



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET

WASHINGTON, D.C. 20503

September 10, 1993

THE DIRECTOR

MEMORANDUM FOR THE FIRST LADY

FROM:  Leon Panetta and Alice Rivlin *Alice*

SUBJECT: Comments on the 8/6/93 Draft of the Health Care Reform Plan

The attached memorandum to Ira Magaziner responds to your request last week that we provide our comments and suggestions regarding the draft Health Care Reform Plan dated 8/6/93. The memorandum is organized into two parts; the first section provides an overview of some of the areas of the plan where we believe further clarification is needed, while the second section provides detailed, chapter-by-chapter comments about aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. This detailed analysis was conducted under our supervision by OMB's staff of budget examiners who have the day-to-day responsibility for analyzing the various Federal health programs.

As noted in the memorandum, we are continuing to review the draft plan in order to ensure that it is consistent with the policy assumptions we have made in the preliminary budget estimates that have been used in the modelling process. Because the chapter on financing was incomplete at the time we reviewed it, and several elements of the financing proposal are still evolving, our analysis of this critical element of the draft plan is still preliminary. Our understanding is that the new estimates of the most current financing proposal will be delivered from the modellers next week. We will direct OMB staff to analyze these cost estimates along with the revised 9/7/93 draft of the plan that we have just received, in order to ensure that the estimates are consistent with the policy. We also want to highlight any budget "scorekeeping" issues that we see as a result of this review, so that we will not be surprised by CBO's scoring of the reform plan. We will provide you and Ira with our analysis of these issues as soon as possible.

We appreciate the opportunity to review this draft of the plan, and stand ready to discuss and clarify any of our comments and to work with you and Ira on subsequent drafts.

Attachment



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September 10, 1993

THE DIRECTOR

MEMORANDUM FOR IRA MAGAZINER

FROM:

Leon Panetta and Alice Rivlin *Alice*

SUBJECT:

Comments on the 8/6/93 Draft of Health Care Reform Plan

We appreciate the opportunity to review the draft Health Care Reform Plan dated 8/6/93. In general, the draft reads well and reflects the tremendous amount of work that has gone into the development of the plan. You and your staff are to be congratulated for addressing this important issue with such dedication and persistence.

A number of detailed comments and questions, organized by chapter, are attached. The comments represent our initial reaction to aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. We are continuing to review the draft policy in order to ensure that it is consistent with the policy assumptions we have made in our budget estimates and modelling; however, because the chapter on financing is not complete (and indeed, was still in the process of being discussed with the President last week), our analysis of this critical element of the draft plan is still preliminary. A few more general comments follow here, highlighting major issues that our initial review has uncovered, and that we believe need clarification.

It is my understanding that OMB staff met with you and your staff this weekend to discuss the chapters of the draft plan dealing with public health initiatives. We are prepared to do that with respect to other aspects of the draft plan if a fuller explanation of the detailed comments that follow would be helpful to you.

Allocation of Responsibility

The draft calls for a complex set of responsibilities to be shared by the Federal government, the new National Health Board, States, and Health Alliances. At each of these levels, there is further division of responsibilities as well. For example, within the Executive Branch, responsibilities are distributed across DHHS, Labor, Treasury, Justice, Commerce and others.

We appreciate the essential American traditions of pluralism and decentralized sharing of powers. At the same time, the practical complexity of the interrelationship of the various agencies and levels of government requires more specificity concerning duties, powers, shared responsibilities and -- most importantly -- final accountability. Specific issues related to implementation and long-term management of the Nation's health sector are difficult at best to predict. It is critical that the structure created to manage this reform be well-designed and easily understood by all concerned.

It is certainly the case that the precise allocation of responsibilities will be a primary focus of negotiations with the Congress, and in that sense, leaving the lines deliberately vague is a rational opening gambit. Insofar as we have not had the opportunity to discuss the contours internally very much, we believe it would be productive to focus on this issue and begin to develop our preferred outcome of this distribution before serious negotiations with the Congress begin.

One particular assignment merits mention here: we strongly object to the proposal set forth in the draft plan that the National Health Board will be organized as an independent agency that will issue regulations without the benefit of OMB review (see Chapter 5, p. 48). We believe it would be extremely unwise to cede Executive Branch control over the Board, especially in the early years, when the Clinton Administration will bear sole responsibility for its successes and failures. For example, the Board will be responsible, at least initially, for developing and enforcing the national health care budget. It is far from clear that it would even be possible, much less desirable, for an agency located outside the Executive Branch to assume such responsibility. Further, the purpose and effect of OMB review of agency-issued regulations is to ensure compliance with the goals and policies of the President. Ceding the authority to review regulations issued by the Board, and in general interposing an independent body between the President and the Executive agencies in effect relinquishes control of a crucial policy. As there may also be constitutional issues involved, at a minimum there should be further discussions about this proposal within the Administration.

### Federal Budget Risk

Related to concerns about authority and management, the draft plan calls for a number of new programs, policies, and initiatives that involve Federal dollars, either in direct funding or as a "backstop" for a potentially turbulent early implementation phase. Several direct subsidies are mentioned, including premium subsidies for low-income persons, an iron-clad cap for employer premium contributions set at 7.5% of payroll, additional subsidies for small, low wage firms, full tax

exemption for health insurance payments by the self-employed, and subsidies for co-pays and deductibles for low-income persons.

Several new sources of funding or funds (similar in concept to national trust funds) are discussed in the draft, including a national Fund/Risk Pool for the Uninsured, Fraud and Abuse Fund, the Veterans Administration Fund for Development into Health Plans, Long-Term Care Trust Fund, State Plan Guaranty Funds, the graduate medical education All-Payer National Pool, and the Inter-Alliance Security Trust Fund. Some or all of these funds could be substantial, both in terms of new tax burdens or potential outlays of Federal dollars. For example, the risk pool/fund discussed in Chapter 29 could be larger than either the Medicare Trust Fund or current Medicaid funding -- with as many as 50 million newly entitled persons. In most cases, the estimated cost or size of these funds is not specified.

We note that the draft plan itself is a discussion of the policy proposals without detailed budget tables. Of course, we have seen and helped to prepare draft estimates of various pieces of the overall reform plan, including proposed Medicare and Medicaid reductions, but as you know, the net cost of the draft health reform proposal has not been estimated as a total package. This is particularly true with respect to the proposal for financing the subsidies discussed with the President late last week, which we understand is still evolving. Interactive effects can be significant, especially in a systematic reform as complicated as this one. Thus, any numbers we have at the moment must be considered preliminary, and must be so regarded and described.

The further point is that there is quite a bit of irreducible uncertainty in any estimate of the ultimate effects of health reform on the Federal deficit. Given that, it seems prudent to spend more time and detailed effort designing "stopgap" protection for the Federal purse, especially in the early years. We at OMB would be glad to undertake this effort.

Our understanding is that estimates of the current financing proposal will be delivered from the Urban Institute next week. Armed with a fuller appreciation of the reform proposal as a whole, we will direct OMB staff to assess the new cost estimates to ensure that they are consistent with the policy as we understand it and will provide you with our analysis of this early next week.

#### Global Budget Enforcement

Nancy-Ann Min's memorandum to you dated July 29 expressed our concerns about the preliminary versions of the global budget. Although the guidelines for calculating the global budget have been amended to change the focus from GDP to CPI, the current version of the policy is similar to the one her memorandum

discussed, and therefore our concerns remain. Several dimensions of this policy raise related concerns about the unpredictability of Federal outlays. The Federal health budget enforcement and responsibility for Years 1 through 3 poses a number of challenges, including the following:

- Although the policy calls for Federal enforcement by the National Health Board of each State's global budget, currently there is no reliable state-by-state baseline of spending for the guaranteed benefit package. The only data available are gross estimates of total spending by HCFA's Office of National Cost Estimates, the accuracy and timeliness of which leave a great deal to be desired;
- Premium bids by plans could be skewed by estimates of increased demand for services by the newly-insured, estimates of adverse risk selection, and general market uncertainty. It will be difficult at best -- without better utilization and risk status information -- to assess the extent to which premium bids reflect efficient plans or delivery of services.

Taken together, these factors could have enormous implications for short-term Federal outlays, and thus for our ability to meet the global budget targets. With respect to the Federal health programs in particular, your argument that Medicare and Medicaid continue to grow at a rate higher than the private sector under the plan's scenarios is a persuasive one; but the fact remains that the global budget scenarios call for the growth rates in these Federal programs to be cut in half very quickly. We should not underestimate the difficulty of persuading the Congress that this is possible, and of actually doing it.

#### Administration of Subsidies

Under almost any plan, the administration of specific subsidies requires a fair amount of complexity and detail, which may in turn be less than helpful to the average reader. Perhaps under separate cover or in the next draft, it would be useful to share the details of the current proposals for the several provisions that imply or directly call for administration or distribution of funds. These include areas such as:

- subsidies to small businesses and/or businesses with low-wage workers;
- subsidies for Medicaid wrap-around coverage, as well as subsidies for co-pays and deductibles for the low-income groups;
- coverage and eligibility rules for the working aged, relative to both the worker and the spouse;

- tax incentives and tax credits for long-term care coverage; and
- transitional policy issues such as moving from a single national payer fund for the uninsured to coverage in private plans under a state-based alliance structure.

We strongly believe that the administration of these aspects of the plan must be reviewed carefully to ensure that there is coordination and streamlining across these administrative structures, rather than duplication and needless fragmentation.

Thank you again for the opportunity to review this draft and provide you with preliminary reactions. OMB stands ready to discuss and clarify any of these comments and to work with you on subsequent drafts.



THE DIRECTOR

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

September 23, 1993

MEMORANDUM FOR THE FIRST LADY

FROM:  Leon Panetta and <sup>Alice</sup> Alice Rivlin

SUBJECT: Comments on the 9/7/93 Draft of Health Care Reform Plan

We have attached OMB's comments on the 9/7/93 draft of the Health Care Reform Plan. As you will recall, we transmitted comments on the 8/6/93 draft in our memorandum dated September 10, 1993. We are working with Ira to resolve the outstanding questions about the plan in order to begin the process of scrubbing the numbers. Please let us know if you have any questions about our comments or this process.

cc: Ira Magaziner



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

September 23, 1993

THE DIRECTOR

MEMORANDUM FOR IRA MAGAZINER

FROM:  Leon Panetta and Alice Rivlin *Alice*

SUBJECT: Comments on the 9/7/93 Draft of Health Care Reform Plan

Thank you for the opportunity to review the revised draft Health Care Reform Plan dated 9/7/93. We look forward to continuing to work with you and your staff over these next few critical weeks as details are finalized.

We are attaching a number of detailed comments and questions, organized by chapter. We have classified comments into 2 types: (1) those that might affect budget estimates, and (2) needed policy clarifications. The greatest number of our comments pertain to three chapters -- "Long-Term Care", "Medicaid", and "Financing Health Coverage".

The 9/7/93 draft contains a number of chapters that remain the same or substantially similar to the 8/6/93 draft. We request that you still review carefully our previous comments on those chapters, which were attached to our memo to you dated September 10, 1993.

A particular continuing concern is the proposed "independent agency" status for the National Health Board. Given the wide-ranging powers of the Board and the President's accountability for the success or failure of its endeavors, we believe the Board should be accountable to the President. To accomplish this, the provision for removal of Board members only for cause should be changed to permit removal at the pleasure of the President. Removal for cause is the key determinant of "independent" status. More generally, the Board should be referred to as an agency in the Executive Branch, not as an independent agency. Further, we continue to believe that an agency with such broad powers should not be exempt from White House regulatory review.

Attachment

## Comments by Chapter -- 9/7 Draft Plan

### Chapter 3: Coverage

This chapter has not changed substantially since last review; previous OMB comments still apply.

#### Additional Comments

##### 1) Budget Issues

None.

##### 2) Policy Issues or Clarifications

- Page 13, under "Sources of Health Care Coverage", individuals who are eligible for Medicaid long-term care services should be mentioned. The document does not state whether these individuals will receive their acute care services through the health alliance, as well as continue to have Medicaid pay for their long-term care.
- Page 14, the mention of the health security card here and on page 111 imply that the card will be required for access. All discussions of the card were with the understanding that it can facilitate and expedite access, but could not be a barrier to access. Individuals will lose cards, some will not be competent to necessarily have possession of a card and will not have a guardian for ensuring its availability. The language in both sections should be revised to use the term facilitate.
- The explicit proposal for health insurance for the unemployed who have lost their jobs appears to have been dropped from the 8/6 draft. The health coverage available to unemployed workers in this draft, however, is not clear.
  - Page 15 states that no health plan may cancel an enrollment until the individual enrolls in another plan;
  - Page 74 states that health plans may not terminate, restrict, or limit coverage for the comprehensive benefit package for any reason, including non-payment of premiums. They may not cancel coverage for any individual until that individual is enrolled in another

health plan.

- Page 68 states that if a corporate alliance fails to make premium payments to a health plan, the plan may terminate coverage after reasonable notice. If coverage is terminated, the corporate alliance is responsible for providing coverage to individuals previously insured under the contract.

It appears the intent is to make large employers in corporate alliances pay for the costs of their unemployed workers. Based on the statements above, this coverage could even go beyond six months if the terminated worker remains unemployed.

- Page 15, under "Employer Obligation", COBRA requirements are not mentioned. Whether to eliminate COBRA requirements in favor of another requirement is a policy-level decision, but COBRA should be addressed.
- Employers "may be required" to provide six months coverage of terminated employees or pay 1 percent of payroll to cover unemployed workers:
  - Who makes the decision concerning "requirement" -- the State? the National Health Board? the Alliance? This should be clearly stated. Otherwise, COBRA requirements should continue to apply.
  - Note also that "terminated" employees are a broader group than laid-off workers.
  - Will the 1 percent of payroll only cover the costs of unemployed workers laid off by that employer? If the 1 percent of payroll is not enough, who pays?
  - Must the terminated employee pay his share of the health insurance costs to maintain the corporate contribution?
  - Is there a comparable requirement for smaller employers or those large (over 5000 employee) employers who enter regional alliances to provide health insurance to terminated employees? If not, who covers the health insurance costs of their laid-off employees?
- Page 16, self-employed and unemployed individuals are responsible for paying the family share of the premium as well as the employer share, unless they are eligible for

assistance based on income.

- What happens to unemployed individuals if they cannot pay (or do not choose to pay) for health insurance? Does the individual remain responsible for paying the premium, and how is this enforced?

