABLE 5-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF $2000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	14.7	39.0
15,000-19,999	6602.	1.8	8.6	24.4	6.5	6.6	9.6	1.6	1.7	5.7	8.1	25.5
20,000-29,999	10400.	8.7	20.5	27.7	4.4	7.5	9.4	0.8	1.3	3.4	4.7	11.6
30,000-39,999	9901.	29.6	32.6	13.1	4.2	10.2	5.2	0.5	0.5	0.7	1.3	2.2
40,000-49,999	8529.	35.6	36.4	12.2	2.1	8.9	3.7	0.3	0.0	0.2	0.4	0.3
50,000-74,999	15034.	57.7	22.4	7.8	1.4	6.5	4.2	0.1	0.0	0.0	0.1	0.1
75,000 +	10648.	62.3	20.2	4.6	0.2	8.7	4.1	0.0	0.0	0.0	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.2	1.1	0.8	1.3	1.3	0.2	2.6	3.7	15.4	20.9	52.6
150% - 199%	6405.	3.8	9.2	7.9	6.6	5.4	0.0	6.1	7.8	19.1	16.5	17.9
200% - 299%	13198.	25.9	23.4	19.6	5.3	11.8	10.4	0.2	0.2	0.4	0.9	2.0
300% +	41458.	45.0	26.3	13.5	1.8	8.0	5.3	0.0	0.0	0.0	0.0	0.0
TOTAL	78309.	28.5	18.7	11.2	2.6	6.8	4.6	0.9	1.3	5.0	6.6	13.9

87764139

TABLE 6-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY; HIGH RISK ADD-ON OF $2000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1584.52	4263.	125.46	1375.14	152.	869.40	539.87	7238.	1729.88
10,000-14,999	5541.	182.85	1449.48	3279.	235.23	1402.66	373.	649.25	442.73	1890.	1729.35
15,000-19,999	8602.	321.59	1241.37	3737.	317.82	1376.59	1330.	708.00	438.18	1555.	1605.44
20,000-29,999	10400.	527.12	877.40	3637.	591.93	1090.62	5426.	613.56	191.63	1337.	904.06
30,000-39,999	9901.	813.46	530.25	2066.	669.98	1686.93	7237.	921.70	192.44	598.	621.66
40,000-49,999	8529.	874.71	262.91	1035.	713.93	1519.57	7165.	938.11	69.48	329.	520.39
50,000-74,999	15034.	1173.81	61.90	345.	785.03	1864.46	14063.	1235.57	19.25	626.	25.52
75,000 +	10648.	1257.44	9.38	34.	653.48	826.41	10182.	1312.88	7.07	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86
100% - 149%	6156.	250.66	1710.81	3650.	331.09	1785.65	288.	1159.99	858.52	2218.	1698.57
150% - 199%	6405.	491.56	1494.40	4458.	522.77	1569.39	646.	1266.96	809.53	1301.	1577.37
200% - 299%	13198.	687.80	832.99	5657.	463.56	1179.14	6048.	1067.45	486.44	1493.	925.73
300% +	41458.	997.18	25.18	432.	680.77	1541.74	38804.	1057.83	8.02	2224.	30.22
TOTAL	78309.	713.07	668.38	18377.	384.02	1533.75	45927.	1062.18	89.33	14004.	1431.86

87764140

TABLE 6-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY; HIGH RISK ADD-ON OF $2000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0
15,000-19,999	6602.	0.7	2.1	4.2	7.8	5.3	0.6	8.3	9.8	14.2	12.3	34.8
20,000-29,999	10400.	2.1	12.2	26.5	6.7	4.8	5.1	2.8	4.1	5.4	9.2	21.3
30,000-39,999	9901.	16.9	28.1	16.1	4.1	7.8	3.6	1.6	2.7	3.4	6.2	9.4
40,000-49,999	8529.	28.6	33.0	12.4	2.9	7.1	2.9	0.7	2.2	2.2	2.9	5.0
50,000-74,999	15034.	55.8	23.8	7.5	1.2	6.0	4.1	0.0	0.6	0.3	0.5	1.0
75,000 +	10648.	61.9	20.4	4.4	0.2	8.7	4.1	0.2	0.0	0.2	0.0	0.0
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.2	15.2	18.8	54.8
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.2	25.5	36.3
200% - 299%	13198.	6.9	12.4	12.0	9.3	5.1	0.3	6.7	10.0	12.2	11.2	13.9
300% +	41458.	44.3	26.3	13.5	1.6	8.0	5.3	0.1	0.1	0.1	0.4	0.4
TOTAL	78309.	24.7	16.3	9.4	2.7	5.5	2.9	1.9	3.0	6.7	9.1	17.5

87764141

TABLE 7-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $2000

	FAMILIES RECEIVING TAX BENEFITS TODAY									DO NOT NOW GET TAX BENEFIT	
	ALL FAMILIES			WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1586.49	4263.	125.46	1377.75	152.	869.40	539.87	7238.	1731.52
10,000-14,999	5541.	182.85	1479.62	3279.	235.23	1430.68	373.	649.25	445.68	1890.	1768.56
15,000-19,999	6602.	321.59	1363.27	4312.	331.01	1361.57	735.	946.47	622.57	1555.	1718.37
20,000-29,999	10400.	527.12	1178.99	5746.	555.69	1600.80	3317.	690.11	412.70	1337.	1267.79
30,000-39,999	9901.	815.46	937.16	3815.	695.50	1681.00	5488.	984.22	417.25	598.	963.41
40,000-49,999	8529.	874.71	843.44	2319.	741.26	1692.36	5881.	976.28	223.09	329.	764.43
50,000-74,999	15034.	1173.81	263.71	1226.	750.21	1688.27	13182.	1268.93	138.11	626.	117.37
75,000 +	10648.	1257.44	39.95	163.	1020.89	1560.01	10053.	1315.39	16.29	433.	17.86
INC AS % OF POV											
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86
100% - 149%	6356.	250.66	1739.24	3650.	331.09	1813.40	288.	1159.99	862.34	2218.	1731.32
150% - 199%	6405.	491.56	1555.35	4481.	528.54	1628.22	623.	1252.51	789.69	1301.	1671.07
200% - 299%	13198.	687.80	1337.80	8983.	585.59	1449.59	2722.	1402.65	980.32	1493.	1317.26
300% +	41458.	997.18	206.98	3829.	508.13	1050.80	35408.	1112.64	117.85	2224.	173.30
TOTAL	78309.	713.07	856.93	25123.	453.17	1524.32	39181.	1134.62	195.53	14004.	1510.23

87764142

TABLE 7-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $2000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7
15,000-19,999	6602.	0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	18.8	15.1	37.1
20,000-29,999	10400.	0.1	4.9	9.5	8.8	8.4	0.5	9.8	7.5	11.6	13.3	25.6
30,000-39,999	9901.	7.3	19.5	15.7	6.7	6.3	2.7	3.1	5.7	5.8	11.5	15.9
40,000-49,999	8529.	18.8	28.0	12.7	4.6	8.9	2.7	2.1	3.2	5.5	6.3	11.3
50,000-74,999	15034.	47.4	22.3	9.4	2.7	5.7	3.7	0.6	1.3	2.1	1.8	3.0
75,000 +	10648.	60.6	20.6	4.4	0.2	8.5	4.0	0.3	0.3	0.2	0.7	0.2
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.5	18.8	54.8
150% - 199%	6405.	0.9	2.1	1.8	2.2	2.4	0.3	5.8	6.1	15.2	23.8	39.3
200% - 299%	13198.	2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.7	25.1
300% +	41458.	37.2	23.9	12.0	4.3	7.9	3.7	2.3	2.3	3.0	2.0	1.7
TOTAL	78309.	20.1	13.6	7.3	3.4	5.5	2.0	3.2	4.2	8.8	11.2	20.

87764143

TABLE 8-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $2000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1508.07	4263.	125.46	1379.84	152.	869.40	539.87	7238.	1732.84
10,000-14,999	5541.	182.85	1503.05	3279.	235.23	1452.02	373.	649.25	448.03	1890.	1799.75
15,000-19,999	8602.	321.59	1412.94	4328.	332.40	1410.68	721.	950.49	627.94	3555.	1783.29
20,000-29,999	10400.	527.12	1360.66	7061.	541.10	1546.66	2003.	829.76	620.99	1337.	1486.72
30,000-39,999	9901.	813.46	1368.58	6091.	701.66	1686.40	3212.	1177.17	766.94	598.	1363.45
40,000-49,999	8529.	874.71	1187.80	4444.	753.78	1667.02	3756.	1094.47	587.29	329.	1301.60
50,000-74,999	15034.	1173.81	844.28	4315.	906.35	1619.44	10094.	1360.94	445.67	626.	550.18
75,000 +	10648.	1257.44	286.80	836.	953.63	1974.05	9380.	1342.53	134.95	433.	209.76
INC AS % OF POV											
< POVERTY	11080.	65.68	1822.93	4181.	144.05	1754.69	132.	953.37	603.02	6768.	1888.86
100% - 149%	6156.	250.66	1761.75	3650.	331.09	1635.21	288.	1159.99	865.37	2218.	1757.53
150% - 199%	6405.	491.56	1599.00	4481.	528.54	1670.07	623.	1252.51	793.93	1301.	1739.79
200% - 299%	13198.	687.80	1499.53	9349.	622.79	1643.57	2356.	1381.93	946.89	1493.	1469.98
300% +	41458.	997.18	691.41	12955.	686.55	1393.57	26286.	1234.40	356.48	2224.	558.21
TOTAL	78309.	713.07	1146.00	34615.	545.91	1587.09	29690.	1244.39	418.52	14004.	1598.19

87764144

TABLE 8-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $2000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	16.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.0	22.0	44.3
15,000-19,999	6602.	0.3	2.4	2.1	2.3	3.9	0.0	5.8	8.6	20.2	18.6	37.9
20,000-29,999	10400.	0.1	1.9	3.0	6.0	8.2	0.0	9.6	8.0	16.4	17.2	29.6
30,000-39,999	9901.	3.1	5.0	8.3	10.2	6.0	0.1	5.1	9.3	11.5	17.6	23.9
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	0.7	4.2	7.2	9.1	15.6	19.2
50,000-74,999	15034.	26.7	19.5	11.6	5.1	4.3	1.7	2.3	4.2	5.5	8.6	10.6
75,000 +	10648.	52.1	21.0	5.1	1.6	0.3	3.6	0.2	0.7	2.3	3.5	9.6
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.3	18.2	55.6
150% - 199%	6405.	0.9	2.1	1.8	2.0	2.6	0.3	5.8	5.9	14.8	23.3	40.4
200% - 299%	13198.	2.0	3.3	3.8	4.5	4.3	0.1	6.2	8.9	16.4	19.4	31.1
300% +	41458.	23.9	15.8	10.4	6.1	7.3	1.7	3.9	5.6	8.3	9.3	7.9
TOTAL	78309.	13.1	9.2	6.4	4.3	4.9	1.0	3.9	5.6	11.7	15.0	25.1

87764145

TABLE 9-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF $5000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1709.28	4263.	125.46	1425.00	152.	889.40	539.87	7238.	1901.38
10,000-14,999	5541.	182.85	1377.60	2633.	211.75	1598.75	1019.	447.27	235.85	1890.	1685.36
15,000-19,999	6802.	321.59	946.74	1883.	315.45	2045.31	3164.	483.23	92.77	1555.	1354.66
20,000-29,999	10400.	527.12	572.38	1995.	593.89	2355.10	7069.	607.99	50.89	1337.	669.56
30,000-39,999	9901.	813.46	208.08	663.	801.28	2495.03	8640.	870.73	14.81	598.	464.27
40,000-49,999	8529.	874.71	85.56	256.	814.81	2522.81	7944.	912.85	6.84	329.	87.99
50,000-74,999	15034.	1173.81	46.98	232.	936.44	2342.76	14176.	1229.49	9.59	626.	41.48
75,000 +	10648.	1257.44	16.62	70.	1461.74	2113.15	10146.	1309.66	2.92	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62
100% - 149%	6156.	250.66	1755.82	3650.	331.09	1785.75	288.	1159.99	844.52	2218.	1825.20
150% - 199%	6405.	491.56	1040.38	3024.	369.61	1389.92	2080.	947.32	394.92	1301.	1260.02
200% - 299%	13198.	687.80	212.53	594.	752.09	3765.94	11110.	776.81	0.00	1493.	379.60
300% +	41458.	997.18	37.61	546.	906.68	2331.09	38690.	1055.75	4.64	2224.	48.59
TOTAL	78309.	713.07	554.58	11995.	327.69	1819.57	52310.	992.35	25.31	14004.	1448.17