For example, an unemployed worker may not qualify for a subsidy based on income from a second earner but still have high recurring liabilities (e.g., a mortgage). Given the average weekly benefit for unemployment insurance of \$170, if a health plan costs \$4,000 a year, the weekly cost of health insurance amounts to 45 percent of the weekly unemployment benefit.

- Page 16, enforcement of employer responsibility to contribute to employees health coverage should be shifted from the Secretary of Labor to the States. States already run their own unemployment insurance systems, and have been delegated most other enforcement responsibilities under the plan.
- Page 17, for part-time workers, employers will be required to make pro-rated contributions. Students, on the other hand, will be covered by their parents' policies or through the regional alliance of their school. The primary payor for students who work part-time is not identified; it should be the parents' policies, rather than the employers' policies.
- Page 17 (and p. 236), issues related to higher student premiums and dismantling of student health plans continue to be of concern. The expanded comments specify that the student is covered under his or her family's policy. A portion of the premium paid by the employer and the family would be transferred to the regional health alliance where the student attends school. If the student is not a dependent, he or she would enroll directly in the regional health alliance, and presumably would be responsible for the premium, subsidized depending on the level of income.

These revisions, while providing increased detail relative to the 8/6 draft, fail to address previous comments about how student health services would fit into the new system, and whether they would have to accept all applicants, including non-students, and raise premiums as a result. In addition, questions remain about how much of the premium would be transferred from the family policy to the regional health alliance, and how this would be determined.

## Chapter 4: Guaranteed National Benefit Package

This chapter has not changed substantially since last review; previous OMB comments still apply.

### Additional Comments

#### 1) Budget Issues

- Home health and extended care benefits for the under-65 population should be brought into line with the Medicare population by requiring a \$5 copayment per visit for home health and \$10 per day of extended care for low cost-sharing plans. The amounts should retain the same ratios to the copayment amount for physician visits. The high cost-sharing plans, as currently constructed, will require 20% coinsurance on these benefits. Under the plan, Medicare will also require cost-sharing on both benefits after a period of free care.

#### 2) Policy Issues or Clarifications

- Page 22, the table has asterisks that do not line up with definitions below. For example, "\*\*\*\*" is placed after "7 clinician visits" for children age 0-2, yet the definition of "\*\*\*\*" provided below the table says it stands for "once three annual negative smears have been obtained."
- Page 26, should a physician be required to reevaluate the need for continued outpatient rehabilitation therapy and home health care? While this could be considered too regulatory, it could discourage excessive utilization.
- Page 33, change the "Expansion of Benefits" section to read, "Additional benefits that could be included in possible future expansions include...".
- Page 33, coverage of investigational treatments should be limited to those trials bearing approval from one of the agencies enumerated, or that meet the cited NIH guidelines. Health plans should not be required to cover any other investigational treatments that have not met Federal standards.
- Page 35, remove the requirement that low cost-sharing plans have an out-of-pocket maximum. It is unlikely that the

maximums will be reached. An individual or family that does reach the maximum is likely overutilizing the health care system and a cap on out-of-pocket costs for low cost-sharing plans does nothing to discourage such usage.

## Chapter 5: National Health Board

This chapter has not changed substantially since last review; previous OMB comments still apply.

### Additional Comments

#### 1) Budget Issues

- Page 47, last paragraph, the discussion of a premium surcharge on all employers does not clearly state that this is the default requirement if states do not establish their own programs.

#### 2) Policy Issues or Clarifications

- Page 43, the NHB breakthrough drug committee seems to create disincentives for drug development in the very area where this should not take place, i.e., when there are significant treatment advances. Congress may already have created enough of a chilling effect with its intensive scrutiny of major breakthrough drugs such as AZT, the new cystic fibrosis drug and the new treatment for multiple sclerosis. The rationale against cost containment is that there will be significant market forces at work under the health care reform system to make such controls unnecessary and overly burdensome. To put in place potential price restrictions in the very areas we want to encourage drug development is counter intuitive. The notion that the committee could judge from other "therapeutically similar" drugs here and in other countries misunderstands breakthrough drugs, and fails to acknowledge price controls in other countries.

## Chapter 6: State Responsibilities

This chapter has not changed substantially since last review; previous OMB comments still apply.

### Additional Comments

#### 1) Budget Issues

None.

## 2) Policy Issues or Clarifications

- Page 52, last paragraph, refers to an agency that assumes control if a plan fails. Is this the same as the guaranty fund?

## Chapter 7: Regional Health Alliances

Previous OMB comments still apply. This chapter contains a few revisions: i) paragraph added on oversight of health alliances through the Department of Labor; ii) reference to HHS responsibility to establish model fee schedule for all services is eliminated; iii) pages on the operation of alliances have been moved from the chapter on State Responsibilities to this chapter.

### Additional Comments

#### 1) Budget Issues

None.

#### 2) Policy Issues or Clarifications

- Department of Labor oversight: A paragraph on "Enforcement" has been added that designates the Department of Labor to oversee the financial operations of the health alliances, including auditing of financial and management systems. Elsewhere, in the chapter on Health Plans, the Department of Labor also is designated with new responsibilities on developing grievance procedures.

In both cases, the National Health Board should be given primary responsibility, with the authority to designate agency responsibilities as it determines to be appropriate. This provides flexibility, along the lines of the NPR Reinventing Government approach, to designate whomever can best perform the job, rather than following pre-set, legislative or regulatory mandates. If any such function is assigned to the Department of Labor independent of National Health Board action, it should be limited to the corporate alliances.

## Chapter 8: Corporate Alliances/ERISA

This chapter has not changed substantially since last review; previous OMB comments still apply.

## Chapter 9: Health Plans

Previous OMB comments still apply. Paragraphs have been added on grievance procedures, provider participation in plans, and loans to community-based health plans.

### Additional Comments

#### 1) Budget Issues and Clarification

- Page 76, under the section "Health Plan Arrangements with Providers," health plans also should be authorized to competitively bid out for services such as durable medical equipment, pharmaceuticals, and other health care products.
- Pages 80-82, supplemental insurance coverage continues to promise excess and unnecessary utilization. Requiring high cost-sharing plans to offer coverage of cost-sharing liabilities will not help control costs and only encourage the opposite result. The requirement that high cost-sharing health plans offer wrap-around coverage of cost-sharing should be made optional.

An alternative would be to ban the coverage of cost-sharing altogether and allow supplemental policies to offer only additional benefits.

- Cost of Loans to Community-Based Health Plans: a new section has been added that requires HHS to establish a loan program to assist with the development of community-based health plans. The program "may provide direct loans to health plans or guarantee loans made by private financial institutions."

The potential for abuse and actual experience with existing Federal loan programs suggests that considerably more analysis and definition is needed regarding the goals and implementation of this program. This description provides no sense of how large the program may be, how much it would cost, what criteria one uses to judge what constitutes a community-based health plan, or what criteria should be used to determine who should receive the loans.

A preferred alternative is to delete this section altogether. The private market has already anticipated a network-based health care system: providers and insurers are already creating networks in anticipation of health care reform. Government-backed loans will only distort the incentives that exist and result in the creation of health plans that would not otherwise exist.

#### 2) Policy Issues and Clarification

Grievance Procedure: as noted in comments on the chapter on Regional Health Alliances, the revised plan designates the Department of Labor for new responsibilities -- in this case, for the establishment and monitoring of grievance procedures, including alternative dispute resolution procedures. The Department of Labor may indeed be in the best position to monitor such practices, but either the states or the National Health Board should assume primary responsibility.

The National Health Board is one option because it could delegate assignments as it deems appropriate. This provides flexibility, along the lines of NPR Reinventing Government approach, to designate whomever can best perform the job, rather than following pre-set, legislative or regulatory mandates. The other alternative would be for states to ensure that regional and corporate health plans establish and monitor grievance procedures. States are responsible for most other survey and certification efforts and jurisdiction on these matters should not be splintered.

Page 75, employers and employees (in regional alliances) pay a community-rated premium. However, payments to health plans by alliances are adjusted to account for the level of risk associated with individuals enrolled in plans.

Also on page 75, health plans may purchase reinsurance to cover disproportionate costs beyond those predicted by risk adjustment formulas.

These two provisions suggest that bad debts due to enrolled individuals not paying their premiums may show up in the community-rated premium. This will socialize the cost across the general population, while the party in default pays no penalty. Because unemployment is cyclical, health insurance premiums could increase to subsidize non-payers. Reinsurance could spread business cycle risks or costs due to structural unemployment across health plans, alliances, and States. Alternatively, the plan could specify a mechanism, through the tax system or a comparable procedure, that States have the option to use to collect overdue assessments.

Page 76, the requirement that plans pay "essential community providers" should be deleted. If health plans comply with non-discrimination requirements, they should be allowed to determine with what types of providers to contract. Requiring plans to contract with a certain class of providers contradicts the provision that health plans can "limit the number and type of health care providers who

participate in the health plan".

## Chapter 12: Integration of Workers' Compensation Insurance

This chapter has not changed substantially since last review; previous OMB comments still apply.

### Additional Comments

#### 1) Budget Issues

None.

#### 2) Policy Issues or Clarifications

- Page 90, paragraph about extent of coverage says that benefits will continue to be defined by states, that plans and providers are not allowed to bill patients for balances, but that workers will not be subject to requirements for co-payments and deductibles. Some state workers' comp laws may already allow for co-payments and deductibles. (There are serious efforts to control costs in some states. We do not keep up with the details but suspect they use deductibles and copayments or will need to so in the future.)

Although workers' comp laws do have broader purposes than "regular" health insurance, there is no reasons to override states' efforts to control costs of workers comp. An alternative would be to suggest adding at the end of the second paragraph, p. 90: "...unless they are allowed under the relevant workers' compensation law."

## Chapter 13: Quality Management and Improvement

Previous OMB comments still apply. Additional comments address the revised section containing greater detail on reforming the Clinical Laboratories Improvement Amendments (CLIA).

#### 1) Policy Issues and Clarifications

- Page 107, the resurrection of the explicit CLIA revisions is strongly applauded. The existing regime is a very costly construct with little evidence of improved quality at the cost of approximately \$1.5 billion annually. This change should stay in the plan.
- The draft states high-risk laboratories would be warned in advance of on-site inspections. High-volume, high-risk

laboratories would be targeted for on-site inspections, which would be announced in advance. An argument can be made that the pre-announcement is necessary to avoid disruption of patient care. No other health care facilities, however, receive this special consideration, e.g., nursing homes, hospitals, mammography screening clinics, home health agencies, etc. Pre-announcing surveys allows facilities to cover up non-compliance. At a minimum, facilities suspected of non-compliance should be subject to unannounced inspections.

## Chapter 15: Information Systems and Administrative Simplification

Previous OMB comments still apply. Additional comments address the revised section on consumer surveys, the deleted reference to PHS budget requirements, and the added new Medicare streamlining proposal to allow doctors to waive coinsurance.

### Additional Comments

#### 1) Budget Issues

- Page 118, the data standards process should be started in advance of health care reform legislation. The longer the standards are delayed the longer the continued administrative waste and delayed start-up of improved automation.
- Page 120, the new proposal allowing physicians to waive Medicare coinsurance in cases of "financial hardship or professional courtesy". Currently, health care providers, including physicians, are not permitted to waive coinsurance because of the increased utilization that waivers may cause. The plan proposes to allow physicians to "presumptively" waive coinsurance in cases of financial hardship or professional courtesy, but does not define these terms. These terms are difficult to define in a way that would prevent them from being used inappropriately. The practical effect -- unless new (and undesirable) paperwork is required to allow for enforcement -- would be to allow physicians to waive coinsurance under any circumstance. This is likely to result in increased costs to the Medicare program due to increased utilization. These costs should be estimated and added to the list of Medicare savings and cost proposals.

Allowing physicians to waive coinsurance also begs the question of why physicians should receive preferential treatment. What about other health care providers, e.g., durable medical equipment suppliers, clinical laboratories,

and home health agencies?

- Pages 119-121, it is unclear whether the costs and savings of other proposals in the Medicare streamlining section have been taken into account in overall cost estimates (see previous comments on this chapter related to streamlining Medicare). An attempt should be made to explicitly estimate these costs.
- Modifications to the chapter on consumer surveys are positive. The chapter no longer designates PHS as responsible for these surveys, and no longer states that PHS will require \$200 million to conduct these surveys. This appears to be responsive to previous OMB comments.

## 2) Policy Issues and Clarifications

- Page 121, the proposal to have the National Health Board explore developing standards for single annual inspections of health care institutions is inconsistent with the proposal to develop minimum standards for health care institutions on page 106, which calls for focused attention on those institutions with problematic records. More frequent inspections may be needed for problematic institutions, while less frequent surveys may be needed for those without problems.

## Chapter 18: Academic Health Centers

Previous OMB comments still apply; additional comments are provided. We note that the only significant change is a deletion of an opening "mission statement" that academic health centers perform "broad community functions that must be sustained."

### Additional Comments

#### 1) Budget Issues

- The plan counts \$6 billion in FY 1994 payments to an academic health center pool. Medicare indirect medical education (IME) payments are currently projected to reach \$4.2 billion in FY 1994. Medicare direct medical education payments are projected to equal \$1.5 billion. The plan should identify the components of the \$6 billion, since it only stakes a claim on the IME funds.

#### 2) Policy Issues or Clarifications

- The plan would add a surcharge to the health plan premium. The plan should specify whether the surcharge shall be paid entirely by the employer, the employee, or whether it will be split between the two parties.
- The plan would require health plans to assure coverage for routine patient care associated with approved clinical trials. Some plans, however, will find it difficult to contract with an academic health center given geographic settings, e.g., rural networks may be hundreds of miles from an academic health center. Secondly, a requirement for plans to contract with an academic health center contradicts the statement on page 76 that allows plans to "limit the number and type of health care providers who participate in the health plan."

An exceptions process should be structured that will allow plans to opt out of contracting with an academic health center. Plans can purchase reinsurance to protect themselves from the high costs of treatment of rare diseases and specialized procedures.

- Page 139, text states that MHS will determine particular diseases or procedures "for which health plans are required to establish contractual relationships with academic health centers." Such central planning is not necessary (such links will form on demand) and not consistent with the principle of Local Responsibility stated in the chapter on Ethical Foundations of Health Reform (page 12).

## Chapter 21: Long Term Care

The chapter has been re-written; OMB comments address this new draft.

### 1) Budget Issues

- Page 152, it is possible that a portion of the SSI/DI population who are not currently receiving institutional care or home based care would qualify for community based care as under the eligibility standards described. Limited ADLs are used as eligibility criteria for SSI/DI, but this population rarely uses institutional care.
- Page 158, would the monthly living allowance change for recipient of Federal benefits (SSI, VA) change?

- Page 162, this tax deduction would represent a double exclusion for SSI/DI recipients. Work related expenses are deducted from an SSI/DI recipients total income when calculating benefits.
- The calculation of the Federal match rate, as it is affected by current State spending on long-term care, is never specified.
- The interaction between maximum budgeted amounts (established nationally for long-term care spending) and the amount of the Federal match is never addressed.
- Funding for the new low-income program is supposed to be based on spending that would have occurred, if Medicaid were unchanged, for individuals receiving home and community-based care who do not meet the 3-ADL criteria. State Medicaid data almost never distinguishes among disability levels of long-term care recipients. Therefore, this projection will be nearly impossible.
- Requiring States to fund both the non-means-tested and the low-income programs may significantly increase the fiscal burden upon them.
- Tax incentives for individuals with disabilities who work -- employed disabled individuals who require assistance with daily living receive a 50% tax credit. Is this credit refundable? Does the credit only apply to earned income? How does the credit interact with EITC? Was this considered in pricing.
- Medicare beneficiaries pay a premium toward coverage, with individuals having incomes below 100% of poverty exempt from the premium. Should assets be included in the in the computation of the premium exemption threshold?
- Matching rates: Secretary of HHS determines matching rates for allowable costs. How are administrative costs treated under the matching rate computation?
- Tax treatment of premiums for long-term care insurance -- such premiums for qualified plans are excluded from taxable income. Are the premiums excluded for both income and

FICA/FUTA payroll taxation? What is the tax treatment for the self-employed?

## 2) Policy Issues or Clarifications

- The relationship between current Medicaid home and community-based care and this new program is still unclear. The addition of a low-income program adds another wrinkle. What happens to current Medicaid recipients who meet the 3-ADL criteria? Do reimbursement rates vary between the two programs?

## Chapter 25: Health Care Access Initiatives

Previous OMB comments still apply.

### Additional Comments

#### 1) Budget Issues

None.

#### 2) Policy Issues or Clarifications

- State Health Care Access initiatives are likely to be influenced strongly by the state's physician community. Low-cost community based care provided by clinics such as Planned Parenthood may not receive access to grants or be permitted to be providers under state access plans.

## Chapter 26: Medicare Outpatient Prescription Drug Benefit

Previous OMB comments still apply. The 9/7 draft includes a provision requiring pharmaceutical manufacturers to offer discounts to all purchasers of pharmaceuticals on equal terms. Manufacturers will be able to differentiate drug sale prices if they can identify "mechanisms that can influence physician prescribing behavior." The plan also yields to the National Association of Insurance Commissioners the power to make any desired changes to Medigap coverage of prescription drugs.

### Additional Comments

#### 1) Budget Issues

- Full protection against out-of-pocket drug costs through private insurance plans could lead to overutilization, the costs of which would be borne primarily by the Federal

government. Studies have shown that a small co-payment of \$3-5 per prescription can effectively reduce unnecessary utilization.

- Page 196, the new sentence on rebates for the dually eligible shifts a substantial amount of funding away from the states to the Feds. The blind, disabled and aged population comprise 70% of all Medicaid expenditures and a comparable portion of a rebate on the \$6.8 billion benefit in 1992 -- no small amount! Do the Feds really need the money more than the states?

## 2) Policy Issues of Clarifications

- What is a "mechanism that can influence physician prescribing behavior?" Will the Secretary be responsible for defining allowable price differentials?
- Page 197, second paragraph under reviews. It is unclear how this electronic claims management system will relate to the national information system. It should at least state clearly that it should be coordinated with the overall information system structure and should not duplicate any of the capabilities or reporting requirements.

## Chapter 27: Medicaid Acute Care

This chapter appears unchanged in some sections; previous OMB comments still apply. Changes to the draft health reform plan included in the 9/7 version include: i) the elimination of disproportionate share hospital (DSH) payments; ii) a possible Federal block grant to help fund supplemental (wraparound) benefits for Medicaid cash and non-cash recipients; iii) the premium calculation for Medicaid recipients is detailed; and iv) the National Board is granted the power to create a transfer payment from low-Medicaid plans to high-Medicaid plans within an alliance if the risk-adjustment mechanism is deemed insufficient.

### Additional Comments

#### 1) Budget Issues

- Will States have a compelling incentive to alter AFDC or SSI eligibility standards to shift the costs of these recipients into the low-income subsidy pool? Would the maintenance of effort requirements prevent this type of cost-shifting? States could, for example, limit eligibility for State supplemental payments to SSI recipients, effectively

lowering the number of cash recipients eligible for Medicaid. This could affect at about 11% of the SSI cash recipients -- over 650,000 people in 1992. States have even greater discretion in establishing eligibility criteria for AFDC cash payments and could potentially eliminate payments for a majority of current (baseline) recipients.

- page 200, depending on how guaranteed benefits for non-cash recipients would be financed, States may have an incentive to remove individuals from the SSI or AFDC roles, i.e., to move from 50/50 funding for Medicaid to 100% Federal dollars for guaranteed benefits.
- Page 200, the SSI disabled population uses emergency care heavily. During the transition period when Medicaid disabled recipients have access to a non-capitated fee-for-service-plan costs could escalate.
- If Federal funding for supplemental services is provided through block grants, will the grant amounts be established to approximate the Federal portion of current State spending on supplemental services?
- What index and base will be used to calculate State Medicaid payments? Payments may be trended forward in two different ways:
  - Multiply spending in the year prior to reform by 95%. Grow the resulting product by the allowable annual rate in the outyears; or
  - "Grow" spending in the year prior to reform by the allowable annual rate. From that amount, subtract 5% of the prior year's spending (in the absence of the growth rate). Repeat this calculation for the outyears.

The difference between these two methods could compound significantly in the outyears.

- What happens to the other 5% of projected Medicaid spending? Does this 5% accrue as savings to the Medicaid program? Who saves the money, the Federal government or the States? Alternatively, is this money spent elsewhere?
- Will the calculated premium paid by States to Alliances for Medicaid recipients cover the costs associated with Medicaid

recipients in even the lowest-cost plan?

- The description of the negotiations between health plans and alliances for non-cash recipients' premiums is extremely unclear. More information and a straightforward description of the process will be necessary for congressional and public readers.
- Who should have primary responsibility for determining whether transfer payments should be made from plans with few Medicaid recipients to those with many Medicaid recipients? How will this determination be made, and how large will these transfer payments be? Requiring the National Board to make this determination for all plans could be extremely burdensome. Alternatively, health alliances could have primary responsibility, subject to National Board oversight.
- Will the schedule to eliminate DSH payments be coordinated with reductions in other Federal subsidies for hospitals serving large numbers of low-income individuals and with the phase-in of the subsidy for low-income payors?

#### Maintenance of Effort Issues

- Is it correct to assume that States' Medicaid spending for AFDC and SSI recipients after the implementation of reform would be credited toward their maintenance-of-effort (MOE) requirements? If a State's post-reform Medicaid spending is less than its required MOE contribution in any given year, would it be required to make some sort of lump-sum payment to the Federal Government or to State Alliances? How would these funds be spent, e.g., to offset Federal low-income subsidies costs?
- It appears that the MOE requirement would not allow States to share in public sector savings that would result from non-AFDC and SSI eligibles gaining coverage through their employers. Is the rationale for this approach that these continued costs would be outweighed over time as States' fiscal liability is reduced because of lower health care/Medicaid costs?
- Why does the MOE requirement not include other State and local health expenditures that are made outside of the Medicaid program?

- Must States also maintain spending for acute-care Medicaid services not included in the guaranteed package?
- Will the MOE requirement include States' share of payments financed through provider taxes and intergovernmental transfers?
- Payments to Alliance plans on behalf of Medicaid recipients would be based on each State's per capita Medicaid spending. If the State MOE does not include State spending associated with DSH and provider-tax-related expenditures, will these dollars be netted out of the initial calculation of Medicaid per capita payments to plans? Or will the Federal government make up the difference?
- Establishing a prospective year on which to base State MOE contributions may invite gaming on the part of States. That is, States may downsize their Medicaid programs in the year prior to reform implementation in order to reduce their MOE contribution. On the other hand, once reform is implemented, States may seek to shift more individuals onto Medicaid to reduce the growth in the weighted-average premium and, thus, the growth in the MOE contribution.
- The MOE contribution would be trended forward by a per capita index factor only. Why not also include indexing for Medicaid caseload growth?

## 2) Policy Issues or Clarifications

- Integration of Medicaid recipients. Alliance offered plans will cover all Medicaid recipients under age 65. This assumes that all elderly individuals will be covered by Medicare. Many elderly individuals (especially those on SSI) are currently on Medicaid. It is unrealistic to expect the current Qualified Medicare Beneficiary (QMB) program to pick up these individuals since the program has not been implemented well.
- Eligibility. No further coverage options are added to current law. Question: Can States drop options?
- Establishment of a single financing pool for plan payments -  
- would Medicaid recipients start having to pay co-payments which they do not currently have to pay?

- In an alliance with only three plans, it is possible that the premium in the median cost plan could be above the weighted average premium -- especially if enrollment were heaviest in the lowest-premium plan. In this case, recipients would be able to choose only the plan with the lowest premium.

## Chapter 29: Transition

Previous OMB Comments still apply.

### Additional Comments

#### 1) Budget Issues

None.

#### 2) Policy Issues or Clarifications

- Page 217, to avoid unnecessary disruption why not allow corporations in early opt-in states to maintain their present coverage systems until all corporations have to comply. This would avoid putting companies at a competitive disadvantage. Alternatively, early opt-in states could be offered more flexibility on phasing in the employer mandate to acknowledge the problem.

## Chapter 30: Financing Health Coverage

The employer premium subsidy is less specific than in the 8/6 version, and is limited to firms with 50 or fewer employees. Employers still have a cap on premiums for all employers equal to 7.5% of payroll. Individual and family subsidy issues appear to be generally the same as in the previous draft.

Self-employed, non-workers, part-time and seasonal employees discussion is significantly expanded since previous version, which mentioned subjects in passing in the finance section. Retiree coverage discussion is new.

### Additional Comments

#### 1) Budget Issues

- Subsidies for Employers: The eligibility criteria for subsidies for employees and employers, and premium caps for employers could be based on total employee compensation, including fringe benefits, instead of payroll. Large

segments of the nation's working population receive employer provided fringe benefits such as health and life insurance, flexible benefit packages, housing, and pensions. Such benefits accounted for 16 percent of total employee compensation in 1989, up from 8 percent in 1960. Most of the growth in employee remuneration over the past 20 years is attributable to the growth in benefit spending. For example, inflation-adjusted benefit spending per full-time employee grew by 63 percent between 1970 and 1989, while average cash wages remained almost flat. The proposed employer subsidy could further encourage firms to pay employees in fringe benefits in order to remain eligible for the government health subsidy, or meet the 7.5% payroll cap.

- Individuals in Regional Alliances: Subsidies are available to individuals and families with incomes up to 150% of poverty. Eligibility could also be based on both income and assets. Numerous income related Federal benefits such as AFDC, Foodstamps and SSI are based on both income and asset tests for eligibility
- Non-workers and part-time workers: Premium payments are reduced for those recipients with family incomes less than 250% of poverty. How does this interact with subsidies that are available to individuals and families with incomes up to 150% of poverty? Does this create work incentives or disincentives? How will this interact with EITC?
  - Overall, specifics and definitions in this area can result in major shifts in premium income and benefit outlays. For example: subsidy interaction with EITC, definition of self-employment income in calculating premium caps.
- Retirees: The effect of this policy goes in the opposite direction of the current law Social Security program, under which the normal retirement age begins to increase from 65 to 67 in year 2000.
  - Retired people over 55 years of age and who meet the social security requirements for quarters of coverage are eligible for subsidies on their employer share of their premium. By encouraging retirements among employer and employees, Social Security and PBGC costs will increase, while Social Security, Medicare and income tax revenues will be reduced.
- Health Premium information on W-2: This will involve some

additional administrative costs for SSA and IRS under the discretionary caps.

## 2) Policy Issues or Clarifications

- The proposal could encounter serious implementation difficulties if the lowest cost plan is less than 80% of the cost of the weighted average premium. In this instance the worker wanting to choose the lowest cost plan will need a rebate, and the employer will pay less than 80% of the weighted average premium. Such events may occur rarely, but shouldn't there be some mechanism to deal with them?
- Page 224/235, the treatment of part-time workers, especially those who are dependent on their families seems unsatisfactory. Are their payments pro-rated according to the number of hours worked? Introducing such a pro-rating scheme may be complicated, but otherwise there is a "big hit" for people working relatively few hours (e.g., 15/week).
- Page 222, the subsidies for low-income families create perverse incentives. It is clear that the government is essentially requiring that poor people enroll in the medium plan rather than in the low cost plan, since for such people the cost will be the same, while presumably the quality is better at the higher priced plan.

An alternative which could save the government some funds, and give cash to the poor would work as follows: Give the poor the right to the average premium plan, but also give them the right to a rebate of say 50 cents on the dollar, if they elect to pick a plan costing \$10 less per month. Some, but not all poor eligible for subsidies will accept this offer, and take the lower cost plan. They will make themselves better off, AND reduce government subsidies. Given the "right" rebate rate, one can ensure that a substantial number of poor people choose to enroll in plans other than the cheapest. Thus one could still avoid the segregation of rich and poor into different plans that is presumably the policy goal that motivated the current draft.

- The administrative costs of the HAs seem ever more imposing. These entities now must worry about bad debt, and end of the year reconciliations for millions of households who are perpetually moving, divorcing and changing employment status, and for employers undergoing bankruptcies. In addition they have to conduct a risk-adjustment exercise,

which may be subject to lawsuits at least during the first years, as AHPs dicker about whether they are fully compensated for their unexpectedly high risk populations. They have to collect from the States for the maintenance of effort funds, although the calculation of these will be problematic, since not all of the MOE funds will go directly to the HAs. Finally, since there will be close to 100 HAs, it is reasonable to expect that some will fail to comply with their Federal mandates. By what process will the proper management of these be maintained if there are accusations of noncompliance, let alone fraud?