87764146

TABLE 9-B
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 200% POVERTY: HIGH RISK ADD-ON OF $5000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.7	26.9	47.9
10,000-14,999	5541.	0.2	1.3	5.4	4.2	7.4	1.6	4.7	5.4	16.2	14.7	39.0
15,000-19,999	6602.	1.8	6.6	24.4	6.5	6.6	9.6	1.6	1.7	5.7	7.6	25.7
20,000-29,999	10400.	8.6	20.4	27.6	4.1	7.3	9.3	0.7	1.2	3.0	3.8	14.0
30,000-39,999	9901.	29.1	31.8	13.0	3.5	10.0	5.1	0.3	0.6	0.8	1.4	4.6
40,000-49,999	8529.	34.9	36.0	11.9	1.9	8.5	3.7	0.2	0.3	0.0	0.5	2.2
50,000-74,999	15034.	56.6	22.6	7.6	1.2	6.3	4.1	0.1	0.0	0.2	0.2	1.1
75,000 +	10648.	61.9	20.0	4.4	0.2	8.7	4.1	0.0	0.0	0.3	0.2	0.2
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.2	1.1	0.8	1.3	1.3	0.2	2.6	3.7	15.4	20.7	52.6
150% - 199%	6405.	3.6	9.2	7.9	6.6	5.2	0.0	6.1	7.8	19.1	16.6	17.9
200% - 299%	13198.	25.5	23.1	19.4	4.8	11.4	10.3	0.0	0.0	0.0	0.0	5.6
300% +	41458.	44.3	26.1	13.4	1.6	7.9	5.3	0.0	0.1	0.2	0.2	0.9
TOTAL	78309.	28.1	18.6	11.1	2.4	6.7	4.5	0.8	1.4	5.0	6.5	15.0

87764147

TABLE 10-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF $5000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1713.56	4263.	125.46	1431.63	152.	889.40	539.87	7238.	1904.36
10,000-14,999	5541.	182.85	1544.69	3279.	235.23	1482.64	373.	649.25	442.73	1890.	1669.76
15,000-19,999	6602.	321.59	1339.58	3717.	317.82	1475.66	1330.	700.00	438.18	1555.	1785.61
20,000-29,999	10400.	527.12	981.00	3637.	591.93	2100.41	5426.	613.58	191.63	1337.	1139.21
30,000-39,999	9901.	613.46	644.04	2131.	699.94	2132.15	7172.	915.06	185.36	598.	843.70
40,000-49,999	8529.	674.71	334.52	1118.	739.08	1993.14	7082.	936.76	63.98	329.	520.39
50,000-74,999	15034.	1173.81	134.52	596.	1023.04	2963.68	13813.	1233.47	14.80	626.	84.82
75,000 +	10648.	1257.44	69.10	229.	1323.94	2798.25	9987.	1310.39	9.56	433.	0.00
INC AS % OF POV											
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62
100% - 149%	6156.	250.66	1823.85	3650.	331.09	1859.55	288.	1159.99	858.52	2218.	1890.74
150% - 199%	6405.	491.58	1606.90	4458.	522.77	1667.43	646.	1266.96	809.53	1301.	1795.23
200% - 299%	13198.	687.60	955.38	5657.	463.56	1399.35	6048.	1067.45	486.44	1493.	1873.28
300% +	41458.	997.18	92.65	1024.	1081.08	3452.66	38211.	1052.94	4.20	2224.	65.19
TOTAL	78309.	713.07	760.61	18970.	414.90	1753.68	45335.	1058.13	87.18	14004.	1595.56

87764148

TABLE 10-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 300% POVERTY: HIGH RISK ADD-ON OF $5000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	16.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	18.5	23.9	41.0
15,000-19,999	6602.	0.7	2.1	4.2	7.6	5.3	0.6	8.3	9.8	14.2	12.3	34.8
20,000-29,999	10400.	2.1	12.2	26.5	6.7	4.8	5.1	2.8	4.1	5.4	9.0	21.4
30,000-39,999	9901.	16.8	27.8	16.0	4.1	7.7	3.6	1.6	2.6	3.3	5.3	11.0
40,000-49,999	8529.	28.5	32.9	12.0	2.8	6.9	2.9	0.6	2.2	2.1	2.5	6.7
50,000-74,999	15034.	55.2	22.3	7.2	1.2	5.9	4.0	0.0	0.3	0.3	0.4	3.1
75,000 +	10648.	60.5	19.7	4.3	0.6	8.7	4.1	0.0	0.0	0.2	0.4	1.5
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.2	15.2	18.6	55.0
150% - 199%	6405.	1.1	1.9	1.9	2.0	2.8	0.3	5.7	6.2	16.2	25.5	36.3
200% - 299%	13198.	6.9	12.4	12.0	9.3	5.1	0.3	6.7	10.0	12.2	11.1	14.2
300% +	41458.	43.7	25.7	13.3	1.7	7.9	5.2	0.0	0.0	0.1	0.2	2.3
TOTAL	78309.	24.4	16.0	9.3	2.8	5.4	2.9	1.9	2.9	6.7	8.9	18.3

87764149

TABLE 11-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $5000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1714.99	4263.	125.46	1433.85	152.	889.40	539.87	7238.	1905.36
10,000-14,999	5541.	182.85	1567.46	3279.	235.23	1504.94	373.	649.25	445.68	1890.	1897.25
15,000-19,999	8602.	321.59	1450.18	4312.	331.01	1436.66	735.	946.47	622.57	3555.	1879.14
20,000-29,999	10400.	527.12	1269.33	5746.	555.69	1716.19	3317.	690.11	412.70	1337.	1474.68
30,000-39,999	9901.	813.46	1038.32	3823.	701.16	1912.71	5480.	980.71	414.86	598.	1161.11
40,000-49,999	8529.	874.71	704.41	2331.	746.27	1915.39	5869.	974.78	220.07	329.	764.43
50,000-74,999	15034.	1173.81	340.55	1432.	908.49	2377.40	12977.	1259.66	120.98	626.	234.49
75,000 +	10648.	1257.44	105.77	307.	1367.57	3150.65	9903.	1308.94	15.36	433.	17.86
INC AS % OF POV											
< POVERTY	11060.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62
100% - 149%	6156.	250.68	1844.81	3650.	331.09	1882.23	288.	1359.99	862.34	2218.	1911.11
150% - 199%	6405.	491.56	1653.06	4481.	528.54	1712.11	623.	1252.51	789.69	1301.	1863.14
200% - 299%	13198.	687.80	1445.66	8983.	585.59	1570.35	2722.	1402.65	980.32	1493.	1544.11
300% +	41458.	997.18	274.09	4198.	625.80	1669.34	35039.	1104.91	110.55	2224.	216.74
TOTAL	78309.	713.07	944.73	25493.	473.34	1696.60	38812.	1127.86	189.68	14004.	1668.71

87764150

TABLE 11-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 400% POVERTY: HIGH RISK ADD-ON OF $5000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.5	23.2	42.7
15,000-19,999	8602.	0.3	2.4	2.1	2.4	4.0	0.0	7.0	11.1	10.6	15.1	37.1
20,000-29,999	10400.	0.1	4.9	9.5	8.8	8.4	0.5	9.8	7.5	11.6	13.2	25.7
30,000-39,999	9901.	7.2	19.5	15.7	6.7	6.3	2.7	3.1	5.6	5.5	11.4	16.3
40,000-49,999	8529.	16.6	28.0	12.7	4.6	6.8	2.7	2.1	3.2	5.2	6.1	12.0
50,000-74,999	15034.	47.1	21.8	9.4	2.5	5.5	3.5	0.4	1.2	1.8	1.7	5.1
75,000 +	10648.	59.7	19.7	4.6	0.5	8.5	4.0	0.2	0.2	0.0	0.7	2.0
INC AS % OF POV												
< POVERTY	11000.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.5	18.6	55.0
150% - 199%	6405.	0.9	2.1	1.0	2.2	2.4	0.3	5.8	6.1	15.2	23.8	39.3
200% - 299%	13198.	2.1	3.7	4.4	4.6	5.9	0.0	7.8	10.7	16.1	19.7	25.1
300% +	41458.	36.6	23.5	12.0	4.3	7.8	3.6	2.0	2.2	2.7	1.8	3.1
TOTAL	78309.	19.9	13.4	7.3	3.4	5.5	2.0	3.1	4.2	8.7	11.1	21.4

87764151

TABLE 12-A
CHANGE IN AVERAGE FAMILY TAX
BENEFITS UNDER TAX CREDIT
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $5000

	ALL FAMILIES			FAMILIES RECEIVING TAX BENEFITS TODAY						DO NOT NOW GET TAX BENEFIT	
				WINNERS			LOSERS				
	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX BENEFIT	AVG TAX CREDIT	FAMILIES (THOUS)	AVG TAX CREDIT
FAMILY INCOME											
< 10,000	11653.	57.52	1716.12	4263.	125.46	1435.61	152.	869.40	539.87	7238.	1906.14
10,000-14,999	5541.	182.85	1585.22	3279.	235.23	1522.11	373.	649.25	448.03	1890.	1919.07
15,000-19,999	6602.	321.59	1491.12	4326.	332.40	1477.29	721.	950.49	627.94	1555.	1929.91
20,000-29,999	10400.	527.12	1437.04	7061.	541.10	1625.20	2003.	829.76	620.99	1337.	1666.19
30,000-39,999	9901.	813.46	1459.06	6091.	701.66	1807.78	3212.	1177.17	766.94	598.	1525.97
40,000-49,999	8529.	874.71	1236.03	4444.	753.78	1779.59	3756.	1094.47	587.29	329.	1301.60
50,000-74,999	15034.	1173.81	906.92	4354.	914.37	2015.74	10055.	1359.22	440.96	626.	679.36
75,000 +	10648.	1257.44	343.27	925.	1044.44	2460.39	9291.	1337.21	138.74	433.	209.78
INC AS % OF POV											
< POVERTY	11080.	65.68	1948.67	4181.	144.05	1816.37	132.	953.37	603.02	6768.	2056.62
100% - 149%	6156.	250.66	1861.57	3650.	331.09	1900.37	288.	1159.99	865.37	2218.	1927.37
150% - 199%	6405.	491.56	1685.42	4481.	528.54	1743.35	823.	1252.51	793.93	1301.	1912.84
200% - 299%	13198.	687.80	1589.82	9349.	622.79	1739.14	2356.	1381.93	946.89	1493.	1669.64
300% +	41458.	997.18	746.78	13082.	698.10	1555.31	26159.	1231.30	354.84	2224.	598.80
TOTAL	78309.	713.07	1223.24	34743.	550.77	1696.72	29562.	1241.68	417.34	14004.	1749.97

8776452

TABLE 12-8
DISTRIBUTION OF FAMILIES BY
CHANGE IN TAX BENEFITS
FAMILIES WITH HEAD < 65

INCOME PHASE-OUT AT 600% POVERTY: HIGH RISK ADD-ON OF $5000

		REDUCTION IN TAX BENEFITS						INCREASE IN TAX BENEFITS				
	FAMILIES (THOUS)	1000+	500-999	250-499	100-249	1-99	NO CHANGE	1-99	100-249	250-499	500-999	1000+
FAMILY INCOME												
< 10,000	11653.	0.1	0.3	0.1	0.5	0.4	0.0	1.4	3.8	18.6	26.5	48.5
10,000-14,999	5541.	0.0	1.1	1.1	0.8	3.3	0.6	4.9	4.8	17.0	22.0	44.3
15,000-19,999	6602.	0.3	2.4	2.1	2.3	3.9	0.0	5.8	8.6	20.2	16.6	37.9
20,000-29,999	10400.	0.1	1.9	3.0	6.0	8.2	0.0	9.6	8.0	16.4	17.2	29.6
30,000-39,999	9901.	3.1	5.0	8.3	10.2	6.0	0.1	5.1	9.3	11.5	17.5	24.0
40,000-49,999	8529.	3.8	13.0	16.2	6.4	4.7	0.7	4.2	7.2	9.1	15.6	19.2
50,000-74,999	15034.	26.7	19.5	11.5	5.1	4.2	1.7	2.3	4.2	5.3	8.4	11.2
75,000 +	10648.	51.7	20.5	4.9	1.8	8.4	3.6	0.2	0.7	1.9	1.6	4.8
INC AS % OF POV												
< POVERTY	11080.	0.1	0.3	0.1	0.5	0.3	0.0	0.9	2.6	14.8	24.1	56.3
100% - 149%	6156.	0.0	1.2	0.8	1.1	1.5	0.2	2.1	4.0	15.3	18.2	55.6
150% - 199%	6405.	0.9	2.1	1.8	2.0	2.6	0.3	5.8	5.9	14.8	23.3	40.4
200% - 299%	13198.	2.0	3.3	3.8	4.5	4.3	0.1	6.2	6.9	16.4	19.4	31.1
300% +	41450.	23.8	15.8	10.4	8.1	7.2	1.7	3.9	5.5	8.1	9.3	8.5
TOTAL	78309.	13.0	9.1	6.3	4.3	4.9	1.0	3.9	5.6	11.6	14.9	25.4