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET

WASHINGTON, D.C. 20503

September 24, 1993

THE DIRECTOR

MEMORANDUM FOR: Ira Magaziner  
FROM:  Leon Panetta and Alice Rivlin  
SUBJECT: Timetable for Budget Estimates

As you have often emphasized, it is important for the credibility of the health reform proposal that all Federal cost and savings estimates be thoroughly scrubbed. In order to provide thorough the estimates, our OMB budget examiners will need clarification of some of the policies in the health reform plan. Decisions are also needed on certain economic and technical assumptions to be used in preparing estimates of the Federal budget effects of the reform.

This memorandum lists the points that need clarification. We understand the pressures for a very rapid turnaround. We will be able to produce cost estimates 2 weeks after we get a complete set of programmatic specifications to price out.

Policy Clarifications: There are a number of policy questions that must be clarified before OMB can estimate the plan's total costs to the Federal budget. A list of these questions is attached at Tab A. (These should look familiar: Many of our questions were forwarded to you as an attachment to our memorandum on the 8/6/93 draft of the health reform plan, and we have compiled an additional list of new questions pertaining to the 9/7/93 draft, which was forwarded earlier this week.)

Economic and Technical Assumptions: Up until now, the economic assumptions used for estimating the costs and savings from the health reform proposal have been the January 1993 "CBO" assumptions, the same assumptions used for the President's February and April budget submissions to the Congress. They include the assumption that inflation will average 2.7 percent per year in 1996-2000. In August, the Administration revised its economic assumptions for the Mid-Session Review. The new assumptions are no longer based on the CBO economic forecast. Inflation averages 3.5 percent per year in 1996-2000 in the new projections.<sup>1</sup> We recommend basing the budget estimates for health reform on the new Administration economic assumptions so that we will be able to compare it with other Clinton Administration proposals and forecasts and to produce an internally consistent estimate of the impact of the proposal on

<sup>1</sup> CBO has also revised its economic forecast. The current CBO economic forecast calls for an inflation rate of 3.0 percent rather than 2.7 percent.

the deficit. You should also be aware that the health reform proposal, as a pending Administration legislative proposal, will have to be re-estimated for the President's FY95 budget submission, using revised economic and technical assumptions. The practice has been that these budget estimates are made by the affected agencies on a budget-account basis using the Administration's own economic assumptions. These are likely to differ somewhat from current forecasts, but the disparities are likely to be minimized by adopting the current Administration forecast now.

"Scorekeeping" Issues: As we have discussed, there are certain Budget Enforcement Act (BEA) "scorekeeping" issues that will need to be resolved before legislation is proposed to implement the health reform proposal. We will need about two days after the OMB/Treasury estimates are final to assess these scorekeeping issues. Please note that for presentation to Capitol Hill, OMB and Treasury estimates will have to be divided into the following categories: discretionary, PAYGO (receipts and mandatory), and indirect impacts. Depending upon how the current policy divides into these categories, we may want to suggest changes in the language used to describe the policy in the detailed specifications you are drafting. Moreover, it might be productive for us at OMB to surface any scorekeeping issues with CBO in advance of finalizing the policy specifications.

In addition, it appears that there will be BEA issues relating to the proposed increases in discretionary spending in the health reform plan, which appear to be far too large to fit within the existing discretionary caps. We have discussed this issue with respect to the proposed increased spending for various programs of the Public Health Service; if these increases are maintained, the BEA will have to be amended, because it sets an absolute limit on discretionary spending that would be breached by this additional spending. While this might conceivably justify a proposal in the health reform bill to amend the BEA to raise the discretionary caps (which might be justified with the argument that the new discretionary spending is more than offset by PAYGO savings that will be achieved by the Medicare savings proposals), this depends on how much of the increase in receipts and the decrease in mandatory spending will be scoreable under the BEA. (It appears that some of the receipts that are currently being scored may reflect indirect impacts that cannot be scored under BEA). As you can see, these issues involve complicated technical questions, as well as questions regarding our approach to the Congress that must be carefully considered as part of the overall legislative strategy for the reform effort.

Attached at Tab B is a proposed schedule for completion of our work. Please let me know if you have any questions.

cc: The First Lady

Attachments

The following code applies to each question or set of questions:

- Priority 1: Cross-cutting questions that more than one group needs answered before pricing can begin.
- Priority 2: Questions that must be answered before pricing of a specific component.
- Priority 3: Questions whose answers may not affect the pricing but which may highlight the need to sharpen the focus of legislative specs.

PRIORITY 1

15 Sep 93

1. From/To health coverage status over time (FY94 - 2000) - where are people now, where will these go each year — detailed pricing and modelling assumptions and data.
  - state and local coverage - mandated? subsidized?
  - uninsured
  - movement from one of two spouses employer's paying premiums to two working spouses having employers pay contributions - When? Alliance by alliance, time period
  - are welfare recipients induced off the AFDC, General Assistance, or Food Stamp rolls
  - coverage of temporary employees — particularly federal temporaries
2. What is the premium plus surcharge, guaranty assessments and other amounts — Are the weighted average premiums *ex ante* or *ex post*?
  - Timing of development of health alliance premium by major state and concentrations of federal beneficiaries
  - Breakout the surcharges for Nationally desired activities, their timing, State Guaranty funds
  - Growth of premiums, and surcharges, etc. over time and changes in benefits — 2000 etc.
3. Amount of payment by FEHB on behalf of over 65 non-Medicare annuitants and the increase in premium cost
4. Interaction of Medicare and Medicaid drug benefits — what are the rules?
5. Maintenance of Effort for Medicaid — detailed description and HHS pricing over time.
6. Assumptions on VA Health Plan participation and direct appropriations — same with Indian Health, DoD/Champus
7. National Health Board function and staffing
8. Health cost containment, its effect on the CPI — and federal revenues/outlays
9. Income and firm subsidy designs E. G. What is income, etc. and the costs of administration and including underlying eligibility, participation and error

rates.

10. Changes in federal tax income from for profit health plans and physician and other provider income.
11. Details on early retiree policy especially DoD and FEHB early annuitants
12. Interaction of Medicaid and Medicare with the new long term care benefits (part c if -) rules, etc.
13. Treatment of Federal auto and workers compensation — Federal Tort Claims Act, FECA
13. Are those in Federal State and other institutions covered (jails, mental hospitals, juvenile centers, etc.)
15. If calculations are on a CY basis, please provide your methodology for estimating the FY/CY switch.
16. Please provide the cash flow incurred costs, outlay lags and related assumptions.

Please provide a list of contact for each of the items.

24-Sep-93  
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**MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR  
PRICING OF HEALTH CARE REFORM**  
(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
<b>Current Law</b>							
Baseline updated for August CEA economics							
Beneficiary Population							
Per-Beneficiary Outlays							
<b>Less Employer-covered Aged (assumes full-time work for full year)</b>							
Outlay savings							
Beneficiaries opting out							
QMB offset							
Admin. costs							
<b>Early Retiree Coverage Effect</b>							
Outlay Change							
Number of Early Retirees							
Admin. costs							
<b>Revised Pre-Savings Baseline</b>							
Outlays							
Beneficiary Population							
<b>Savings Package Assumed for HCR</b>							
Outlay savings							
Effect on Beneficiary Population							
Change in Admin. costs							
<b>Post-Savings Baseline</b>							
Outlays							
Beneficiary Population							

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**MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR  
PRICING OF HEALTH CARE REFORM**

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

1994      1995      1996      1997      1998      1999      2000

**HCR Effect on Baseline**

**Number of enrollees in "standard" Medicare**

- QMBs
- Dual Eligibles
- Standard Medicare HMO
- Other/Fee-for-service
- Total

**NON-ADD Supplemental coverage effect on outlays**

**Number of enrollees moved to alliances**

- QMBs
- Dual Eligibles
- Other
- Total

**Enrollees in VA health plans with Medicare as primary payor**

**NON-ADD Supplemental coverage effect**

*Where does Medicare pay (plan or point of service)*

- Admin. costs VA
- Medicare

**Enrollees in CHAMPUS/VA health plans with Medicare as primary payor**

**NON-ADD Supplemental coverage effect**

- Admin. costs CHAMPUS/VA
- Medicare

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## MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Enrollees in CHAMPUS health plans with Medicare as primary payor							
<i>NON-ADD Supplemental coverage effect</i>							
Admin. costs CHAMPUS							
Medicare							
Enrollees in DoD/Champus health plans with Medicare as primary payor							
<i>NON-ADD Supplemental coverage effect</i>							
Admin. costs DoD/CHAMPUS							
Medicare							
Average Federal Medicare contribution for Alliance-based Medicare beneficiaries							
Average Beneficiary Contribution							
Admin. costs							
Average Federal Medicare contribution for DoD plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							
Average Federal Medicare contribution for VA plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							

POST-HEALTH CARE REFORM, NET MEDICARE OUTLAYS

24-Sep-93  
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**MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR  
PRICING OF HEALTH CARE REFORM**  
(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
<b>Related Assumptions</b>							
Drug price growth rate							
Drug premium							
Pre rebate							
Post rebate							
W/O rebate							
Admin costs							
Cost shift/capturing secondary effects							
Revenue affects							
Employer taxes							
Employee taxes							
State and local government taxes							
Medicare Beneficiary Cost-Sharing							
Average for standard plan							
Premium							
Deductible							
Copoly.							
Total							
Plus:							
Drug Premium							
Drug Copay.							
Total							
Effect of supplemental coverage on drug utilization							

September 24, 1993

### Health Care Reform Pricing Issues – Medicare

The cover table and the following list of pricing and policy questions contains significant overlap and duplication. The intent is that the answers to these questions and stated assumptions will provide enough specification to provide estimates of health care reform's impact on Medicare.

On a fiscal year-by-fiscal year basis through the year 2000, what are the assumptions concerning:

- Medicare beneficiary enrollment through the Alliance rather than traditional Medicare? Does the percentage of enrollees gaining coverage through the Alliance increase over time? (See table; Categories 1 & 2)
  - What percentage of them enroll in HMOs? (See table; 2)
  - Do Medicare beneficiaries pay the surcharges on the premium, or does the Federal subsidy include them? (1, 2, 3)
  - What incentives, e.g., differential premiums, will exist to encourage enrollment in managed care settings? (3)
  - What is the assumed deductible in health plans for Medicare-eligible enrollees? (1, 2)
- How many (and what percentage of) non-working, non-QMB people who would have been in Medicare will elect to enroll in alliances instead? (1, 2)
- Does the employer mandate apply to employers of Medicare-eligibles or is employment sponsored insurance merely a mandated option for Medicare-eligibles? (3)
  - Does the mandate apply to the cohort of working aged in corporate alliances? (3)
  - Suppose both spouses are Medicare enrollees, and only one works. Does the mandate require worker/employer to buy a "couples" policy or a single policy? (1, 2, 3)
  - If a Medicare beneficiary is married to a non-Medicare worker, does the worker-employer have to buy a couples policy or could they decide to

*Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.*

purchase only a single plan? (2, 3)

- What limits on enrollee choice of policies/coverage exist? (3)
- How will savings accruing to the States be shared between beneficiaries and Medicare? (1, 2, 3)
- For the Medicare-eligible alliance enrollees, what will be the total amount the alliances charge, and the average per capita amount, to Medicare?
  - What are the assumptions regarding the amount charged to Medicare, e.g., is it based on the average per capita amount? (See table; 3)
  - Is it risk-adjusted to a level lower than the average Medicare fee-for-service level to reflect an assumed better health status and/or younger average age of Medicare-eligible alliance enrollees? (See table; 3)
  - Is it geographically adjusted by state? Would Medicare subtract lost premium income from the amount paid to the alliance? How much? (See table; 3)
- Are Medicare IME outlays folded into the funding pool for academic health centers, along with the GME payments? Or are they held separate, but at a lower IME rate of payment, e.g., 3%? (1 & 2)
  - What are the assumed impacts on Medicare GME/IME payments under the workforce changes contemplated by the 9/7 draft?
- Are those eligible for Medicare through disability enrolled in a separate pool, or do they continue to receive care under Medicare? What are the assumptions about the disabled's enrollment through Alliances and the effect of marriage status? (1, 2, 3)
- Are dual eligibles folded into the Alliances along with the rest of the Medicaid population, or does Medicare cover them?
  - Who is the primary payor for prescription drug cost-sharing for dual eligibles, Medicare or the States? (See table; 1 & 2)
  - Are States required to cover Rx cost-sharing for QMBs? Is this going to

*Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.*

be reflected in the MOE calculation? How will the Medicare and Medicaid drug benefits be integrated? (1, 2)

- What percentage of QMBs will enroll through Alliances?
- Are there separate assumptions about elderly utilization of health care services under different cost-sharing schemes? If so, what is assumed about Medicare beneficiary utilization with lower cost-sharing requirements, e.g., managed care enrollment with no Medigap allowed? (2)
- Will the elderly be allowed to purchase Medigap if they enroll in managed care settings? (3)
  - What are the assumptions about reduced Medigap purchasing as the result of the new Medicare benefits/options, e.g., coverage of copayments on drugs rather than the entire drug? (See table)
- What income levels are assumed of veterans before Medicare will pay VA for covered services? (1, 2, 3)
  - What are the assumptions about the number of Medicare beneficiaries also eligible for VA care? What is the assumption about Medicare payment to the VA for care rendered Medicare enrollees? (2)
- What are the assumptions about Medicare beneficiary utilization of VA and DoD facilities? What are the assumptions about Medicare enrollees enrolling in DoD, VA, CHAMPUS, and CHAMP/VA plans? (2)
- What assumptions are made about the average out-of-pocket cost for a Medicare-eligible alliance enrollee (i.e., 20% of premium with subsidies for low-income, \$200 deductible, some coinsurance), versus the average out-of-pocket cost if they choose to stay in Medicare (i.e., 25% of Part B costs, \$676 Part A deductible, \$100 Part B deductible, and copays). Are these relative costs taken into account in developing a model to determine how many will opt for alliances versus staying in Medicare? (See table; 3)
  - In addition, do the assumptions about how many Medicare-eligibles enroll in alliances take into account the varying levels of income-related subsidies for alliance premiums? (3)