87764153

THE CONSUMER CHOICE HEALTH REFORM PROPOSAL: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764154

THE CONSUMER CHOICE MODEL

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EMPLOYER RESPONSIBILITY

- *EMPLOYERS MUST CONTRIBUTE TO HEALTH INSURANCE COSTS FOR ALL WORKERS.*
  - *Employers must cover all full-time workers (25 or more hours per week) except seasonal and temporary workers.*
  - *Employers must pay a tax equal to 8 percent of the first $27,150 in wages for uncovered workers (part-time, seasonal and temporary).*[a]
  - *Small employers may pay the 8 percent payroll tax in lieu of offering insurance to full-time workers.*
  - *Self-employed individuals will obtain insurance through a public plan (see discussion below).*
- *WORKING DEPENDENTS ARE REQUIRED TO TAKE COVERAGE ON THEIR OWN JOB.*
- *THE PLAN COVERS:*
  - *Inpatient and Outpatient Hospital Care*
  - *Physicians Services*
  - *Prescription Drugs*
  - *Laboratory and Diagnostic Tests*
  - *Mental Health and Substance Abuse*

a *The taxable wage base under the plan ($27,100) is equal to one-half of the Social Security Taxable Wage Base.*

87764156

EMPLOYER RESPONSIBILITY

(continued)

- *COST SHARING*
  - *$250 Deductible ($500 Per Family)*
  - *Out-of-Pocket Limit of $2,000 Per Person ($4,000 Per Family)*

Coinsurance	Plan Provisions
Inpatient Hospital Services	
Days 1-30	*80%-20%*
Days 31-365	*50%-50%*
Outpatient Hospital Services	*80%*
Hospital Alternative (Extended or Home Health Care)	*Yes*
Physician Services	*75%*
Prenatal/Well Baby/Well Child-Care	*100%*
Diagnostic Tests	*75%*
Prescription Drugs	*75%*
Emergency Services	*100%*
Mental Health Care	
Inpatient Days 1-21	*80%-20%*
Inpatient Days 21-365	*50%-50%*
Outpatient	*75%-25%*
Dental Care	*Not Covered*
Routine Physicals and Tests	*50%-50%*

- *EMPLOYER PAYS 80 PERCENT OF PREMIUM FOR BASIC BENEFITS PACKAGE*

87764157

PERSONS NOT COVERED BY AN EMPLOYER PLAN

- *ALL PERSONS NOT COVERED UNDER AN EMPLOYER PLAN OBTAIN COVERAGE THROUGH THE PUBLIC SPONSOR INCLUDING:*
  - *Part-time and seasonal workers not covered by employer plan*
  - *Non-Workers*
  - *Self-Employed Persons*
- *COVERED SERVICES AND COST SHARING REQUIREMENTS ARE THE SAME AS UNDER THE EMPLOYER PLAN EXCEPT FOR LOW-INCOME FAMILIES.*
- *PREMIUM AND COST SHARING SUBSIDIZED FOR PERSONS BELOW 150 PERCENT OF POVERTY.*
  - *Premium and cost sharing eliminated for persons below poverty.*
  - *Premium and cost sharing phased-in between poverty and 150 percent of poverty.*
  - *All above 150 percent of poverty pay 20 percent of premium and full cost sharing amounts.*
- *SUPPLEMENTAL BENEFITS ARE PROVIDED FOR PERSONS BELOW POVERTY (SEE FIGURE 1).*
- *ALL PERSONS NOT OTHERWISE COVERED BY AN EMPLOYER PLAN PAY AN 8 PERCENT TAX ON AGI UP TO $27,100.*[1]

1 *The taxable wage base varies with family size in proportion to the poverty threshold. The taxable wage base for a family of three was assumed to be $27,100.*

87764158

Figure 1

SUPPLEMENTAL BENEFITS FOR LOW INCOME INDIVIDUALS

Benefits	*Plan Provisions*
Private Duty Nursing	*100%*
Dental Care	*100%*
Clinic Services	*100%*
Physical Therapy	*100%*
Occupational Therapy	*100%*
Speech, Hearing and Language Disorders	*100%*
Dentures	*100%*
Prosthetic Devices	*100%*
Eyeglasses	*100%*
Preventive Services	*100%*
Rehabilitative Services	*100%*
Inpatient Psychiatric Care for Individuals Under Age 21	*100%*
Hospice Services	*100%*
Transportation	*100%*
Case Management	*100%*
Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Age 21	*100%*
Podiatrists, Optometrist, and Chiropractor Services	*100%*

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STRUCTURAL INCENTIVES TO CONTAIN HEALTH SPENDING

- *PLAN ENCOURAGES AND FACILITATES COST CONSCIOUS DECISION MAKING IN SELECTING COVERAGE.*
- *INCENTIVES FOR INDIVIDUALS TO REDUCE COSTS.*
  - *Employers may provide supplements to the basic benefits package but at full cost to the employee.*
  - *Employees will purchase supplemental insurance coverage out of after-tax income (i.e., the tax exclusion is eliminated for health benefits over minimum standard).*
  - *Employers who currently provide coverage in excess of the basic benefits package are required to shift contributions for these excess benefits to employees as in other forms of compensation.*
- *MANAGED COMPETITION.*
  - *Public sponsors created to aggregate buying power of small employers and individuals.*
  - *Individuals select among plans competing on the basis of price and quality.*
  - *Health plans paid with capitated rates to provide incentives to contain costs.*

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KEY ASSUMPTIONS

- *UTILIZATION OF HEALTH SERVICES FOR NEWLY INSURED INDIVIDUALS IS ASSUMED TO INCREASE TO THE LEVEL REPORTED FOR INSURED PERSONS WITH SIMILAR CHARACTERISTICS. (THE UTILIZATION INCREASE FOR NEWLY INSURED PERSONS IS ESTIMATED TO BE $14.3 BILLION).*

- *EMPLOYER CONTRIBUTIONS FOR INSURANCE IN EXCESS OF THE MINIMUM BENEFIT STANDARDS ARE ASSUMED TO BE CONVERTED TO WAGES AND SALARIES SO THAT TOTAL EMPLOYER COSTS (INCLUDING FICA PAYMENTS) REMAIN UNCHANGED FOR THESE WORKERS. (THE INCREASE IN WAGES AND SALARIES IS ESTIMATED TO BE $23.6 BILLION).*

- *ALL INDIVIDUALS IN PLANS WHICH EXCEED THE MINIMUM BENEFITS STANDARDS ARE ASSUMED TO SHIFT TO SOME FORM OF MANAGED CARE PLAN IN WHICH HEALTH SPENDING IS REDUCED TO THE POINT WHERE THE EMPLOYEE AFTER TAX PREMIUM CONTRIBUTION IS THE SAME AS UNDER CURRENT POLICY. (THE REDUCTION IN HEALTH SPENDING IS ESTIMATED TO BE $9.7 BILLION IN 1991).*

- *EMPLOYERS HAVE THE OPTION OF COVERING PART-TIME, SEASONAL AND TEMPORARY WORKERS RATHER THAN PAYING THE PAYROLL TAX. EMPLOYERS ARE ASSUMED TO PROVIDE INSURANCE TO THESE WORKERS WHENEVER THIS IS LESS COSTLY THAN PAYING THE TAX.*

87764161

Table 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)

Household Payments		***$ 9.8***
Tax Payments	*47.3*	
Premium Payments	*(18.8)*	
Out-of-Pocket Spending	*(18.7)*	
Private Employers		***7.7***
Currently Provide Insurance	*(9.6)*	
Currently Do Not Insure	*17.3*	
State and Local Governments		***(12.2)***
Federal Government (Program Fully Funded)		***0.0***
Change in National Health Spending		***$5.3***
Utilization Increase for Newly Insured	*12.2*	
Tax Induced Reduction in Utilization	*(9.7)*	
Net Change in Administrative Costs	*2.8*	

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764162

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)

Sources of Funds[a]			Uses of Funds		
Employer Payroll Tax For Workers Covered Under Public Plan[c]		$ 7.3	*Benefit Payments*		$102.3
			Workers and Dependents Covered Under Plan[g]	22.6	
			Self-Employed and Others[h]	47.2	
			Cost-Sharing Subsidies to Low-Income Persons[i]	24.8	
			Supplemental Benefits[j]	7.7	
Premium Payments[b]		10.2	*Administrative Costs*[k]		5.9
Workers Covered Under Plan	4.3		*Workers and Dependents*	2.7	
Non-Workers	5.9		*Non-Workers*	3.2	
Tax on AGI For Persons Not Covered Under Employer Plan[d]		19.8	*Change in Corporate Tax Revenues*[l]		2.4
State Contribution to Public Plan[e]		19.9	*Offsets to Other Federal Programs*		(27.1)
			Medicaid	(25.4)	
			CHAMPUS and Other[m]	(1.7)	
Tax on the Value of Benefits Provided in Excess of the Minimum Standard[f]		10.3			
Personal Income Tax Increase[f]		16.0			
Total Sources of Funds		$ 83.5	*Total Uses of Funds*		$ 83.5

(Footnotes on Next Page)

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Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)

Footnotes to Previous Table

a Employers will pay an eight percent tax on payroll up to $27,100 for all uninsured workers. These include part-time and seasonal workers and employees in small firms that decide to pay the tax rather than not to purchase insurance.

b Individuals not otherwise covered under an employer plan can purchase insurance from the public sponsor by paying 20 percent of the premium ($35.80 per month). The premium is eliminated for persons below poverty and phased-in between poverty and 150 percent of poverty.

c Self-employed persons and everyone else not cover through employment would be required to pay an eight percent tax on adjusted gross income (AGI) up to a ceiling which varies with family size. The ceiling is assumed to be $27,100 for a family of three and varies with family size in proportion to the poverty threshold.

d States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care. Medicaid is assumed to be retained for long-term care.

e Employers that now contribute to insurance in excess of the minimum standard are assumed to shift these contributions to employees in the form of wages and salaries which become subject to FICA and personal income taxes.

f The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (3.26 percent).

g Workers covered under the public fund include workers in small firms and part-time and seasonal workers where the employer decided to pay the tax rather than purchase insurance.

h Includes self-employed persons and others not otherwise covered by employer plans.

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Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)

Footnotes to Previous Table
(continued)

i *The program pays cost sharing for all persons below poverty and phases in cost sharing through 150 percent of poverty.*

j *Includes the cost of supplemental benefits for persons below poverty.*

k *Administrative costs are assumed to equal 12 percent of claims for the workers component of the program; 5.0 percent of claims for self-employed and others covered under the public plan; and 2.7 percent of the cost of subsidies to low income persons.*

l *Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.*

m *Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.*

SOURCE: LewinICF estimates using the Health Benefits Simulation Model (HBSM).