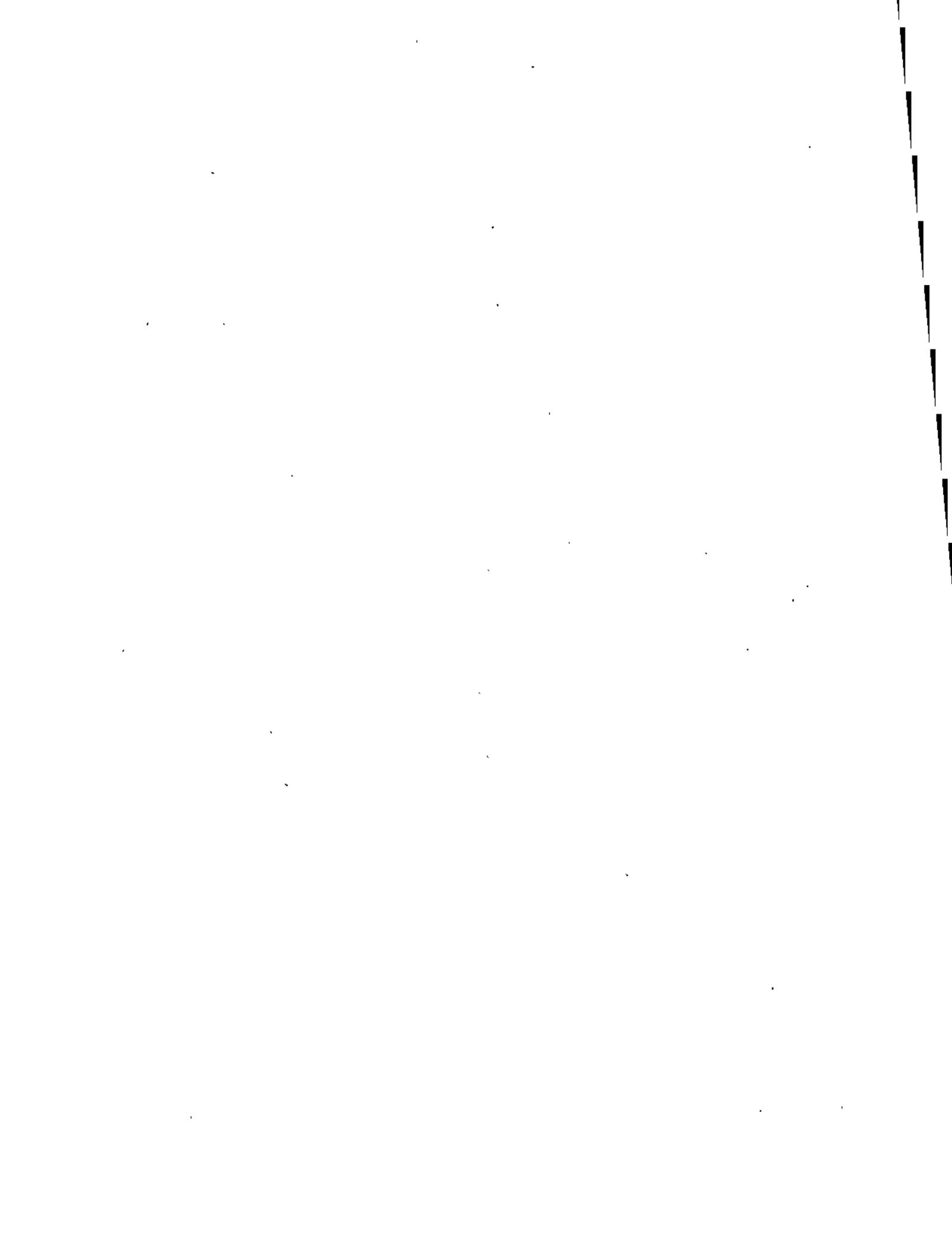
*Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.*

- The plan asserts that States will assume Medicare administrative costs in situations in which Medicare is enrolled into the alliance (pg. 191). If Medicare is not reimbursing the States for these costs, how much administrative savings are assumed for the Medicare program? (1, 3)
- What are the assumptions regarding Medicare beneficiaries already enrolled in managed care plans? (See table)
  - How many stay in existing plans versus joining plans under the health alliances?
- What are the assumptions regarding beneficiaries joining Medicare point-of-service plans (pg. 193)?
  - How many from current baseline enrollees in Medicare managed care plans will switch to point-of-service networks? How many additional beneficiaries will join point-of-service networks? What will be the average per-capita Federal cost and savings versus the baseline for these plans? What Federal administrative costs are assumed for these point-of-service plans? (3)
- What are the assumptions about physician discretion in waiving Medicare coinsurance requirements in cases of "financial hardship and professional courtesy" (p. 120)? What is the induced utilization effect? (2, 3)
- What are the assumptions about the effects of Medicare proposals on administrative costs? (2)

*Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.*

Pricing Questions Concerning the Medicare Drug Benefit

1. What effect do you assume the drug benefit will have on drug usage and expenditures among Medicare Part B beneficiaries? (2)
2. How many beneficiaries do you assume will enroll in Medigap policies that cover the cost-sharing requirements included in the drug benefit and what affect will Medigap coverage have on drug usage and Federal expenditures? (2)



To: Lew Nichols  
RonDKK

Kronick 9/22

Medicare As Secondary Payer Policy

Ag - HF - 3

Policy questions that need to be answered in order to accurately estimate the size of the 'Offset for Medicare Eligibles in the Alliance':

1) Is policy that Medicare beneficiaries who are full-time workers must be members of the alliance (either corporate or regional) with Medicare as a secondary payer, or that they can choose to be alliance members with Medicare as secondary payer?

a) If a Medicare beneficiary works for an employer who only contributes the required 80%, then choosing alliance coverage will require an additional payment (20% on average, more for a more expensive plan less for a less expensive). For a single person, this will average \$380, for a couple perhaps \$800. For most this will be a better value than Medigap has to offer. It is reasonable to require the full-time worker beneficiary to take alliance coverage; however, it is, at a minimum, politically sensitive to require payments for the 20% (more or less) for people who are eligible for Medicare.

If it is decided to require alliance membership for a full-time over-65 worker, it would make sense also to require membership for the spouse of a full-time worker even if the spouse is a Medicare beneficiary.

b) To avoid disruption and reduce expenditures, if a beneficiary is working full-time during annual open enrollment but subsequently stops working, could potentially leave then in the alliance for the rest of the calendar year and provide the 80% retiree subsidy (this would probably be less expensive to the federal till than returning them to Medicare because of the community rating effect). Alternatively, if a full-time worker stops working during the year, could end alliance coverage and return them to Medicare. (If there is thought of leaving them in the alliance, would we require this or leave it as an option?)

c) If a Medicare beneficiary is not working at time of open enrollment but starts working full-time during the year, makes sense to add them to the alliance roles during the year. Same questions about what to do if they stop working during the year.

2) Part-time workers

a) If a Medicare beneficiary works part-time, could potentially require employer pro-rate payment, require the beneficiary to join the alliance, and provide the retiree subsidy to fill in the unpaid portion of the 80% employer

contribution. Similar issues as for full-time workers on whether we are willing to require such persons to pay the 20%.

3) Modelling, not policy questions: If we leave to workers the decision on whether or not to join the alliance and pay (more or less) the 20%, what will DACT and/or others assume about beneficiary behavior?

a) What was assumed, either for policy or behavior, in the estimate that the Medicare offset is \$59 billion?

9/24/93  
5:15 PM

# MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
Current Law									
Caseload									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
Institutionalized (non-add)									
Per Capita Costs (Basic Benefits) 1/									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									

# MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
<b>Current Law</b>									
<b>Per Capita Costs (Supplemental Benefits) 1/</b>									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
<b>Per Capita (Long Term Care) 1/</b>									
Nursing Facilities									
ICFs/MR									
Non-Institutional Care									
<b>Aggregate MAP Costs 1/</b>									
<b>Administration Costs 1/</b>									
<b>Total Medicaid Costs 1/</b>									

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# MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
<b>Health Care Reform</b>									
<b>Caseload</b>									
AFDC (under 65)									
SSI (under 65)									
QMBs									
Dual Eligibles									
Institutionalized (non-add)									
<b>Former Recipients</b>									
Community-Based Long Term Care									
Alliance Buy-Ins									
<b>Per Capita Costs 1/</b>									
Basic Benefits (Budgeted Premium)									
Supplemental Benefits									
Institutionalization									
Community-Based Long Term Care									
(new LTC program)									
<b>Aggregate MAP Costs 1/</b>									
<b>Administration Costs 1/</b>									
<b>Total Medicaid Costs 1/</b>									

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5:15 PM

# MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>
Health Care Reform									

## Table Line Items

Aggregate State Maintenance of Effort

Liberalized Long-Term Care Eligibility (Institutionalized)

Offset for Current Law Medicaid Eligibles 1/

Community-Based Long-Term Care  
Alliance Buy-Ins

Savings Due to Budget Cap 2/

## Notes

1/ Show State, Federal, and total computable costs where appropriate.

2/ Break out for specific savings provisions, including DSH.

## Questions About Pricing of Medicaid Provisions

### General.

- 3 • HCFA is largely dependent on State data to estimate future Medicaid spending and to disaggregate projected, as well as actual, Medicaid spending into particular categories, e.g., acute care spending for AFDC recipients. What data sources have been used in pricing the President's plan, e.g., determining State's maintenance-of-effort contribution, estimating the number of employed Medicaid recipients, and carving out current Medicaid spending for services in the national benefit package?
- 3 • Will these same sources continue to be used or will there be special State data queries, surveys, or audits to validate currently-available data?
- 2 • Which Medicaid service categories will be included in the national benefit package and which are defined as long-term care services?
- 2 • What assumptions were made about the behavior of States in response to the proposed changes in Medicaid? For example, what assumptions, if any, were made about the effect of likely State efforts to reduce Medicaid spending during the year prior to reform or to move individuals from Medicaid to fully-Federally financed low-income subsidies? Also, if the match rate system for financing Medicaid is retained, what assumptions were made about States' ability to generate Federal funds through "costless spending" programs involving provider taxes?

### Caseload.

- 2 • On a fiscal year basis through the year 2000, what are the assumptions regarding the size of the Medicaid caseload in the absence of reform and where these Medicaid eligibles "go" under the President's plan, i.e., how many obtain coverage through:
  - their employers?
  - low-income subsidies?
  - remaining on Medicaid?(see attached table).
- 2 • In developing these caseload estimates, what assumptions were made

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about the behavioral effects of increased work incentives on the number of Medicaid cash recipients?

**Per Capita Costs.** Please provide a detailed description of policy, assumptions, and pricing over time.

- 3 • Will different premiums be computed for AFDC and SSI recipients?
- 2 • According to page 201 of the 9/7 draft of the plan, annual rates of increase in the per capita payments from Medicaid to alliances will be "subject to the national health care budget." Does this imply that annual increases will be equal to, no greater than, or otherwise related to the budgeted amounts? Please explain how the negotiating process with plans will work and how the budgeted annual increases in State Medicaid payments to alliances will be computed and enforced.
- 2 • Will Medicaid per capita payments be adjusted to include costs associated with services that will be included in the national benefit package but are not currently covered by Medicaid, e.g., coverage for treatment of persons age 21-65 in institutions for mental diseases (IMDs)?

**Wrap Around Coverage.**

- 2 • Will the wrap-around package vary State-by-State, depending on the mix of services each State now provides? Can States alter the package? Who will be eligible for these wrap-around services, who will pay for these services, and how will payments be computed? If Federal funding for wrap-around services is provided through block grants, will the grant amounts be established to approximate the Federal portion of current State spending on wrap-around services?
- 2 • Will Medicaid recipients in the Alliance be subject to the same cost-sharing requirements as other low-income individuals or would cost-sharing subsidies be included as part of Medicaid wrap-around coverage?
- 2 • Under the plan, would Medicaid continue to finance the Medicare cost-sharing expenses for Qualified Medicare Beneficiaries and dual eligibles now covered by Medicaid?

**Maintenance of Effort.**

- 2 • What are the various components of the State's maintenance-of-effort

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(MOE) contribution?

-- Does the MOE contribution include States' share of DSH payments, as well as payments for services not included in the national benefit package? If the MOE contribution does not include State DSH spending, will these dollars be netted out of the initial calculation of Medicaid per capita payments to alliances?

-- Does the MOE contribution include current State spending for:

- Medicaid services that are not included in the national benefit package; and
- for individuals who are no longer eligible for Medicaid, but also not eligible for low-income subsidies, e.g., pregnant women with incomes between 150% and 185% of poverty?

2 • In calculating the annual growth in the MOE offset, what assumptions were made about the level of budgeted growth in States' average weighted premiums?

3

3 • Will States be given an opportunity to appeal the calculation of their initial MOE contribution, i.e., will there be some sort of appeals process for States?

#### Long-term Care.

2 • Exactly how will State contributions and Federal matching be calculated for new community-based long-term care (both low-income and non-means-tested)?

2 • What will the Medicaid offset be for home and community-based spending folded into the new long-term care program?

2 • How will acute care for Medicaid institutionalized patients be coordinated and financed?

2 • How will institutional long-term care spending be budgeted?

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Working (AFDC cash) Recipients.

- 2 • Will Medicaid continue to buy into employer health plans?
- 2 • What are the transition payment rules for those moving into and out of AFDC and into and out of employment?

DSH

- 2 • What is the schedule for phasing-out DSH?
- 2 • Medicare DSH payments are computed according to a formula that is based on the number of the Medicaid inpatient days. What assumptions have been made regarding the effect on Medicare DSH payments resulting from the substantial reduction in the number of Medicaid eligibles under reform?

Cash Flow.

- 3 • What assumptions were made about the effect on Medicaid spending at the point of implementation when States are paying for Medicaid costs that have been incurred by current beneficiaries, as well as paying prospective premiums to Alliances?

## Long-term care program questions

2 By year, how many individuals are projected to receive services from the new community-based LTC program? Please show projections for both the 3-ADL program and the low-income program. How many of these individuals would otherwise have been Medicaid-eligibles?

2 Will reimbursement rates under the new program be comparable to those under the current Medicaid program? Will there be a difference between reimbursement rates for the 3-ADL program and the low-income program?

2 What assumptions are being made about the phase-in of coverage over several years?

2 How will program spending be budgeted? What annual growth rates are assumed?

2 What assumptions are being made about utilization rates and costs per recipient under the new program? Do these assumptions change over time?

2 Will Medicare beneficiaries have to pay a premium for the new program? Who will pay and how much will the premium be? What is the projected revenue from premiums?

1 What will the Medicaid offset be for home and community-based spending folded into the new program?

2 Exactly how will State contributions and Federal matching payments be calculated under the new program? How much are the State and Federal government expected to spend?

2 Are the costs of tax credits for the working disabled included in the LTC program estimate, or do these costs only affect the "receipts" line item?

## Long Term Care (pp.151-165)

Status: Changed

### Budget Issues

- P. 152 It is possible that a portion of the SSI/DI population who are not currently receiving institutional care or home based care would qualify for community based care as under the eligibility standards described. Limited ADLs are used as eligibility criteria for SSI/DI, but this population rarely uses institutional care.
- P. 158 Would the monthly living allowance change for recipient of federal benefits (SSI, VA) change?
- P. 162 This tax deduction would represent a double exclusion for SSI/DI recipients. Work related expenses are deducted from an SSI/DI recipients total income when calculating benefits.

### Policy Issues or Clarifications

- Medicare beneficiaries pay a premium toward coverage, with individuals having incomes below 100% of poverty exempt from the premium. Should assets be included in the in the computation of the premium exemption threshold?
- Matching rates: The Secretary of HHS determines matching rates for allowable costs. How are administrative costs treated under the matching rate computation?
- Tax treatment of premiums for long-term care insurance. Such premiums for qualified plans are excluded from taxable income. Are the premiums excluded for both income and FICA/FUTA payroll taxation? What is the tax treatment for the self-employed?
- Tax incentives for individuals with disabilities who work. Employed disabled individuals who require assistance with daily living receive a 50% tax credit. Is this credit refundable? Does the credit only apply to earned income? How does the credit interact with EITC? Was this considered in pricing.

- SD, RP

(IM branch comments)

23 September 93

**Financing for the Under 65 Population**  
(based on provisions listed in prior drafts,  
however these items were mentioned in the President's speech.)

Policy Questions or Clarifications

An employer premium subsidy is limited to firms with 50 or fewer employees. Employers also have a cap on premiums for all employers equal to 7.5% of payroll.

- 3
- Subsidies for Employers: for firms with less than 50 employees in which the average full-time wage is less than certain thresholds, employers receive government subsidies for health premium contributions on workers with wages under certain thresholds. All employers benefit from a cap on premiums limited to 7.5% of payroll.

The eligibility criteria for subsidies for employees and employers, and premium caps for employers could be based on total employee compensation, including fringe benefits, instead of payroll. Large segments of the nation's working population receive employer provided fringe benefits such as health and life insurance, flexible benefit packages, housing, and pensions. Such benefits accounted for 16 percent of total employee compensation in 1989, up from 8 percent in 1960. Most of the growth in employee remuneration over the past 20 years is attributable to the growth in benefit spending. For example, inflation-adjusted benefit spending per full-time employee grew by 63 percent between 1970 and 1989, while average cash wages remained almost flat. The proposed employer subsidy could further encourage firms to pay employees in fringe benefits in order to remain eligible for the government health subsidy, or meet the 7.5% payroll cap.

The President has stated that under the proposed plan, the self-employed will be able to deduct 100% of alliance premiums.

- 2
- Premiums for Self-employed The self-employed are currently allowed to deduct only 25% of their health insurance premiums for tax purposes. Would the proposal result in a reduction in SECA income to the OASDI and HI trust funds?

Priority Code 2

#### HCR Administration: Overview

The fundamental issue is to clearly specify the functions that will be performed by each entity, new or existing, and to draw the boundaries between these entities as clearly as possible.

Since there is so much Federal oversight and backup or default control, in the absence of a clear demarcation, we will have to assume the function will be performed at the Federal level, either by an existing agency or the National Health Board (perhaps through a contract with an existing agency).

We intend to provide an estimate of the total administrative cost associated with each function and the portion of that cost that would be borne by the Federal government.

Priority Code 2

HCR Administration Questions  
Pricing Issues: Scope & Parameters

- (I) Define administration. Is this Federal only? Or system-wide (Federal, State, local, Alliance, plan, corporate, etc.)? Keeping pricing limited to the Federal level makes the task 'easier' (though not necessarily possible), and begets the question of whether Federal costs are being shifted to other levels of the system.

How is this to be measured? Dollars? Staffing? Paperwork burden? All?

What encompasses administration? Is it 'direct only' (i.e. Health insurance administration; Provider administration)? Or does it include 'indirect' but essential support functions (i.e. Fraud and abuse investigation and prosecution; Data system management; Data analysis)? What about consumer education, advertising, etc.?

- (II) Assignment of administrative functions in the plan. There are a host of administrative functions identified in the plan, but little consistent assignment of these functions to a specific entity, or discussion of how they will be financed.

Examples of unfunded, vague (difficult to price accurately), or unassigned functions: State qualification of health plans. State establishment of demographic service requirements. State Guaranty Funds. Establishment of 'capital standards.' Regional alliance administration. Administration of allocation of consumers to plans when capacity is insufficient. Development of State fee for service schedule. Alliance administration. Federal coordination among principal agencies (DOL, DHHS, VA, DOD), and with States, local grantees, alliances, plans, etc. Health professions loan administration, as well as other Federal programs (training and education oversight and administration). Administration of the Inter-alliance Health Security Fund. Budget administration, oversight, and enforcement. State licensure and certification of plans, health professionals. Federal licensure and certification of 'essential providers.' Survey administration and analysis (outcomes, quality, satisfaction, etc.). Premium tap fund collection and administration. Research and demonstration administration. Income monitoring and subsidy administration. Administrative capacity for Federal assumption of alliance operation for non-starting States or or States in default. Quality control program.

- (III) Funding sources. There are numerous, over-lapping funding sources for data-

## Priority Code 2

related activities. Presumably some data costs (capital, maintenance, administration, data processing and analysis, etc.) are funded within alliance or plan budgets. But, PHS also includes some start-up funds for state data systems, as well as separate funds for special surveys (the data from which could easily come from hospital admitting records, coroner reports, etc). PHS also includes funds for data analysis. PHS also has a separate 'administrative cost' category, which we have no idea what is contained therein. These need to be identified.

Are funds for data activities also included under more generic administration funding sources, such as premium taps? What about HCFA ORD? Medicare administration? VA, DOD, and IHS administration? This gets back to assignment of functions to specific entities, and funding sources for each. What is a centralized, Federal function, and what are private responsibilities?

### (IV) Medicaid Administrative Expenses

Will current Federal policy with regard to matching of administrative expenses be changed to reflect a smaller, simpler Medicaid program?

Have potential savings from the reduced administrative burden in the Medicaid program been identified? Even if Federal matching policies remain intact, some savings could be expected.

Will States and Alliances continue to administer wrap-around benefits (i.e. current Medicaid benefits not included in the basic benefit package)?

### (V) National Health Board

Fundamental questions about the board's functions, responsibilities, and operations require clarification (e.g. contract, in-house..):

Is the board to be advisory to an existing or new Executive Branch agency which is under control of the President or is the board to be free-standing and accountable primarily to Congress?

Will the states be responsible for enforcing budgets within the states (subject to board monitoring), as requested by NGA on 9/23/93, or will the board have both monitoring and enforcement responsibilities?

Will the benefits package be defined in law or by the board, through regulatory rulemaking? Will the benefit package be exhaustively described or

## Priority Code 2

merely sketched out, deferring details to States? Will the Board adjudicate disputes between individuals and plans regarding the benefit package or will such disputes be handled in Federal district courts?

Will data and quality management systems be operated by states and monitored by the board or operated by the board? What will the adjudicatory responsibilities of the board be?

What will be the extent of the board's actions to oversee state plan implementation? How much flexibility will be left to states and how much will this monitoring role resemble the current Medicaid waiver process?

Indicate which portion of each of the functions described above are to be carried out by Federal employees of the board and which may be contracted out.

## Questions for Pricing 9/7/93 HCR Package: Public Health

Contacts for Public Health Q's -- Bill Dorotinsky (x 4926; h-301-916-1227)  
Richard Turman (x4926; h-301-270-0895)

### Part One: Basic Questions on Scope & Parameters

In order to evaluate the PHS funding proposals, we need the following for each proposal or initiative.

- (I) Proposed Increases. Exactly what are these funds for? Specific programs? What will these funds buy (number of vaccines, trips to the doctor, etc.)? What are the assumptions for these estimates?

Do these duplicate items funded through the benefit package?

What is the amount of the proposed increase above current appropriation levels? What is the amount of funding in the current 'base' reallocated to each initiative?

How much of the increases and reallocations are for administrative costs versus services? What are the bases for these assumptions? How many more Federal staff will be required for these proposals?

How much money will flow to these activities from alliances, plans, and insurance? (Include basic payment rates, as well as any special incentives to rural/underserved/primary care providers, etc.)

Does initiative funding increase over time? How was the timing of increases determined?

- (II) What are the secondary and interactive effects of these proposals? For example, assuming a simple linear relationship between NIH funding and new discoveries, what is the effect of increasing NIH funding on the cost of the health system for new procedures produced? What will happen to the cost of research when we suddenly increase demand significantly (researcher salary, etc.)? If academic health centers receive special subsidies, special grants,

and indirect cost funding through NIH, how many times are we funding the same things? What effect does this have on the cost of research? The type of health innovations produced? What effect do these have when adopted into the health system? Does this excessively favor high-tech medicine?

Or, if we have PHS health professions programs in addition to DME/IME and other provider incentives, what happens to the absolute number of health professionals as well as their distribution by specialty? What happens if we have too many doctors (in Canada, it increases total cost, as each doctor produces roughly the same volume; in Germany, with global budgets, increased number of doctors means lower average physician salary, so physician associations tightly regulate medical school entry)? How many types of supply-management do we really need?

Or, States are required to establish service requirements for health plans related to the level of service and geographic distribution of service to ensure adequate choice and in low-income and underserved areas. Plans will spend funds to provide access, or face penalties. This is a regulatory approach. What effect, then, do all the PHS 'access' and 'enabling' services have on utilization? Will it increase utilization beyond medically-necessary limits? Is it necessary? (This applies to mental health & substance abuse, as well as general medical care.) And where does personal responsibility come into the equation? How broad is "enabling service" (e.g. public health police)?

- (III) Proposed Off-sets. What are the assumptions underlying the proposed off-sets? How were they calculated? How were individual programs categorized between service and non-service aspects? On what basis was this done?

What are the administrative expenses associated with these off-sets? Are administrative costs included in the off-sets? How many FTEs are associated with the off-sets?

Do off-sets increase over time? How was the timing of off-sets determined?

For all facts and figures used in calculations or estimates, please cite the source. Please provide copies of internal studies or documents used to support the proposals or assumptions (e.g. MDS study referenced in HRSA off-set background material).

Part Two -- Questions about Specific Sections of Proposal

**"Prevention" Research** -- What is the basis for the \$1.5 billion (58%) increase in biomedical and behavioral research labeled "prevention"-related. How many more multi-year research projects would be funded? How much out-year funds would commencing so many projects commit? Is there sufficient capacity in the health research system to make such an expansion without requiring massive new capital spending by Federal and university laboratories? What specific connections do these increases have with the implementation of Reform during FY96-2000, since the results of such research funding would not be available until well into the 21st Century?

**Health Services Research** -- How much of this increase would be spent on each of the categories listed on pp. 138-9 of the draft plan, and what would be accomplished with each allocation? How soon would the results of the consumer choice and decision-making research be available, if funds are appropriated in FY96 and initiated in FY96-77

**Workforce** -- Please provide estimate details, including numerical outputs desired and how \$204 million would be used to achieve the outputs.

**Access**

**NHSC** -- how would the \$75 million increase for NHSC be split between state loan repayment, Federal loan repayment, and Federal scholarships? How many more doctors and other health professionals would this bring into the field over a 20-year period, starting in FY96? How much of an increase in field staff support spending would be required in FY2000-2010 to support the increased numbers of scholarships & loan repayment agreements awarded in FY96-2000? What is the cost of maintaining NHSC field staff on a per person basis?

**Capacity** -- How many additional low-income Americans currently uninsured would these funds help? How many low-income Americans would this funding help connect up to health plans so that they no longer need assistance through publicly-subsidized clinics? How many health plans would this funding encourage to serve rural and other uninsured Americans? How many provider networks would be established? If the design assumes continued maintenance funding as opposed to short-term capacity expansion linked to the implementation of Reform, please describe and explain. Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario?

School-based Expansion -- How many schools with high proportions of low-income Americans would this funding assist? How many students would be served? How much of clinic funding would be captured from health plan payments for covered services provided through these clinics? What is the start-up costs of opening a clinic? What are the annual costs of maintaining a clinic? What portion of each of these costs would the Federal assistance provide in the first, second, third, etc. years?

Formula grants -- what services would the formula grant support, and how would they differ from the capacity expansion grants? Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario? How many low-income Americans would be connected to health plans each year through these grants?

#### Indian Health

The package states that *tribal* employers are exempt from the national employer mandate. However, the term "tribal" is not defined. Can any employer become a tribal employer by moving to a reservation? Why should tribal employers be treated differently from any other employers?

What mechanism to control costs exist for IHS, since IHS is outside the Health Alliance structure?

Mental health/substance abuse -- what will the additional funds pay for (e.g. short term treatment vs. long-term treatment; residential vs. outpatient; heavy users vs. casual users; inside or outside of the criminal justice system, etc.).

If the policy is to provide high-quality, cost-effective drug abuse treatment, will the parameters described meet that objective? Most of the studies on the effectiveness of drug abuse treatment indicate that time in treatment is the most significant indicator of success (as measured by reduced drug use and criminality and increased employment). The substance abuse treatment benefit is capped at 60 days initially, expands by 1998 to 90 days, and by the year 2000 the day limits appear to drop off entirely. The benefit structure appears to provide incentives for 30-day programs, far less than 12-24 months in treatment recommended for heavy users. Moreover, thirty days in a hospital setting can cost than one year in a community-based residential program.

What is the rationale and/or underlying assumptions for placing a day-limit -

## Priority Code: 2

-as opposed to a dollar-limit -- on residential substance abuse treatment, given that the community-based programs which tend to provide more days of care cost substantially less than the hospital-based programs that tend to provide fewer days of care? If two of the principles of HCR are cost-containment and quality, why design a benefit that may encourage higher costs (hospital rates versus alternative settings) and lower quality care (fewer versus more days in treatment)?