87764165

Table 3

CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Care	$115.5	--	$115.5
Increase in Employer Cost			
Cover Persons Not Now Insured at Minimum Standard Benefit[a]	14.3	30.6	44.9
Minimum Benefit Standard[b]	2.0	--	2.0
Cost Offset Under Plan			
Limit on Employer Costs to 8 Percent of Payroll for:[c]			
Part-Time and Seasonal Workers	(2.1)	(1.2)	(3.3)
Small Employers	(0.8)	(6.4)	(7.2)
Working Dependents Shifted to Their Own Job[d]	(21.0)	--	(21.0)
Cost Shift Savings	(5.2)	--	(5.2)
Total Employer Cost	102.7	23.0	125.7
Net Change in Employer Costs	(12.8)	23.0	10.2
Change in Tax Payments	3.2	(5.7)	(2.5)
Net After Tax Change in Employer Costs	$ (9.6)	$17.3	$ 7.7

(Footnotes on next page)

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Table 3

CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE CONSUMER CHOICE MODEL IN 1991
(In Billions)

a *Insurance costs for persons not now covered under existing plans (part-time, seasonal, etc.)*

b *Employer plans that do not provide the minimum level of benefits will be required to upgrade to conform to the minimum standard.*

c *Employer expenditures for health benefits are effectively capped at 8 percent of payroll for small employers and employers of part-time and seasonal workers.*

d *Working dependent spouses will be required to take coverage on their own job. Dependent children in two worker families will also be allocated across the two employers.*

e *Note: We assume that employers that now provide coverage in excess of the minimum standard shift the premium contribution over the allowed amount to the employee in the form of increased wages and salaries. Thus, the limitation on employer health benefits contributions under the Consumer Choice Model is assumed to have no effect on total employer compensation costs.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 4

IMPACT OF THE CONSUMER CHOICE MODEL ON STATE AND LOCAL GOVERNMENTS IN 1991
(In Billions)

		Change in Expenditures
Changes in Employee Benefit Costs		$(1.7)
Current Employee Benefit Costs	23.9	
Change in Employee Benefits Costs	(1.7)	
Total Employee Benefit Costs	22.2	
Change in Medicaid Spending[a]		0.0
Savings to Public Hospitals and Other Programs[b]		(9.4)
Change in State Income Taxes Due to Changes in Wages and Salaries		(1.2)
Reduction in Corporate Tax Payments		0.1
Net Impact on State and Local Governments		$(12.2)

a *All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.*

b *Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program.*

SOURCE: *LewinICF estimates using the Health Benefits Simulation Model (HBSM).*

87764168

Table 5

CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER THE CONSUMER CHOICE MODEL IN 1991

(In Billions)

	Change From Current Policy
Individual Premium Payments	
Net Change in Employee Share of Employer Plan Premium[a]	(18.6)
Non-Group Premium Payment	(10.4)
Premium Payments For Persons Covered Under Public Plan	10.2
Tax Payments	
Change in Federal Taxes Due to Changes in Wages and Salaries	$10.3
Change in State Taxes Due to Changes in Wages and Salaries	1.2
Personal Income Tax Increase	16.0
Tax on AGI For Persons Not Covered by An Employer Plan	19.8
Direct Payments for Care	
Households Out-of-Pocket Expenditures	(18.7)
Net Change in Household Health Spending	$ 9.8

a Includes changes in employee premium payments net of increases in wages and salaries for persons covered under plans which exceed minimum benefits standards.

b Includes FICA and increased personal income tax payments on increased wages and salaries for currently insured workers in firms that exceed the minimum benefits standard.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764169

THE PUBLIC/PRIVATE PARTNERSHIP PLAN: FOR UNIVERSAL ACCESS ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

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THE PUBLIC/PRIVATE PARTNERSHIP PLAN

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THE PUBLIC/PRIVATE PARTNERSHIP PLAN

- MEDICARE CHANGES
  - All persons age 60 and over covered under Medicare
  - $2,000 *out-of-pocket* expenditure cap per family
  - Individual Part B premium is reduced by half
  - Cover all state and local workers under Medicare
- FIRMS WITH UNDER 25 WORKERS COVERED UNDER MEDICARE
  - Employer pays community-rated fee to Medicare:
    - 80 percent paid by employer;
    - 20 percent paid by employee
  - Refundable tax credit for 40 percent of employer cost in firms with average payroll below twice the *minimum* wage.
- FIRMS WITH 25 OR MORE WORKERS MUST PROVIDE INSURANCE
  - Community rated premium varied by age and geographic location
  - Employer pays 80 percent of premium
  - 80 percent of expenditures over $25,000 covered under Medicare
  - $2,000 out-of-pocket expenditure cap
  - Employers may purchase coverage through Medicare
- INTER-EMPLOYER EQUITY PROVISIONS
  - Working spouses take coverage on own job
  - Dependents allocated across employers in two worker family
- NON-WORKERS COVERED UNDER MEDICARE
- SUPPLEMENTAL MEDICAID BENEFITS TO PERSONS BELOW POVERTY

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REVENUE PROVISIONS

- TAXABLE WAGE LIMIT ELIMINATED FOR EMPLOYER PORTION OF HI PAYROLL TAX (CURRENTLY $125,000) FOR ALL WORKERS
- EMPLOYER MEDICARE PAYROLL TAX INCREASE OF 0.75 PERCENT TO COVER MEDICARE SUBSIDIES TO EMPLOYER COVERAGE
- ESTATE TAX DOUBLED
- TAX 85 PERCENT OF SOCIAL SECURITY BENEFITS
- THREE PERCENT TAX ON UNEARNED INCOME (EXCLUDING SOCIAL SECURITY) UP TO $125,000 WHERE TAXABLE UNEARNED INCOME IS OFFSET BY EARNINGS SUBJECT TO HI PAYROLL TAX
- FEDERAL INCOME TAX INCREASE OF $49.2 BILLION

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TABLE 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in billions)

Household Expenditures		$36.2
Premiums and Out-of-Pocket Payments	($48.2)	
Tax Payments	$78.4	
State Governments		(5.9)
Local Governments (Public Hospitals)		(8.5)
Net New Federal Spending (Program Fully Funded)		0.0
Employers		21.8
Currently Insuring Firms	(0.8)	
Firms That Do Not Insure	22.6	
Provider Uncompensated/Undercompensated Care[a]		(10.8)
Net Change in National Health Spending		$26.8

a Includes reduction in hospital uncompensated care and increased reimbursement for persons previously covered under Medicaid.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764174

TABLE 2
MEDICARE REVENUES AND EXPENDITURES UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN ASSUMING FULL IMPLEMENTATION IN 1991
(in billions)

PROGRAM REVENUES		PROGRAM EXPENDITURES	
Funding for Current Beneficiaries[a]		**Current Medicare Beneficiaries[g]**	
HI Payroll Tax	$ 88.6	HI Benefits and Administration	$ 71.7
SMI General Revenue Contribution	41.2	SMI Benefits and Administration	52.2
Individual Part B Premium (Premium Eliminated)	6.2	$2,000 Cap on Out-of-Pocket Spending	18.6
Subtotal Current Beneficiaries	$136.0	Subtotal Current Beneficiaries	$142.5
Revenues for Employer Programs		**Medicare Employer Programs**	
Employer Premium for Small Firms[b]	$ 30.9	Cover Workers and Dependents in Small Firms (Under 25 Employees)[h]	$ 48.7
Employee Premium in Small Firms[b]	9.8	Medicare Stop-Loss for High Cost Cases (Over $15,000)[i]	5.3
Employer Payroll Tax to Cover Employer Savings (0.75 Percent)[c]	24.8	Subtotal Employer Programs	$ 54.0
Subtotal Employer Programs	$ 73.5	**Medicare Eligibility Coverage Expansions[j]**	
Supplemental Financing		Cover All Persons Age 65 and Older	$ 20.8
OASDI Tax Transfer (2.2 Percent of Payroll)[d]	$ 89.3	Cover Nonworkers Under Age 65	56.3
Tax 85 Percent of OASDI Benefits	3.9	Home Health Benefits	15.9
Estate Tax Increase[e]	11.5	Subtotal Eligibility Expansion	$ 93.0
State Contribution for Home Health[f]	7.9		
Subtotal Employer Programs	82.6	Program Surplus	$ 2.6
Total Medicare Revenues	$292.1	Total Medicare Expenditures	$292.1

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TABLE 2
MEDICARE REVENUES AND EXPENDITURES UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN ASSUMING FULL IMPLEMENTATION IN 1991
(Continued)

a The HI payroll tax and SMI general revenue contributions will continue as under current law. The individual Part B premium payments are reduced by half. The taxable wage *limit for the HI tax is eliminated (*it is currently $125,000) and coverage is extended to all state and local workers.

b Small firms will pay a community rated premium (varied by age and geographic region) equivalent to the cost of covering workers and dependents under Medicare. Employers will pay 80 percent of the premium, with employees paying 20 percent.

c The employer share of the Medicare payroll tax would be increased by 0.75 percent to cover savings to employers attributable to: (1) covering workers and dependents age 60 and over under Medicare; (2) Medicare stop-loss insurance for high cost cases (over $25,000); and (3) savings in worker and retiree benefits due to the $1,000 cap on out-of-pocket expenses for Medicare enrollees. The tax applies to the full amount of payroll for all workers.

d OASDI will be put on a pay-as-you-go basis with excess payroll tax revenues (2.2 percent of payroll) transferred to Medicare.

e Estate taxes will be doubled with the full amount earmarked for Medicare.

f States are required to pay half of the cost of the Medicare home health expansion.

g Medicare HI and SMI benefits will be combined into a single program with a $1,000 cap on out-of-pocket spending. The HI trust fund balance is assumed to increase as projected under current law in 1991.

h Workers and dependents in firms with under 25 employees will be covered under Medicare.

i A Medicare stop-loss program is established to cover high cost cases in privately insured firms with 25 or more employees. The program will cover 80 percent of costs for individual cases in excess of $25,000.

j Medicare coverage is extended to cover persons age 60 and over and all nonworkers under age 60. These estimates include the cost of extending coverage to persons receiving social security disability payments who are not currently eligible for Medicare. These estimates also include the cost of covering persons age 65 and older who are not now eligible for Medicare and the cost of restoring Medicare as primary payer for workers and dependents with employer coverage who are also covered under Medicare.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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TABLE 3
IMPACT OF THE PUBLIC/PRIVATE PARTNERSHIP PLAN ON THE FEDERAL GOVERNMENT ASSUMING FULL IMPLEMENTATION IN 1991
(In billions)

SOURCES OF FUNDS		USES OF FUNDS	
Tax on Unearned Income	$13.2	Medicare General Revenue Requirement (See Table 2)	($2.6)
Personal Income Tax Payment	49.2	Reduced HI Trust Fund Balance[a]	12.6
		Reduced OASDI Trust Fund Balance[b]	59.3
		Change in *Medicaid* Program Costs (See Table 5)	(16.3)
		Savings in Other Federal Health Programs[c]	(3.4)
		Tax Credit for Employers of Low Wage Workers	6.3
		Corporate Income Tax Loss[d]	6.5
Total Revenues	$62.4	Net Federal Revenue Requirement	$62.4

a. The HI Trust Fund balance is projected to grow by $12.6 billion under current policy in 1991. These funds would be used to pay for Medicare program expenditures which represents an increase in the federal deficit.

b. OASDI payroll tax revenues will be transferred to the Medicare program as *Social Security is placed on a pay-as-you-go basis* which represents an increase in the federal deficit.

c. There will be savings under CHAMPUS and the federal civil service employees programs as working spouses become covered on their own job and children are collected across employer plans in two earner families. There will also be savings in federal direct services programs.

d. Employers can deduct insurance expenditures as a cost of doing business.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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TABLE 4
CHANGE IN MEDICAID PROGRAM COSTS FOR ACUTE CARE ONLY UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(In billions)

	Total Program	Federal Cost	State Cost
A. Current Medicaid Program (Acute Care Only)	$45.3	$25.3	$20.0
OFFSETS TO EXISTING PROGRAM			
B. Coverage for All Workers	(2.0)	(1.1)	(0.9)
C. Nonworkers Covered Under Medicare	(30.5)	(17.1)	(13.4)
D. $2,000 Out-of-Pocket Limit for Medicare Recipients	(4.8)	(2.7)	(2.1)
E. Total Offsets (B+C+D)	($37.3)	($20.9)	($16.4)
SUPPLEMENTAL PROGRAM COSTS			
F. Supplemental Benefits for Current Medicaid Recipients (A+E)	8.0	4.4	3.6
G. Supplemental Benefits for All Others Below Poverty	7.2	4.6	2.6
H. Total Supplemental Program	$15.2	$9.0	$6.2
NET CHANGE IN MEDICAID COSTS			
I. Net Change (A-H)	($28.8)	($16.3)	($12.8)

a Includes benefits and administration for acute care only. Excludes long-term care.