### "Core" Public Health functions

- Health-related data collection, surveillance, and outcomes monitoring:
  - 1) How will funds for these activities be allocated, and who is eligible to receive these funds?
  - 2) Will these funds support Federal data efforts or will States, Alliances, providers, and insurers also receive funds?
  - 3) What exactly will these funds purchase: What kind of data processing hardware would be purchased (computers, printers, network support, dedicated phone lines), and exactly how many of each type of unit would be purchased? What kind of software would be purchased to operate the envisioned hardware?
  - 4) How many and what type of personnel would be hired to support these activities (i.e., computer programmers and operators, epidemiologist, statisticians)?
- For each of the four categories of listed below, please answer questions 1-4:
  - Protection of environment, housing, food, and water
  - Investigation and control of diseases and injuries
  - Public information and education
  - Accountability and quality assurance
  - 1) How will funds for these activities be allocated, and who is eligible to receive these funds?
  - 2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?
  - 3) How many and what type of personnel would be hired to support these activities?

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4) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Laboratory services**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many laboratories would be supported and which specific laboratory services would be financed?

4) What is the estimated volume of each laboratory service.

5) How many and what type of personnel would be hired to support these activities?

6) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Training and education**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many of each type of health professional would be trained?

4) Would professionals trained using these funds then be hired and supported using Federal funds?

**"Priority" Public Health**

- **Immunization**

1) How many and what type of personnel would be hired to support these

Priority Code: 2

activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

3) Will these funds be used to purchase vaccine, and if so how many doses of each specific vaccine would be purchased?

- For the four categories of funding listed below, please answer two questions:

**HIV/AIDS**

**Tuberculosis**

**Chronic and Environmentally Related Diseases**

**Health-related Behavior and Other Priority Issues**

1) How many and what type of personnel would support these activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

9/23/94

National Health Reform  
Cost Questions - Veterans Affairs

1. What should be the scope of the VA scoring effort (i.e., should it reflect only reform's impact on VA appropriations or should it include estimates of Federal and non-Federal receipts that VA will receive)?
2. Will VA plans be subject to premium/price restraints that may be applied to private insurance plans?
3. What are estimated maximum allowable national average annual percentage increase in premiums/prices for 1995 through 2000?
4. Please provide the following national average cost data for plans covering individuals as currently assumed in the health care package for 1995 through 2000 (In each case we are requesting dollar amounts, not percentages.)
  - a. annual average premium,
  - b. annual average employer contribution,
  - c. annual average employee contribution, and
  - d. annual average employee deductibles/co-payments.
5. What is the current poverty level for:
  - a. an individual, and
  - b. a family of four?
6. What are the anticipated national average health alliance subsidies for an individual and a family of four for 1995 through 2000 at the following annual income levels:
  - a. 25% of poverty level,
  - b. 50% of poverty level,
  - c. 75% of poverty level,
  - d. 100% of poverty level,
  - e. 125% of poverty level, and
  - f. 150% of poverty level?
7. What is the projected national average health alliance subsidy for 1995 through 2000 for:
  - a. an unemployed individual, and
  - b. an unemployed family of four?

8. What are the projected national average Medicare part A and B reimbursements for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
  - a. office visits (i.e., outpatient care), and
  - b. hospital care.
  
9. What are the projected national average Medicare beneficiary copayments for parts A and B for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
  - a. office visits (i.e., outpatient care), and
  - b. hospital care.
  
10. What is the anticipated timeline for implementing national health reform in the VA, DOD, PHS and other public health organizations?
  
11. With regard to the VA revolving fund that would be established with national health reform:
  - a. What would these loans fund (e.g., new facilities, expand current facilities, hire additional staff, high-tech equipment)?
  - b. Will there be a limitation on the dollar amount an individual hospital can borrow from the fund?
  - c. What will be the repayment conditions for hospitals that borrow from the fund?
  - d. What happens if a hospital is incapable of repaying the loan it receives from the fund?
  - e. Who will manage the revolving fund?
  - f. The fund is for the "start-up costs of VA health plans". The fund would continue "without fiscal year limitation". Does "without fiscal year limitation" apply to new loans made, or does it refer to the loan repayment schedule? If it refers to new loans made, why would start-up requirements continue for more than 5 years?

*If there are any questions concerning the information requested please contact Todd Grams or Alex Keenan at 395-4500.*

September 24, 1993

PRIORITY 2

SUBJECT: Federal Employees Health Benefits Program:  
Costing Assumptions

1. Medigap: Addressing Medigap the policy reads: "annuitants with Medicare obtain coverage through an OPM-administered Medigap plan." Will OPM develop and price the Medigap plan or are there central estimates to use in pricing the cost to the Government of Medigap for Federal retirees?
2. Early Retirees: Please clarify the policy for Federal early retirees?
3. Annuitants: Addressing coverage of annuitants with or without Medicare, the policy reads: "In both cases, OPM pays a premium contribution sufficient to prevent an increase in annuitants' costs over current fees."
  - a) Is the policy that the annuitants' share of the premium contribution or the dollar amount of the premium contribution remains constant?
  - b) If the answer is dollar amount, do we use nominal or constant dollars, and how long would that deal remain in effect?
4. Civilian Downsizing: Should our estimates assume a 252,000 reduction in Federal civilian personnel as called for in the President's Executive Order of September 11, 1993 (while a majority would fall into the retiree/early retiree categories, a portion would be employees who simply leave Government service)?
5. Option to continue coverage: Currently, under certain circumstances employees that would otherwise lose FEHB coverage (including employees that separate from Government service) may elect temporary continuation of coverage at 102% of premium price. Under reform, will Federal employees retain this option or will they be required to move immediately to the alliances?
6. Transition: Are assumptions available about the expected time frame for phasing-in the states?

Christine Lidbury  
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395-5017 (secretary)  
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PRIORITY 2

o DoD indicates that it has final approval to receive Medicare payments for care provided by DoD to Medicare eligibles. If true, will:

- the reimbursement be on a fee-for-service basis or only on a capitated basis?
- DoD have to comply with Medicare rules and regulations including beneficiary co-payments, beneficiary premium payments (for Part B services), and cost-accounting standards?

o Is it the President's intention to sustain benefits significantly higher than the national benefit (and unrelated to DoD's readiness requirements) for new DoD beneficiaries or is the national benefit sufficiently generous for post national reform entrants into the DoD work force?

o DoD will be providing medical services and paying for the care of active duty military personnel. In the case where there is a working spouse of a military member:

- What will be DoD's payment responsibility when the spouse (or the spouse and dependents) choose a non-military health plan?
- What will the private employers responsibility for payment to DoD when the spouse (and family) choose a DoD plan?

o If the DoD health plan functions as a corporate alliance, will DoD have to pay the 1% surcharge to regional health alliances that has been discussed?

o Will DoD have to pay for care for a period of time after personnel separate from the military? If so, what will have to be paid for how long?

o What exactly does the proposed health care legislation authorize?

o Will DoD be treated as any other employer with respect to retirees over age 55 (i.e. will DoD be relieved of the obligation to pay for health care for non-working retirees over age 55)?

J. Fish Ext. 3776

September 20, 1993

Questions on Pricing for Medicare Payment to DoD and VA

We believe that the issue of Medicare payment to DoD and VA facilities warrants further attention. We have raised some of the questions involved below, albeit in a somewhat disorganized fashion. Additional questions and comments will follow.

- Will DoD and VA health plans be required to meet the same standards as other Medicare providers, e.g., cost reporting, JCAHO standards, peer review, mortality and morbidity data collection, etc.? (3)
- What does it mean to say that Medicare will only pay for services to higher-income veterans eligible for Medicare? Medicare does not currently income-relate any part of the program and the rationale for implementing this policy on this particular population is unclear. (1, 2)
- How will Medicare payment to DoD and VA facilities be calculated and adjusted? VA and DoD pay on a national scale, whereas other facilities will naturally reflect geographic wage differences. (1, 2)
- How much care do DoD and VA currently provide beneficiaries who are also eligible for Medicare? What are the five-year outlay projections, broken down by veterans and military retirees? (1, 2)
- If a Medicare-eligible individual does not enroll in DoD/VA health plans, but receives care at a VA facility (for a service-connected injury) or at a DoD facility (on a space available basis), is Medicare liable for payment? (1, 2)
- What, if any, are the assumptions about adjustments in DoD and VA appropriations to reflect Medicare payments? How will DoD and VA appropriations be adjusted if Medicare is to make payments for such care? (1, 2)
- What are the assumptions about beneficiary cost-sharing in these settings? What are the corresponding assumptions concerning utilization? Will DoD and/or VA be required to offer high or low cost-sharing plans? What are the assumptions on subsidies for cost-sharing? (1, 2, 3)
  - Will DoD and/or VA be allowed to offer supplemental, "wrap-around" coverage of cost-sharing liabilities? High cost-sharing plans are required to offer wrap-around policies. (1, 2, 3)
  - What are the assumptions about DoD and/or VA acting as secondary payors to Medicare? (1, 2, 3)
  - How will Medigap and other possible third-parties be treated for cost-

September 20, 1993

sharing coverage? (1, 2)

- Is Medicaid the payor of last resort for any veterans or their family members? (1, 2, 3)
- What benefit packages will these dually-eligible individuals receive? Will the DoD and VA plans be required to offer the standard benefit package? Or will the Medicare benefit package be required to be offered those individuals otherwise eligible for Medicare? (1, 2, 3)
- Will Medicare Secondary Payor rules also apply to VA and DoD? Will DoD and VA be required to collect from other parties under TPL guidelines, as well as Medigap and retiree health policies? (1, 2, 3)

TESTIMONY OF LEON E. PANETTA AND ALICE M. RIVLIN  
DIRECTOR AND DEPUTY DIRECTOR  
OFFICE OF MANAGEMENT AND BUDGET  
COMMITTEE ON FINANCE  
UNITED STATES SENATE  
NOVEMBER 4, 1993

Mr. Chairman, it is a pleasure to be here today to discuss the Clinton Administration's health care reform plan. No one needs to remind this Committee that our health care system is in crisis. While the quality of health care in the United States is the best in the world for those who can afford it, the total cost of care is unnecessarily high and rising at frighteningly rapid rates. Moreover, millions of Americans are without adequate health care coverage and millions more live in fear that they will lose their health insurance.

The challenge before the Congress is to develop a plan that preserves what is best in the current system while controlling costs and providing universal access to high quality health care. The plan presented to you by the President and the First Lady does that. It controls costs and guarantees health security: For the first time, every American will have health insurance coverage with a comprehensive package of benefits that can never be taken away.

We would like to focus first this morning on the vital part the Administration's health reform plan plays in our overall strategy to improve the future vitality of the American economy. Then we would like to turn to the impact of the plan on the Federal budget -- what new costs would be incurred and how we propose to pay for them.

HEALTH REFORM IS AN ECONOMIC IMPERATIVE

If we are to have the productive, high wage economy that we all want, we must reform the health care system. Indeed, health reform may be the single most important change that is needed to make the economic future brighter for our children and grandchildren.

The current health financing system threatens America's economic future in three ways: (1) health costs are unnecessarily high and rising too rapidly -- draining resources from more productive uses to support an inefficiently organized health care system; (2) the rising costs of government health programs add to the Federal deficit and reduce national saving; and (3) health care insecurity locks people into existing jobs or onto welfare

rather than allowing them to move into more productive employment.

The United States spends more of its Gross Domestic Product (GDP) on health care than any other country in the world. The numbers bear repeating: Today, 14% percent of our GDP goes for health care, and by the end of the decade, we could be spending an almost unthinkable 19% of GDP on health care. No other country spends more than 10% of its output on health care. During the last decade, our real per capita health care costs grew at a rate of 4.4% per year, while our real per capita GDP grew at only 1.6% a year. Only Canada's rate of health care cost growth, at 4.3%, was close to ours. By any measure, it must be said that our consumption is way out of proportion to our income.

And health care spending is "crowding out" other government spending and contributing to the deficit. The Federal government devotes 19% of its budget to health care right now. If current projected trends continue, that percentage will rise to 25% by fiscal year 1998. This means that almost 50% of Federal spending growth between 1993 and 1998 will be for health care.

Inflation in health care costs is robbing government budgets of scarce resources needed for critical investment in our future -- education, job training, infrastructure, and technology development. Make no mistake about it: getting Federal health spending under control is essential to long-run deficit reduction.

Despite all this spending, 37 million Americans are uninsured, and increasing numbers of Americans are vulnerable to losing their insurance upon developing a serious illness or medical problem. Pre-existing condition restrictions lead to "job lock": it is estimated that 30% of workers restrict their search for better jobs for fear of losing their health insurance coverage.

#### WHAT TO DO -- REFORM THE MARKET

Economists have written volumes on why health costs are rising, and there are debates about how much each of the relevant factors has contributed to the cost spiral. There is no argument, however, that we need to change the incentives in the marketplace today.

There is broad consensus that the health insurance market, especially the small group insurance market, performs poorly today. The absence of universal coverage and community rating makes it more profitable to select healthy enrollees than to organize the delivery of cost-effective health care. The result is:

- Very expensive insurance for the covered -- we pay more per capita for health care than any other nation, and by quite a margin;
- All Americans feel vulnerable; many of us are one serious illness away from being uninsured;
- No insurance at all for 37 million Americans, most of whom are working or in families with workers; and
- Higher health service prices for the insured, as we pay hidden taxes to cover the costs of providing caring for the uninsured and the underinsured.

The market for health services is also performing poorly. The incentives for providers in traditional fee-for-service medicine and for patients with comprehensive indemnity coverage simply guarantee that unnecessary care will be delivered in virtually every setting.

Insured patients have no incentive to learn about how little medical value per dollar is delivered by the services they receive, because they usually do not bear the costs themselves. Fee-for-service providers have every incentive to provide additional services no matter how low value, because they are reimbursed for every added procedure they perform regardless of their value.

This inefficiency spreads throughout the health care system. Managed care providers, in most markets where fee-for-service still dominates, have strong incentives to match their prices to those prevailing in fee-for-service plans. The higher volume and greater intensity of services resulting from these pricing decisions drives up insurance premiums even further.

Faced with markets performing poorly because the incentives are so wrong, reformers have two basic choices:

- One option would be for the government to take over the functions of the health insurance industry. It could set the prices for providers, and draw up rules for allocating care. We rejected this alternative.
- Another option -- the one embodied in the Clinton plan -- is to restructure the incentives within our existing system to permit market forces to work better than they have up until now.

## RESTRUCTURING THE MARKET FOR HEALTH CARE

The Administration plan would preserve and strengthen the system of employer-based health insurance that Americans are used to. It would ensure universal coverage by mandating that all employers provide a standard benefit package to their employees, and make that coverage affordable through discounts for small and low-wage firms.