SOURCE: Levin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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TABLE 5
CHANGE IN NUMBER OF PERSONS BY PRIMARY SOURCE OF COVERAGE IN AN AVERAGE MONTH UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(In millions)

		CHANGE IN COVERAGE				
	Primary Source of Coverage Under Current Policy	Persons Age 65-64 Covered Under Medicare	Cover Small Firms Under Medicare	Cover Non-Workers Under Medicare	Employer Coverage of Workers in Large Firms	Primary Source of Coverage Under Policy
Employer Coverage	160.6	(2.4)	(34.6)	0.0	14.4	126.7
Non-Group Coverage	19.9	(2.1)	(7.9)	(2.0)	(0.3)	6.8
CHAMPUS/MHory	9.3	0.0	(2.4)	0.0	(1.3)	4.7
Medicare	28.1	4.8	57.8	27.1	0.0	117.8
Medicaid	15.9	(0.2)	(1.0)	(14.1)	(0.5)	0.0
Uninsured	35.4	(1.0)	(11.9)	(10.9)	(11.6)	0.0
All Persons	249.2	--	--	--	--	249.2

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

87764179

TABLE 6

CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN FOR EMPLOYERS WHO NOW OFFER INSURANCE IN 1991
(in billions)

Current Employer Expenditures for Health Care[a]	$143.2
ADDITIONAL COSTS UNDER POLICY	
Coverage of Currently Excluded Members[b]	1.4
Minimum Employer Premium and Cost Sharing Provisions[c]	3.1
Increased Payroll Tax Payments[d]	21.7
Total Increases in Cost	$ 26.4
COST OFFSETS UNDER POLICY	
Medicare Stop-Loss Coverage[e]	(2.9)
Workers Age 60-64 Covered Under Medicare[f]	(9.8)
Savings in Retiree Health Benefits	(5.8)
Working Spouses Covered on Own Job[g]	(7.9)
Tax Credit for Employers of Low Wage Workers[h]	(1.4)
Total Offsets	($27.5)
NET CHANGE IN EMPLOYER COSTS	
Net Change Under Policy	(1.1)
Change in Corporate Income Tax Payments[i]	0.3
Net After Tax Change in Employer Costs	(0.8)

(Footnotes on Next Page)

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TABLE 6

CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN FOR EMPLOYERS WHO NOW OFFER INSURANCE IN 1991 (Continued)

a Includes employer contributions for health benefits for workers, dependents and retirees.

b Many employer health plans currently exclude part-time and seasonal workers from coverage. Employers would be required to cover these workers.

c Employers are required to pay 80 percent of the cost for the minimum standard level of coverage. About 20 percent of firms that now offer coverage will be required to upgrade coverage to conform to these standards.

d An employer payroll tax equal to 8.75 percent of payroll is created to pay for savings to employer plans due to Medicare expansions. The taxable payroll limit for the HI payroll tax is also eliminated.

e Medicare will pay 80 percent of claims for individuals in employer plans with expenditures in excess of $25,000.

f Includes savings due to: (1) coverage of workers age 60 and over under Medicare; and (2) savings to employer plans due to the $2,000 out-of-pocket limit for workers covered under the existing Medicare program.

g Working dependent spouses will be required to take coverage on their own job and dependent children will be allocated across employer plans in two worker households.

h The employer tax credit would reimburse employers for 40 percent of the employer share of the cost of insurance for firms with 25 or fewer employees where average earnings per worker are less than twice the minimum wage.

i Employer expenditures for health care are deductible in determining corporate income tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

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TABLE 7

CHANGE IN SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN FOR EMPLOYERS WHO DO NOT NOW OFFER INSURANCE IN 1991
(in billions)

Coverage of Uninsured Workers	$31.3
Payroll Tax to Fund Employer Subsidies	6.9
OFFSETS TO PROGRAM COST	
Workers Age 60-64 Covered Under Medicare	(2.5)
Catastrophic Limit on Employer Cost	(1.4)
Net Impact on Employer Costs	29.4
TAX EFFECTS	
Corporate Income Tax Offset	(6.8)
Tax Credit for Employers of Low-Wage Workers	(4.9)
After-Tax Employer Cost	$22.6

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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TABLE 8

CHANGE IN HOUSEHOLD SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN IN 1991
(in billions)

PREMIUM AND OUT-OF-POCKET PAYMENTS	
Employer Plan Premium Payments	($1.2)
Non-Group Premium Payments	(19.5)
Out-of-Pocket Payments for Care	(21.3)
Part B Premium Payments	(6.2)
Total Premium and Out-of-Pocket	($48.2)
HOUSEHOLD TAX PAYMENTS	
Tax 85 Percent of Social Security	$3.9
Estate Tax Increase	11.5
Tax on Unearned Income	13.1
Personal Income Tax Payments[a]	49.2
HI Tax for State and Local Workers Not Now Covered	0.6
Total Tax Payments	$78.4
Net Change in Household Spending	$30.2

a The marginal rates of the federal personal income tax would be increased by 10 percent. For example, the 28 percent rate would increase to 31.0 percent and the 31.5 percent rate would increase to 34.9 percent.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764183

THE EMPLOYER MANDATE PROPOSAL: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

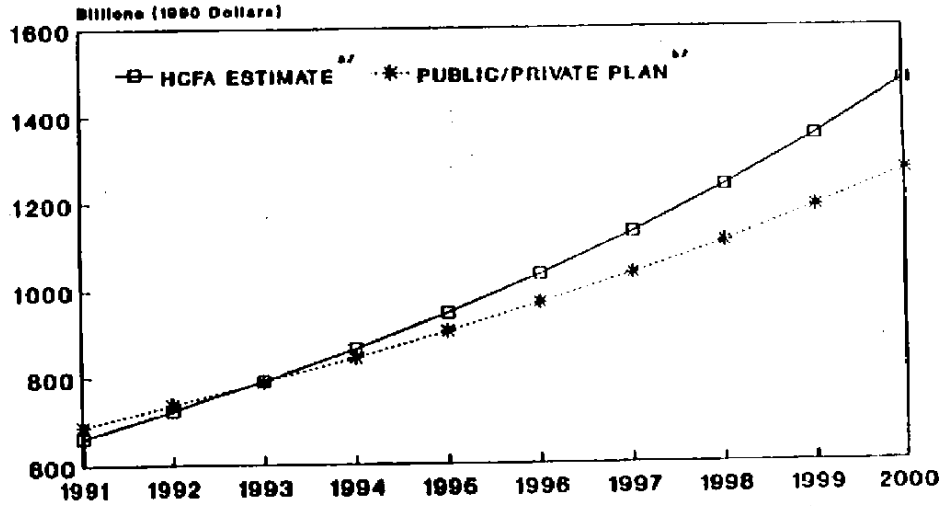
Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764184

NATIONAL HEALTH SPENDING UNDER THE PUBLIC/PRIVATE PARTNERSHIP PLAN 1991 - 2000



a/ HCFA estimates per capita health spending will grow 8.6% annually between 1991 and 2000.

b/ Assumes the annual growth in per capita health spending is slowed to 6.6% under the expenditure target system implemented by the public/private partnership plan.

Source: Lewin/ICF estimates.

LEWIN/ICF

A Health & Medicine Investment Company

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OVERVIEW OF PLAN

- *SMALL GROUP INSURANCE MARKET REFORM AND OTHER REFORMS TO MAKE INSURANCE MORE WIDELY AVAILABLE*
- *MEDICAID EXPANSION FOR ALL PERSONS LIVING BELOW POVERTY REGARDLESS OF CATEGORICAL ELIGIBILITY*
- *MEDICAID BUY-IN FOR PERSONS BETWEEN 100 AND 150 PERCENT OF POVERTY*

87764186

THE INSURANCE MARKET REFORM PROPOSAL

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87764187

SMALL GROUP INSURANCE MARKET REFORMS

- *GUARANTEED ISSUE AND RENEWABILITY*
  - *Insurers are required to offer coverage to all applicants regardless of health status*
  - *Insurers must renew coverage for all groups regardless of health status*
  - *Failure to pay premiums is the only grounds an insurer may use to terminate coverage*
- *ONCE A WORKER HAS SATISFIED PRE-EXISTING CONDITION REQUIREMENTS ON ONE PLAN, THOSE REQUIREMENTS ARE WAIVED IF THE INDIVIDUAL CHANGES JOBS OR THE EMPLOYER CHANGES INSURERS*
- *STATE MINIMUM BENEFITS LAWS ARE ELIMINATED TO PERMIT CREATION OF LOW COST INSURANCE PLANS*
- *PREMIUM SETTING LIMITATIONS*
  - *Premiums may not vary among groups by more than a specified percentage (e.g., 50 percent) of the average premium charged by the insurer for groups with similar age, sex, industry and geographic characteristics*
  - *Year-to-year premium increases for any group could not be more than a specified percentage (e.g., 15 percent) above the carriers general cost trend*
- *A REINSURANCE MECHANISM IS ESTABLISHED*
  - *Spreads risk for high risk groups across all insurers*
  - *Reinsurance funded by an assessment on all small group insurance policies*

Lewis/ICF

87764188

EMPLOYER BASED INSURANCE

- *EMPLOYER BASED COVERAGE IS ENCOURAGED AND FACILITATED RATHER THAN MANDATED*
- *THE SELF-EMPLOYED WOULD BE ABLE TO DEDUCT 100 PERCENT OF THE COST OF HEALTH INSURANCE*
  - *The deduction for self-employed persons is currently limited to 25 percent of benefit costs.*
  - *The self employed are already permitted to deduct the full cost of benefits for workers.*
- *SMALL EMPLOYERS (FEWER THAN 25 EMPLOYEES) WILL BE PROVIDED A REFUNDABLE TAX CREDIT FOR EMPLOYEE HEALTH BENEFITS COSTS IN EXCESS OF FIVE PERCENT OF GROSS REVENUES*

87764189

STANDARD MEDICAID BENEFITS PACKAGE

BENEFITS	PLAN PROVISIONS
Inpatient Hospital Services	100%
Outpatient Hospital Services	100%
Rural Health Clinic Services	100%
Laboratory & X-ray Services	100%
Early and Periodic Screening, Diagnosis and Treatment Services for Individuals Under Age 21	100%
Physician Services	100%
Home Health Services	100%
Private Duty Nursing	100%
Preventive Dental Care	100%
Clinic Services	100%
Physical Therapy	100%
Occupational Therapy	100%
Speech, Hearing and Language Disorders	100%
Prosthetic Devices	100%
Diagnostic Tests	100%
Preventive Services	100%
Rehabilitative Services	100%
Case Management	100%
Podiatrist and Optometrist	100%

87764190

MEDICAID EXPANSION

- *ALL PERSONS BELOW POVERTY ARE COVERED UNDER MEDICAID REGARDLESS OF CATEGORICAL ELIGIBILITY STATUS*
- *PROVIDER REIMBURSEMENT LEVELS ARE INCREASED TO LEVELS COMPARABLE TO THE MEDICARE PROGRAM*
- *A UNIFORM NATIONWIDE MINIMUM STANDARD BENEFITS PACKAGE (SHOWN ON NEXT PAGE) IS ESTABLISHED (COMPARABLE TO THE MEDIAN BENEFITS PACKAGE CURRENTLY OFFERED BY THE STATES)*
- *THE CURRENT FEDERAL/STATE MATCH IS USED FOR THE MEDICAID EXPANSION*

Lewis/ICF

87769191

TABLE 1

CHANGE IN THE NUMBER OF UNINSURED PERSONS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Thousands)

	Number Who Obtain Insurance	Reduction In Number Of Uninsured	Percent Of Uninsured
Extend Medicaid to Cover All Below Poverty	12,158	5,834	18.3%
Medicaid Buy-In Through 150 Percent of Poverty	11,877	4,937	15.5
Insurance Market Reform[a]	921	515	1.6
Eliminate State Mandated Benefits[a]	2,314	1,214	3.8
Increase Self-Employment Deduction[a]	181	91	0.3
Combined Impact	27,451	12,591	39.6%

a Assumes each percentage reduction in premium costs is associated with a 0.4 percent increase in the number of employers offering insurance.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764192

MEDICAID BUY-IN

- *A MEDICAID BUY-IN PROGRAM IS CREATED FOR PERSONS BETWEEN POVERTY AND 150 PERCENT OF POVERTY*
- *COVERED SERVICES*
  - *Inpatient and outpatient hospital care*
  - *Physicians services*
  - *Prescription drugs*
  - *Laboratory and diagnostic tests*
  - *Mental health and substance abuse*
  - *Prenatal/well-baby/child care*
- *COST SHARING*
  - *$250 deductible ($500 family)*
  - *80 percent coinsurance (50 percent mental health)*
  - *No cost sharing for prenatal and well child care*
  - *Out-of-pocket limit of $3,000 per family*
- *PREMIUMS PHASED-IN BETWEEN 100 AND 150 PERCENT OF PREMIUM*
  - *Individual premium of $86*
  - *Family premium of $172*
- *THE CURRENT FEDERAL/STATE MEDICAID MATCH IS MAINTAINED FOR THE BUY-IN PROGRAM*

8776193

Table 3

SOURCES AND USES OF FEDERAL FUNDS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)

Sources of Funds		Uses of Funds	
Personal Income Tax Increase[a]	$19.5	Federal Share of Medicaid Expansion	$20.2
		Tax Credit for Small Employer Costs Over 5 Percent of Revenues[b]	0.2
		Self Employed Deductions[c]	0.4
		Change in Corporate Tax Revenues[d]	(1.3)
Total Program Revenues	$19.5	Total Program Costs	$19.5

a The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (5 percent).
b Employers with 25 or fewer employees will receive a refundable tax credit for health expenditures in excess of 15 percent of revenues.
c Self employed persons are permitted to deduct the full amount of their health benefits expenditures.
d Employers are assumed to absorb changes in employer costs as changes in profits resulting in changes in corporate income tax deductions for health benefits and tax payments.

SOURCE: Levin/ICF estimates using the Health Benefit Simulation Model (HBSM).

87764194

TABLE 2

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991
(In Billions)

Household Payments			*$19.3*
Tax Payments	*33.4*		
Premium Payments	*(3.0)*		
Out-of-Pocket Spending	*(11.2)*		
Private Employers			*(4.8)*
Currently Provide Insurance		*(5.9)*	
Currently Do Not Insure		*1.1*	
State Governments (Program Fully Funded)[a]			*0.0*
Federal Government (Program Fully Funded)[a]			*0.0*
Local Governments			*(3.0)*
Change in National Health Spending			*$11.4*
Utilization Increase for Newly Insured		*6.9*	
Net Increase in Provider Reimbursement[b]		*4.2*	
Net Change in Administrative Costs		*0.3*	

a *We assume that state and federal governments raise the revenues needed to fully fund the program so that the proposal has no net impact on government spending.*

b *Increases in Medicaid reimbursement for hospital services are assumed to be passed-on to employers in the form of cost-shift savings. Increases in physician reimbursement are assumed to be retained as income.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764195

Table 5

SOURCES AND USES OF STATE FUNDS UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991

(In Billions)

Sources of Funds		Uses of Funds	
Increase in State Taxes to Fund Program	$13.9	State Share of Medicaid Expansion (see Table 4)	$14.3
		State Corporate Income Taxes	(0.2)
		Savings to Indigent Care Programs	(0.2)
Total Sources of Funds	$13.9	Total Uses of Funds	$13.9

a Premium payments are subsidized for persons with incomes between the poverty line and 150 percent of poverty.

SOURCE: Lewin/ICF estimates using the Health Benefit Simulation Model (HBSM).

877641 96

Table 4

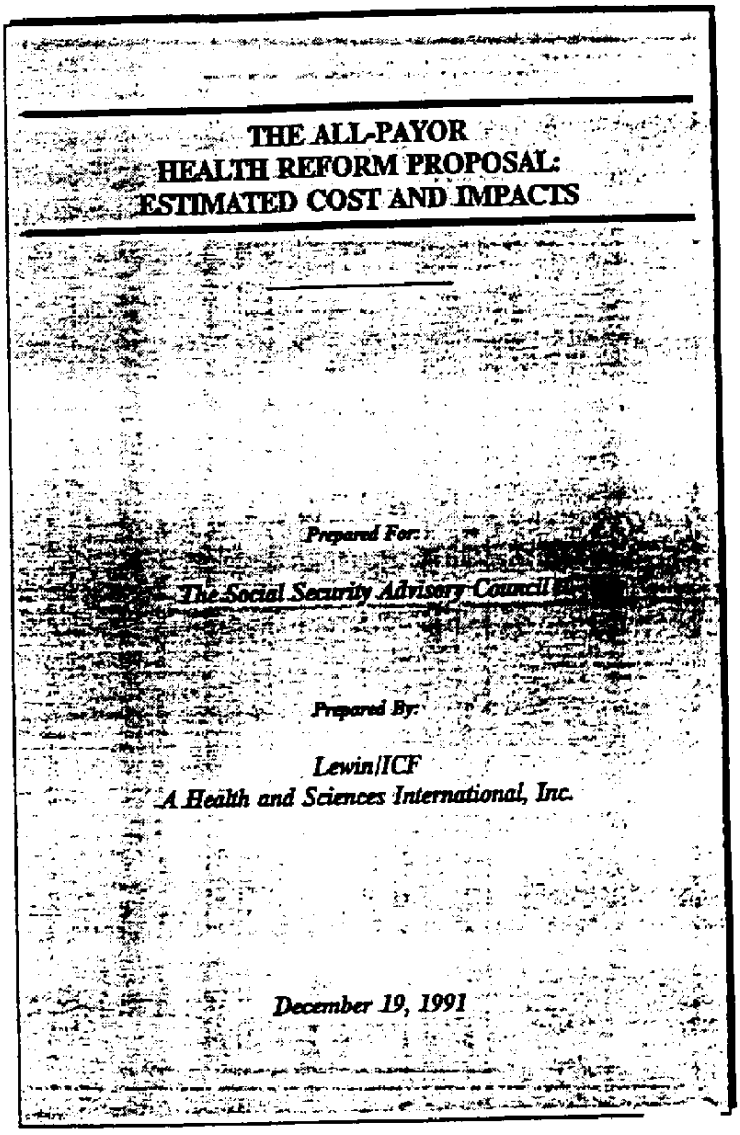
CHANGE IN MEDICAID PROGRAM COSTS FOR ACUTE CARE ONLY UNDER THE INSURANCE MARKET REFORM PROPOSAL IN 1991 (In Billions)[a]

	Total Program	Federal Cost	State Cost
Current Medicaid Program (Acute Care Only)	$45.3	$25.3	$20.0
Offset to Existing Program			
Cover Persons Up To Poverty Level	10.7	6.3	4.4
Minimum Benefits Standard	6.4	3.7	2.7
Improved Provider Reimbursement	12.6	7.4	5.2
Net Cost of Medicaid Buy-In Benefit Costs $9.0 Premium Receipts (4.2)	4.8	2.8	2.0
Net Change in Medicaid Costs			
Net Change	$34.5	$20.2	$14.3

a Included benefits and administration for acute care only. Excludes long-term care.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

877641197



THE ALL-PAYOR HEALTH REFORM PROPOSAL: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF

A Health and Sciences International, Inc.

December 19, 1991

87764198

Table 6

IMPACT OF THE INSURANCE MARKET REFORM PROPOSAL ON PRIVATE EMPLOYERS
(In Billions, 1994)

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance[a]	$115.5	--	$115.5
Change in Employer Costs			
Cost of Insuring Workers and Dependents Not Now Covered	0.8	1.7	2.5
Tax Credit to Small Employers	0.0	(0.2)	(0.2)
Cost Shift Savings	(0.4)	--	(7.6)
Total Employer Costs	107.7	1.5	109.2
Net Change in Employer Cost	(7.8)	1.5	(6.3)
Change in Corporate Income Tax	1.9	(0.4)	1.5
Net After-Tax Change in Employer Costs	(5.9)	1.1	(4.8)

a Includes employer share of premium for workers, dependents, and retirees.

b The plan provides a refundable tax credit which limits employer expenditures for health benefits in small firms not to exceed 5 percent of revenues.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764199

EMPLOYER RESPONSIBILITY

- **EMPLOYERS MUST INSURE ALL EMPLOYEES AND DEPENDENTS WORKING 17.5 HOURS OR MORE PER WEEK.**
  - A refundable tax credit is created which caps employer health expenditures to seven percent of employee payroll.
  - Firms with under 100 employees will be covered under government operated public plans.
  - Large firms (100 or more employees) will have the option of participating in the public plan.
- **WORKING DEPENDENTS ARE REQUIRED TO TAKE COVERAGE ON THEIR OWN JOB.**
- **THE PLAN COVERS:**
  - Inpatient and Outpatient Hospital Care
  - Physicians Services
  - Prescription Drugs
  - Laboratory and Diagnostic Tests
- **EMPLOYERS HAVE THE OPTION OF SUPPLEMENTING THE BASIC BENEFITS PACKAGE.**
- **THE PUBLIC PLAN CAN ALSO OFFER A HIGHER OPTION PLAN TO BE PURCHASED OUT-OF-POCKET.**

Lewin/ICF

87764200

THE ALL-PAYOR MODEL

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87764201

PERSONS NOT COVERED BY AN EMPLOYER PLAN

- *PUBLIC PROGRAM ESTABLISHED TO COVER NON-WORKERS:*
  - *Includes persons working less than 17.5 hours per week*
  - *Medicaid subsumed into program*
- *COVERED SERVICES AND COST SHARING REQUIREMENTS ARE THE SAME AS UNDER THE EMPLOYER PLAN EXCEPT FOR LOW-INCOME FAMILIES.*
- *PREMIUM AND COST SHARING SUBSIDIZED FOR PERSONS BELOW 200 PERCENT OF POVERTY.*
  - *Premium and cost sharing eliminated for persons below poverty.*
  - *Premium and cost sharing phased-in between poverty and 200 percent of poverty.*
  - *All above 200 percent of poverty pay the full premium and cost sharing amounts.*

87764202

EMPLOYER RESPONSIBILITY

(continued)

- **COST SHARING**
  - $250 Deductible ($500 Per Family)
  - Out-of-Pocket Limit of $2,000

Coinsurance	Plan Provisions
Inpatient Hospital Services	80%
Outpatient Hospital Services	80%
Hospital Alterative (Extended or Home Health Care)	Yes
Physician Services	80%
Prenatal/Well Baby/Well Child-Care	100%
Diagnostic Tests	80%
Prescription Drugs	80%
Emergency Services	80%
Mental Health Care	Not Covered
Dental Care	Not Covered

- **EMPLOYER PAYS 80 PERCENT OF PREMIUM FOR BASIC BENEFITS PACKAGE**

LewisRCF

87764203

ADMINISTRATION

- **GOVERNMENT ADMINISTRATIVE AUTHORITY ESTABLISHED TO:**
  - Select carriers to administer coverage
  - Develop and coordinate health policy
  - Assess quality and efficiency of statewide delivery system
  - Regional planning for the aquisition of new capital and technology
  - Negotiate with providers.
- **EMPLOYERS AND NON-WORKERS WILL SELECT AN INSURANCE CARRIER FROM A LIST OF INSURERS APPROVED BY THE STATE:**
  - Approved carriers will include HMO's and other organized systems of care.
  - Carriers will compete on the basis of price and quality.
  - Carriers will be required to accept all applicants.
- **ALL CARRIERS WILL REIMBURSE PROVIDERS ON THE BASIS OF UNIFORM FEE SCHEDULES:**
  - DRG and RBRVS reimbursement schedules used throughout the system.
  - Balance billing is eliminated.
- **UNIFORM REIMBURSEMENT LEVELS ASSURE THAT ALL INDIVIDUALS HAVE EQUAL ACCESS TO CARE REGARDLESS OF INCOME OR SOURCE OF INSURANCE (I.E., ELIMINATE COST-SHIFTING).**

Lewin/ICF

8746204

Figure 1

SUPPLEMENTAL BENEFITS FOR PERSONS BELOW POVERTY

Benefits	Plan Provisions
Private Duty Nursing	100%
Dental Care	100%
Clinic Services	100%
Physical Therapy	100%
Occupational Therapy	100%
Speech, Hearing and Language Disorders	100%
Dentures	100%
Prosthetic Devices	100%
Eyeglasses	100%
Preventive Services	100%
Rehabilitative Services	100%
Inpatient Psychiatric Care for Individuals Under Age 21	100%
Hospice Services	100%
Transportation	100%
Case Management	100%
Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Age 21	100%
Podiatrists, Optometrist, and Chiropractor Services	100%

Lewin/ICF

87769205

COST CONTAINMENT

- *EXPENDITURE TARGETS ENFORCED THROUGH DRG's AND RBRVS RATE SCHEDULES TO ASSURE LONG-TERM COST CONTAINMENT.*

- *PROMOTE ECONOMIC DISCIPLINE IN HEALTH CARE MARKETS THROUGH COMPETING ORGANIZED SYSTEMS OF CARE.*

- *REGIONAL PLANNING FOR ACQUISITION OF CAPITAL AND TECHNOLOGY.*

ASSUMPTION

- *FOR ILLUSTRATIVE PURPOSES WE ASSUME THAT THE PER CAPITA GROWTH IN HEALTH SPENDING IS REDUCED BY TWO PERCENT PER YEAR UNDER THE EXPENDITURE TARGETS.*

87764206

FINANCING

- EMPLOYER CONTRIBUTIONS TO HEALTH INSURANCE PREMIUMS.
- EMPLOYEE CONTRIBUTIONS FOR HEALTH INSURANCE PREMIUMS.
- PREMIUM PAYMENTS BY NON-WORKERS (BASED ON ABILITY TO PAY).
- PERSONAL INCOME TAX PAYMENTS TO COVER THE COST OF SUBSIDIES TO LOW-INCOME FAMILIES AND EMPLOYERS OF LOW WAGE WORKERS:
  - Total increase in personal income taxes: $36.1 billion
  - Personal income tax rates would be increased by 7.4 percent (e.g., the 28 percent marginal rate would increase to about 30 percent).

87764207

Table 2
SOURCES AND USES OF FEDERAL FUNDS UNDER THE ALL PAYOR MODEL IN 1991
(In Billions)

SOURCES OF FUNDS			USES OF FUND		
Premium Payments for Small Employers Covered Under Public Plan [a]		$ 78.8	Benefit Payments		$139.9
Employer Share	60.8		Small Employers Covered Under Public Program [a]	65.3	
Employee Share	18.1		Non Workers Program [b]		
			Current Medicaid		
			Newly Eligible	40.4	
			Supplemental Benefits	25.8	
				7.7	
Premium Payments for Non-Workers [b]		16.1	Administrative Costs [c]		10.1
			Workers and Dependents	7.9	
			Non-Workers	2.2	
State Contribution to Public Program [a]		17.7	Tax Credit for Employer Health Benefits Over 7.9 Percent of Payroll [d]		10.7
General Revenue Contribution [d]		36.1	Change in Corporate Tax Revenues [e]		8.1
			Offsets to Other Federal Programs		(26.3)
			Medicaid	(25.4)	
			CHAMPUS and Other [f]	(0.9)	
Total Sources of Funds		$139.8	Total Uses of Funds		$139.8

(Footnotes on Next Page)

87764208

Table 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE ALL-PAYOR MODEL IN 1991 (In Billions)

Household Payments		$ 3.8
Tax Payments	36.1	
Premium Payments	(11.0)	
Out-of-Pocket Spending	(21.3)	
Private Employers		16.6
Currently Provide Insurance	0.7	
Currently Do Not Insure	17.9	
State and Local Governments		(10.8)
Federal Government (Program Fully Funded)		0.8
Change in National Health Spending		$11.8
Utilization Increase for Newly Insured	12.2	
Net Change in Administrative Costs	(0.4)	

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764209

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE CONSUMER CHOICE MODEL
IN 1991
(In Billions)

Footnotes to Previous Table
(continued)

i *The program pays cost sharing for all persons below poverty and phases in cost sharing through 150 percent of poverty.*

j *Includes the cost of supplemental benefits for persons below poverty.*

k *Administrative costs are assumed to equal 12 percent of claims for the workers component of the program; 5.0 percent of claims for self-employed and others covered under the public plan; and 2.7 percent of the cost of subsidies to low income persons.*

l *Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.*

m *Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764210

Table 2

SOURCES AND USES OF FEDERAL FUNDS UNDER THE ALL-PAYOR MODEL
IN 1991
(In Billions)

Footnotes to Previous Table

a *Firms with under 100 employees would be covered under the public plan.*

b *Individuals not otherwise covered under an employer plan can purchase insurance from the public sponsor by paying the premium. The premium is eliminated for persons below poverty and phased-in between poverty and 200 percent of poverty.*

c *States are assumed to transfer to the program all funds currently used to finance the state share of Medicaid spending for acute care. Medicaid is assumed to be retained for long-term care.*

d *The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (7.37 percent).*

e *Workers covered under the public fund include workers in firms with under 100 employees.*

f *Persons currently enrolled in Medicaid who do not become covered under an employer plan are transferred to the public plan (includes increased reimbursement for hospital and physicians care). Among newly eligible persons, the program pays cost sharing for all persons below poverty and phases in cost sharing through 200 percent of poverty. Includes the cost of supplemental benefits for persons below poverty.*

g *Administrative costs are assumed to equal 12 percent of claims for the workers component of the program and 3.0 percent of claims for non-workers*

i *Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax deductions for health benefits and tax payments.*

h *The plan establishes a refundable tax credit which limits employer expenditures for the minimum benefits package not to exceed 7.9 percent of payroll.*

j *Includes the change in insurance cost for federal employees and CHAMPUS beneficiaries.*

SOURCE: *Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).*

87764211

Table 4

IMPACT OF THE ALL-PAYOR MODEL ON STATE AND LOCAL GOVERNMENTS IN 1991 (In Billions)

		Change in Expenditures
Changes in Employee Benefit Costs		$(0.3)
Current Employee Benefit Costs	23.9	
Change in Employee Benefits Costs	(0.3)	
Total Employee Benefit Costs	23.6	
Change in Medicaid Spending[a]		0.0
Savings to Public Hospitals and Other Programs[b]		(10.3)
Reduction in Corporate Tax Payments		6.1
Net Impact on State and Local Governments		$(10.5)

a All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.

b Public hospitals that now serve indigent patients will be reimbursed for services provided to patients who become insured under the program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764212

Table 3
IMPACT OF THE ALL-PAYOR MODEL ON PRIVATE EMPLOYERS
(In Billions, 1990)

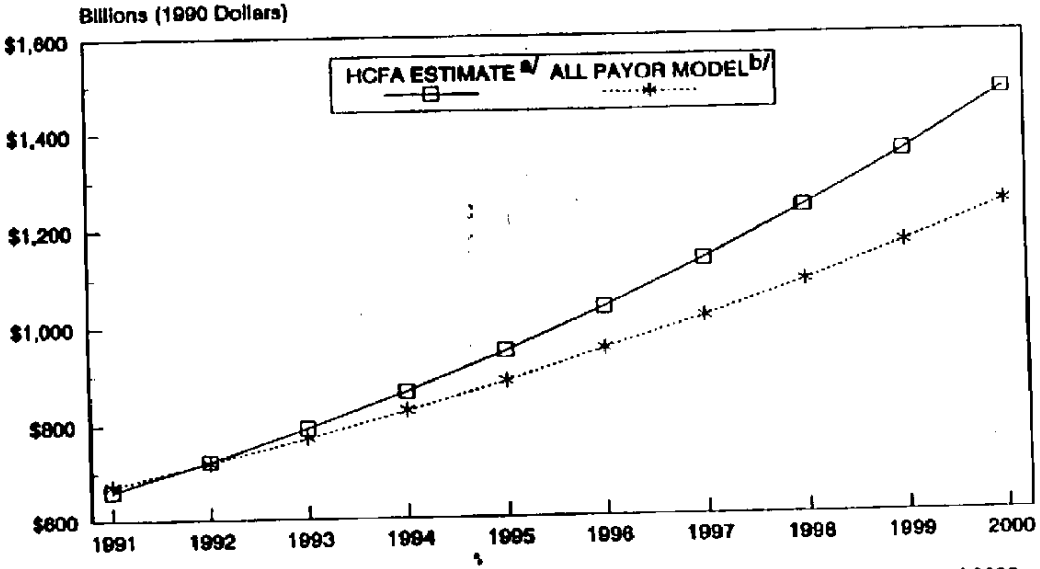
	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Insurance[a]	$116.6	–	$116.6
CHANGES IN EMPLOYER COSTS			
Cost of Insuring Part-Time Workers and Dependents	23.8	34.0	57.8
Impact of Minimum Benefit and Premium Standards Employer Premium Share Increase 3.4 Improvement in Plan Provisions 1.8	5.2	–	–
Working Spouses and Dependents Shifted to Other Employer Plans	(21.0)	–	21.0
7.9 Percent Cap on Employer Costs	(0.7)	(10.2)	(10.9)
Administrative Savings for Plans in Public Plan[b]	(1.2)	–	(1.2)
Retirees Covered Through Second Employer	(0.7)	–	(0.7)
Cost-shift Savings	(4.5)	–	(4.5)
Total Employer Costs	116.4	23.8	140.2
Net Change in Employer Costs	0.9	23.8	24.7
Change in Corporate Tax Expenditure Payment	(0.2)	(5.9)	(6.1)
Net After-Tax Change in Employer Costs	0.7	17.9	18.6

a Includes employer share of premium for workers, dependents and retirees.
b Assumes all firms with 100 or fewer workers enroll in the public plan.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

87764213

NATIONAL HEALTH SPENDING UNDER THE ALL PAYOR MODEL -- ILLUSTRATIVE PROJECTIONS 1991-2000



a/ HCFA estimates per capita health spending will grow 8.6 % annually between1991 and 2000

b/ Assumes the annual growth in per capita health spending is slowed to 6.5%under the expenditure target system implemented by the All Payor Model

Source: Lewin/ICF estimates

87764214

Table 5

IMPACT OF THE ALL-PAYOR MODEL ON HOUSEHOLD HEALTH RELATED EXPENDITURES IN 1991 (In Billions)

	Change From Current Policy
Funding for Public Program	
Premium Payments for Non-Worker Program Participants	10.1
General Revenue Tax Payments to Fund Balance Program	36.1
Offsets to Tax Payments	
Employee Share of Employer Plan Premiums	(5.4)
Non-Group Plan Premium Payments	(15.7)
Household Out-of-Pocket Expenditures	(21.3)
Total Net Change	**$ 3.8**

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

87764215

THE PUBLIC HEALTH INSURANCE MODEL

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Lewin/ICF

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THE PUBLIC HEALTH INSURANCE MODEL FOR ACUTE CARE: ESTIMATED COST AND IMPACTS

Prepared For:

The Social Security Advisory Council

Prepared By:

Lewin/ICF
A Health and Sciences International, Inc.

December 19, 1991

87764217

FINANCING

- *THERE ARE NO PREMIUM PAYMENTS IN THE PUBLIC PLAN*
- *A PAYROLL TAX OF 11.2 PERCENT IS ESTABLISHED TO COVER THE COST OF BENEFITS TO WORKERS AND DEPENDENTS*
  - *Employer Share of Payroll Tax is 80 Percent (9.0 Percent of Payroll)*
  - *Employee Share of Payroll Tax is 20 Percent (2.2 Percent of Payroll)*
- *FUNDING FOR MEDICAID AND MEDICARE IS TRANSFERRED TO THE PUBLIC PROGRAM.*
  - *Federal Share of Medicaid*
  - *State Share of Medicaid*
  - *Medicare HI Payroll Tax Revenues*
  - *Medicare SMI General Revenue Contribution Transferred to Public Program*
- *THE BALANCE OF THE PROGRAM IS TO BE FINANCED BY A COMBINATION OF STATE AND FEDERAL REVENUES WHERE THE FEDERAL MATCH RATE VARIES WITH THE ECONOMIC CHARACTERISTICS OF THE STATE.*
- *FOR ILLUSTRATIVE PURPOSES, WE ASSUME THAT THE BALANCE OF THE PROGRAM IS FINANCED BY AN ACROSS THE BOARD INCREASE IN PERSONAL INCOME TAXES*
  - *Total Increase in Personal Income Taxes: $48.9 billion*
  - *Personal Income Tax Rates Would be Increased by 10.0 Percent (e.g., the 28 Percent Marginal Rate Would Increase to 30.8 Percent); The Top Marginal Rate Would Increase From 31.5 Percent to 34.6 Percent).*

87764218

PLAN STRUCTURE

- *ALL INDIVIDUALS ARE COVERED UNDER A NATIONAL HEALTH INSURANCE PLAN.*
- *THE PLAN COVERS.*
  - *Inpatient and Outpatient Hospital Care*
  - *Physicians Services*
  - *Prescription Drugs*
  - *Laboratory and Diagnostic Tests*
  - *Mental Health and Substance Abuse*
  - *Prenatal/Well-baby/Child Care*
  - *Dental Care*
- *NO COST SHARING FOR ACUTE CARE SERVICES.*
  - *Full First Dollar Coverage for All Services*
  - *No Copayments or Deductibles*

87964219

EMPLOYER RESPONSIBILITY

- *EMPLOYERS WOULD NO LONGER OFFER HEALTH INSURANCE*
- *EMPLOYERS WOULD PAY A TAX EQUAL TO 9.0 PERCENT OF EMPLOYEE PAYROLL (SEE FINANCING SECTION ABOVE)*
- *SAVINGS IN EMPLOYER HEALTH INSURANCE PREMIUM COSTS IN EXCESS OF THE EMPLOYER PAYROLL TAX WOULD BE PASSED ON TO EMPLOYEES IN THE FORM OF INCREASED WAGES AND SALARIES*

87764220

ADMINISTRATION/COST CONTAINMENT

- *HOSPITALS WOULD BE PLACED ON ANNUAL BUDGETS*
  - *Operating Budgets for Health Services*
  - *Capital Budgets for Facilities Expansion*
- *PHYSICIANS WOULD BE PAID ON A FEE-FOR-SERVICE BASIS*
  - *Uniform Fee Schedules*
  - *No Balance Billing*
- *COST CONTAINMENT IMPLEMENTED THROUGH GLOBAL BUDGETS*
  - *Hospital Operating Budgets*
  - *Physician Fee Schedules*
  - *Hospital Capital Budgets*

8796221

Table 2

SOURCES OF CHANGES IN NATIONAL HEALTH SPENDING UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991
(In Billions)

	CHANGE IN EXPENDITURES
SAVINGS IN ADMINISTRATIVE EXPENSES	
Insurer Administrative Cost[a]	*$(15.4)*
Hospital Claims Filing Costs[b]	*(10.8)*
Physician Billing Costs[c]	*(1.2)*
CHANGES IN UTILIZATION	
ACUTE CARE	
Increased Utilization for Newly Insured Persons	*12.2*
Increase in Utilization Due to Elimination of Cost Sharing	*39.0*
NET CHANGE IN HEALTH SPENDING	***$23.8***

(Footnotes on Next Page)

Lewis/ICF

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Table 1

CHANGE IN NATIONAL HEALTH SPENDING UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991 (In Billions)

Household Payments		$(54.5)
Tax Payments	117.9	
Premium Payments	(85.1)	
Out-of-Pocket Spending	(87.3)	
Private Employers		92.8
Currently Provide Insurance	42.8	
Currently Do Not Insure	50.0	
State and Local Governments		(14.5)
Federal Government[a]		0.0
Increase in Federal Spending	394.1	
Additional Federal Revenues (offset)	(394.1)	
Net Change in National Health Spending		$23.8

a The program specifies revenue raising measures which are sufficient to cover projected program costs.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 3
SOURCES AND USES OF FEDERAL FUNDS UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991
(In Billions)

PAYROLL TAX PAYMENTS[a]		$345.3	*BENEFITS PAYMENTS*	$524.4
Employer Share	276.3		*Acute Care*	
Employee Share	69.0		*Workers and Dependents*	334.9
			Non Workers	189.5
MEDICARE HI PAYROLL TAX SHIFTED TO PROGRAM[b]		53.4	*Administrative Costs*[c]	13.2
STATE CONTRIBUTION TO PUBLIC PLAN[d]		19.9	*Change in Corporate Tax Revenues*[e]	28.5
PERSONAL INCOME TAX INCREASE[f]		69.9	*Offsets to Other Federal Programs*	(78.7)
			Medicaid (Federal Share)	35.4
			Medicare (General Revenue Portion)[g]	39.8
			CHAMPUS and Other[h]	3.5
TOTAL PROGRAM REVENUES		*497.4*	*TOTAL PROGRAM EXPENDITURES*	$497.4

(Footnotes on Next Page)

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Table 2

SOURCES OF CHANGES IN NATIONAL HEALTH SPENDING UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991

(Footnotes to Previous Page)

a *Insurer administrative costs under the current system are about $30.7 billion (administrative costs as a percentage of claims are 11.7 percent for private insurance and 2.7 percent for public programs). Administrative costs under the public program are estimated to be about $15.3 billion (2.5 percent of claims) resulting in net savings of $15.4 billion.*

b *Under the Public Health Insurance plan hospitals will be funded through annual operating budgets. The budgeting model eliminates the need for claims filing by hospitals resulting in administrative savings estimated to be $10.8 billion.*

c *Balance billing is eliminated resulting in savings in physician administrative costs of $1.2 billion.*

d *Utilization of health services for previously uninsured persons is assumed to adjust to the level reported by insured persons with similar characteristics under the universal coverage model.*

e *We assume that utilization will increase by 10 percent for persons who were previously covered in plans with cost sharing. This assumption is based upon studies indicating that utilization is roughly 10 percent higher for persons in plans without cost sharing than among persons in plans with cost sharing.*

f *Most long-term care is currently provided informally by family members. We assume that much of this care will now be provided by health professionals. We assume that nursing home enrollment will increase by 30 percent and that utilization of paid home health services will increase by 100 percent.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 4

CHANGE IN PRIVATE EMPLOYER SPENDING UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991 (in Billions)[a]

	Firms That Now Offer Insurance	Firms That Do Not Insure	All Firms
Current Employer Expenditures for Health Care	$115.5	--	$115.5
Employer Payroll Tax	172.6	66.7	239.3
Elimination of Employee Coverage	(105.7)	--	(105.7)
Retirees Covered Under Public Plan	(9.8)	--	(9.8)
Total Employer Cost	172.6	66.7	239.3
Net Change in Employer Cost	57.1	66.7	123.8
Change in Tax Payments	(14.3)	(16.7)	(31.0)
Net After-Tax Change in Employer Costs	$42.8	$50.0	$91.8

a Increases in employer costs under the program are assumed to be absorbed by employers in the form of reduced profits resulting in a loss of corporate income tax payments.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 3

SOURCES AND USES OF FEDERAL FUNDS UNDER THE PUBLIC HEALTH INSURANCE MODEL IN 1991

(Footnotes From Previous Page)

a A payroll tax of 11.3 percent is established to cover the cost of insuring workers and dependents of which 80 percent is paid by the employer and 20 percent is paid by the employee.

b The Medicare HI portion of the FICA payroll tax is transferred to the program.

c States are assumed to transfer to the program all funds currently used to finance the state share of medicaid spending.

d The net increase in program costs is assumed to be funded by a proportional increase in personal income taxes (22.4 percent).

e Administrative costs are assumed to be equal to 2.5 percent of benefit payments. This assumption is based upon Medicare program administrative data adjusted for the elimination of hospital claims filing.

f Employers are assumed to absorb the cost of expansions in coverage resulting in changes in corporate income tax payments.

g General revenue contributions to the Medicare SMI program are eliminated.

h Includes the change in insurance cost for federal employee and CHAMPUS beneficiaries.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 6

CHANGE IN HOUSEHOLD HEALTH SPENDING UNDER THE PUBLIC INSURANCE MODEL IN 1991
(In Billions)

	Change From Current Policy
Individual Premium Payments	
Employee Premium Payments	*(42.5)*
Medicare Part-B Premium Payments	*(12.4)*
Non-Group Premium Payments	*(30.2)*
Tax Payments	
Employer Share of Payroll Tax	*69.8*
Personal Income Tax Payments	*48.9*
Direct Payments for Care	
Households Out-of-Pocket Expenditures	*(128.1)*
Net Change in Household Health Spending	*$(19.7)*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 5

IMPACT OF THE PUBLIC HEALTH INSURANCE MODEL ON STATE AND LOCAL GOVERNMENTS IN 1991

(In Billions)

		Change in Expenditures
Changes in Employer Benefit Costs		$5.5
Elimination of Employer Plan	(23.9)	
Payroll Tax Payments	29.4	
Change in Medicaid Spending[a]		0.0
Contribution to Public Plan	19.9	
Medicaid Spending	(19.9)	
Savings to Public Hospitals and Other Programs[b]		(23.4)
Reduction in Corporate Tax Payments		2.5
Net Impact on State and Local Governments		$(14.5)

a *All funds currently allocated to the Medicaid program are assumed to be transferred to the public program.*

b *Public hospitals that now serve indigent patients will be reimbursed for services who become insured under the program.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Table 7

SCENARIO 1

ILLUSTRATION OF THE POTENTIAL IMPACT OF HOSPITAL AND NURSING HOME BUDGETING ON INITIAL YEAR NATIONAL HEALTH SPENDING IN 1991 (In Billions)

	Unconstrained Growth in Health Spending	No Growth in Hospital or Nursing Home Spending Permitted[a]
Change in Health Service Utilization	$1.3	$4.3
Administrative Savings[b]	($27.4)	($27.4)
Net Change in National Health Spending	$23.8	$ 6.8

a *In this scenario, capital and operating budgets are assumed to be constrained so that spending for hospital and nursing home services does not increase above the level projected under current law.*

b *Includes savings in both insurer and provider administrative costs.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulator Model (HBSM).

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COST CONTAINMENT

- *HOSPITAL AND NURSING HOME BUDGETS*
  - *Hospital operating budgets could be used to limit growth in hospital spending*
  - *Capital budgeting could limit the growth in hospital and nursing home utilization*
- *GLOBAL BUDGETING FOR HEALTH CARE EXPENDITURES TO LIMIT THE GROWTH IN HEALTH SPENDING*
- *ILLUSTRATION OF POTENTIAL IMPACTS*
  - *Scenario 1 in the Initial Year Hospital and Nursing Home Budgets are Constrained so That Hospital and Nursing Home Utilization Does Not Increase Above the Level Expected Under Current Law plus an allowance for increased utilization among previously uninsured person.*
  - *Scenario 2 Expenditure Targets are Set Which Limit the Growth in Per Capita Health Spending to 6.5 Percent Per Year (Per Capita Spending is Projected to Grow by 8.6 Percent Per Year Through 2000 Under Current Law).*

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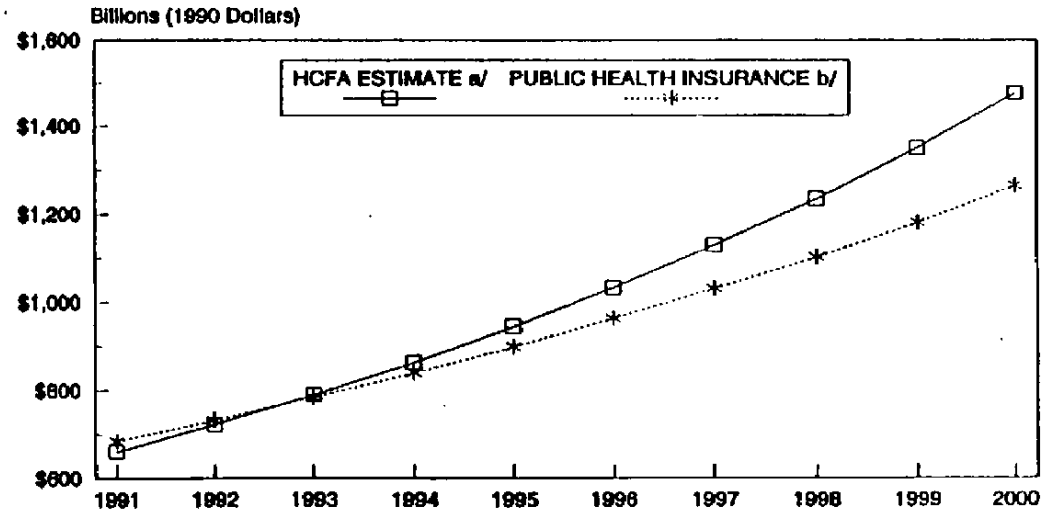
NATIONAL HEALTH EXPENDITURES UNDER THE PUBLIC HEALTH INSURANCE MODEL FOR ACUTE CARE ILLUSTRATIVE PROJECTIONS, 1991-2000



a/ HCFA estimates per capita health spendingwill grow 8.6% annually between 1991 and 2000

b/ Assumes the annual growth in per capita health spending is slowed to 6.5% under the expenditure target system implemented by the public health insurance plan

Source: Lewin/ICF estimates

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