At the same time the plan would change the way the health care market works in fundamental ways. First, it would give consumers a financial stake in choosing the lowest cost health plan and information on which to base that choice. While employers would pay 80% of the average cost of health plans in the area, employees will have a choice of health plans that provide at least the standard benefit package at various prices. Experience in large companies has shown that employees tend to choose lower cost plans when they have the financial incentive to do so.

Second, the Administration plan would encourage health providers to join together in groups that provide care as effectively as possible and to reduce unnecessary costs in order to compete for members.

Third, the plan would build on the experience of recent years in which large companies and other large purchasers of health care have demonstrated their ability to bargain hard with health plans to get the best price. The Administration plan would require the States to set up regional health alliances to bargain on behalf of small- and medium-sized businesses. The alliances would use their collective market power to obtain for their members the favorable prices now available only to employees of large companies.

Fourth, the Administration plan would reform insurance markets by requiring community rating. Risk selection will be eliminated by the introduction of:

- A comprehensive benefits package, to homogenize the product and make shopping among health plans easier for consumers;
- Community rating to remove the incentive to select healthier enrollees, with risk adjustment to compensate plans that have a disproportionate share of medical claims ; and by
- Ending pre-existing conditions restrictions, medical underwriting, lifetime limits, and other techniques that deny many Americans coverage.

Providers and insurers will also be required to provide vital information. Meaningful and interpretable medical outcomes reporting at the plan level will be required in all alliances. This will provide Americans with the information they need to assess the relative quality of competing plans. In addition, it will provide insurers and providers with incentives to be efficient while satisfying their customers and patients.

These insurance market reforms will force insurers to organize cost-effective delivery networks which preserve choice for consumers while delivering medical value for the dollar. In this sense, our targets for the growth of insurance premiums should be viewed essentially as backstop devices to provide some breathing space while insurers, providers and consumers learn to make managed competition work.

There is reason to think that introducing these new market incentives will lower the rate of growth of health care costs. The most effective means of cost control known to economists is to let producers compete and consumers choose.

Other means of controlling costs may work in the short run, but are likely to be ineffective in the long run. Experience with price controls from other areas is sobering. The best chance of bringing health care costs under control is through market reforms such as the President has proposed.

#### ECONOMIC ADVANTAGES OF HEALTH SECURITY

Universal health insurance coverage will have economic advantages beyond providing a needed benefit to the uninsured. No longer will Americans be afraid to change jobs because they would risk losing their health insurance. By ending "job lock", health security will increase economic flexibility and improve productivity.

No longer will Americans be afraid to leave welfare because they would lose Medicaid benefits. A welfare mom who gets a job will not have to turn it down to protect her children from uninsured illness. The end to "welfare lock" will also promote the health of our economy.

#### HEALTH REFORM AND THE FEDERAL BUDGET

The President's Economic Plan, which the Congress approved in August, will bring about a significant reduction in the Federal budget deficit -- \$500 billion over the period from FY 1994 to FY 1998. But we have not conquered our deficit problem.

Health reform is absolutely essential to further deficit reduction. [Chart 1]

The President's health reform plan will begin to get Federal health expenditures under control. It will take time. The bulk of the savings in the President's plan occurs after the end of 1997, once the alliances are fully up and running.

In the interim some Federal expenditures will rise. After all, extending coverage to the uninsured will have some cost, as will the new drug benefits for Medicare recipients and the public health access initiatives we propose. The President's plan offers a responsible means of financing the new health benefits it provides.

### FINANCING HEALTH REFORM

Now I would like to turn to the specific effects of health reform on the Federal budget: what we propose to spend on the new system, and how we propose to finance it. [Chart 2]. Let me make clear that in our system of health alliances, 74% of total health insurance spending comes from the same place it comes from now: the private sector -- businesses and households paying insurance premiums. The President's Health Security Act builds upon existing employer-sponsored insurance arrangements to create a new foundation of coverage for all Americans.

The Health Security Act proposes new Federal outlays in the following 5 areas:

1. Expanded public health service activities and administrative costs of the new system -- \$31 billion. Approximately \$18 billion of these funds will be devoted to new public health programs to ensure that underserved populations have access to the new system, and to enhance funding for the WIC program, which provides nutrition services to impoverished children. We estimate that \$10 billion will be needed for Federal administrative and start-up costs of the new system, including activities such as developing data systems, monitoring quality, and issuing health security cards. In addition, we will increase support to academic health centers to support medical education and training by \$3 billion.
2. Long-term Care -- \$65 billion. There are three major components of our long-term care initiative: (1) a new home and community-based service program for the disabled; (2) liberalized spend-down rules for the Medicaid-eligible institutionalized; and

(3) tax incentives for the purchase of long-term care insurance.

3. Medicare drug benefit -- \$66 billion.

As you know, many elderly Americans are constantly worried about paying for necessary prescription drugs, prescriptions that can improve the quality of their lives, prevent more serious illnesses and help avoid hospitalization. Our plan introduces a prescription drug benefit with cost sharing very similar to that in the standard benefit package for all Americans under 65: \$250 deductible and 20% coinsurance with a \$1000 limit on out-of-pocket spending for the year. This means that our elders will no longer have to worry about foregoing necessary prescriptions in order to buy food or pay the rent.

4. 100% Tax Deduction for Self-Employed Health Insurance -- \$10 billion.

Historically, self-employed individuals have been penalized by being unable to deduct all of their health insurance premiums, while their counterparts in business and industry have been able to deduct the full amount. Our proposal will "level the playing field," and extend full deductibility to the self-employed. This issue has had bipartisan support for some time now; we must finally pass and implement this change. The total cost of this benefit is \$10 billion over five years.

5. Net new subsidies or discounts for employers and households -- \$349 billion [Chart 3].

Net of other savings made possible by reform, the added Federal cost is \$161 billion. To enable all Americans to take responsibility for their health insurance, premium discounts are available to the following types of households:

- those with family incomes less than 150% of poverty;
- those with unearned incomes less than 250% of poverty if they don't have a full time working member;
- those which include early retirees;
- those with relatively low incomes from self-employment.

To share the cost of insuring workers equitably across different firms, the following firm level guarantees are available:

- no firm will pay more than 7.9% of payroll, and most will pay less;
- firms with fewer than 75 employees with low average wages will pay less than 7.9% of payroll, in fact as little as 3.5%, depending on their exact size and average wage.

Finally, we provide out-of-pocket discounts for individuals who earn less than 150% of poverty and who do not have access to HMOs, to compensate them for the higher expected cost of fee-for-service coverage.

The point-estimate that our model-builders arrived at for their subsidies was \$305 billion over the 6 years 1995-2000.

In addition, we added 15% (about \$44 billion) to cover potential behavioral changes that are difficult to model directly. Simulations of those potential behavioral changes suggest that our cushion is more than adequate to cover those extra subsidy costs.

The total estimated cost of the discounts for people served by the alliances is \$349 billion over 1995-2000. This figure, however, is offset by \$188 billion in Federal program savings, so that the net cost of the premium discounts to the Federal Government is \$161 billion, or \$117 billion plus the amount that ends up being spent out of the cushion.

The offsets to the discounts come from three sources. First, \$28 billion will be saved as working Medicare beneficiaries get employer-sponsored insurance and Medicare becomes a secondary payor for them. Second, current Medicaid enrollees who are not cash recipients (AFDC plus SSI) will leave the Medicaid program entirely and get their coverage through regional alliances. This will result in \$85 billion in direct Federal savings as Medicaid rolls shrink. Third, states will be required to maintain their current current financial effort on the non-cash Medicaid population in the form of payments to the regional alliances for the express purpose of offsetting the Federal subsidy liability. \$75 billion is the sum of these payments over 1995-2000. Thus, the net cost of discounts is \$161 billion.

Sources of funds:

We propose to pay for these new Federal outlays in the following 5 ways (Chart 2):

1. Reductions in the rate of growth in the Medicare program -- \$123 billion.  
 Medicare has been growing at a rate of almost 11% per year. We have identified a set of approximately 25 policy changes that will achieve \$123 billion in savings. These policy changes include "reconciliation-type" reductions that affect the payment rates to providers, as well as new proposals to control utilization. We have also included a proposal to income-relate the Part B premium for high-income Medicare beneficiaries -- singles with income of \$100,000+ and couples with incomes of \$125,000+.

[Chart 4] As you can see, these spending reductions produce a moderate decrease in the extremely rapid baseline growth of the Medicare program. Under our plan, by FY 2000 we will have reduced the rate of growth from its current annual rate of 11% per year to around 8.4% -- even while adding new coverage for prescription drugs.

2. Medicaid savings -- \$65 billion.  
 The Medicaid savings counted here result from two sources. The Health Security Act will provide all Americans with health coverage and, therefore, it will nearly eliminate uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat low-income populations, including undocumented persons. In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because under our plan, Medicaid recipients will be receiving health care services, like other Americans with private insurance, in alliance health plans. [Chart 5]
3. Tobacco tax and corporate assessment -- \$89 billion.  
 These revenues will come from a combination of the increased tobacco tax, which the Treasury Department estimates will raise \$65 billion in revenues, and a 1% of payroll assessment on the large corporations that will benefit from reduced cost-shifting, and thus lower health care costs, in the new system. Treasury estimates that this assessment will raise \$24 billion.

4. Federal Program Savings -- \$40 billion. [Chart 2]  
As the Federal health programs -- Veterans' Administration health, Department of Defense health, Federal Employees Health Benefits program, and the Public Health Service -- are integrated into the reformed health system, we expect savings from lower expected premiums and new revenues. For example, the VA will receive new revenue from previously uninsured veterans and DOD will share in premium contributions for the employed dependents of military personnel. I should emphasize that these savings estimates are not derived from reductions in services; in fact, we believe that the services provided to these beneficiaries will be improved.
5. Other Revenue Effects -- \$68 billion.  
Health reform will lower insurance premiums relative to our baseline projections and thereby raise taxable incomes and tax revenue. Changes in the tax treatment of health insurance will also lead to increased revenue. Finally, modest savings in debt service, about \$4 billion, will be realized as the deficit is reduced.

#### How the Numbers Were Derived

There are three broad types of estimates underlying the summary budget data:

1. Estimates of outlay effects on existing programs;
2. Estimates of revenue effects;
3. Estimates of new subsidies, or premium and out of pocket discounts.

Standard OMB methods were used to determine the first type of estimates. OMB budget examiners worked in conjunction with HCFA and SSA actuaries, as well as agency program personnel, to "scrub" the estimates and account for the many interactive effects among programs.

The Treasury Department estimated the revenue effects and the tax-related provisions of the Medicare savings package, as they would for any Administration proposal.

A unique interagency process produced the subsidy estimates. Economists and actuaries from many different departments and agencies -- including the Health Care Financing Administration, the Agency for Health Care Policy and Research, the Departments of Treasury and Labor, the Council of Economic Advisers, and OMB

-- worked to develop a consensus on analytical methods. Experts from private think tanks and consulting firms were also involved. A team of private actuaries and health economists was brought in to evaluate and make suggestions about our estimation methods and data sources.

Estimating a complete health care system overhaul is obviously an immensely complex task. Reasonable people can differ about the many assumptions that must be made. But the thing I want to make clear is that our team tried consistently to err on the side of conservatism.

#### HOW ARE THE DEFICIT SAVINGS PROTECTED?

The total new costs of the Health Security Act to the Federal government will be \$331 billion, and we will have \$390 billion in revenues to finance these new costs. This will leave us with approximately \$58 billion in deficit reduction over the FY 1995-2000 period. We believe these numbers are real, because of the process we used to produce them, and because of the protections we have built into the new system.

First, we tried to be as conservative and realistic as we could in estimating the costs. For example, we asked two agencies to estimate the cost of the premiums for the comprehensive benefit package. An interagency team spent months analyzing the estimates, and we chose to use the higher estimate. That number, of course, is one of the major elements of the costs of the new system. And after the initial estimating was done, we spent several weeks in an intensive "scrubbing" of the numbers to vet the assumptions and make sure we accounted for interactive effects.

Second, we have set targets for the rate of premium growth in the alliances. If competition alone does not keep premium growth within the targets, premium caps will be triggered. If the combination of competitive forces and premium caps work as we expect they will, then future savings will grow progressively, as the rising trend in health costs is broken.

Third, we made realistic assumptions about the speed at which states would come into the new system. We looked long and hard at the most realistic phase in of the new system, and settled on a plan that assumes that states representing 15% of the population will come into alliances during FY 1996; another 25% (for a total of 40%) will come into alliances during FY 1997; and the remaining 60% will be phased into the new system by no later than January 1, 1998. Some groups such as Federal employees will be integrated at the beginning of calendar year 1998. We believe that these assumptions are not only realistic; they give the system a reasonable amount of time to get

established and to provide for some valuable learning experiences.

Fourth, as I discussed earlier when I was outlining new Federal outlays, we added 15% to the consensus point estimate of the subsidy cost -- about \$44 billion -- to cover potential behavioral changes that are difficult to model. Simulations of those potential behavioral changes suggested that our cushion is more than adequate to cover those extra subsidy costs.

Finally, we rejected the notion of an open-ended entitlement program. We believe that our estimates of the Federal funds that will be needed for the subsidies are conservative and reasonable, particularly in view of the 15% cushion and the mechanism allowing excess funds to be carried forward and applied to the next year's cap. It is unlikely that the caps will ever be breached. If, however, expenditures seemed likely to run up against the caps, because of a severe downturn in the economy or some other massive economic dislocation, it would mean we had a serious problem that the President and Congress would have to solve. That is how it should be.

#### THE BOTTOM LINE -- CONCLUSION

Mr. Chairman, we have begun one of the most important debates in the history of this country. It will take place not only in the committee rooms and the chambers of the Congress but in newspapers, in meeting halls, and over kitchen tables throughout the nation.

For 16 years, as you know, I served as a member of Congress. And for 16 years, as you also well know, because we entered the Congress at the same time, the health care issue became a bigger and bigger problem. It was ignored until it became a crisis, as costs for families, businesses, and government spiraled out of control, as the number of uninsured Americans grew, and as more and more families came to fear the loss of their insurance coverage.

We saw a lot of suggestions, a lot of ideas, a lot of concepts proposed. But until this President, nobody presented the kind of specific, comprehensive, responsible, detailed, paid-for plan that you now have before your Committee.

We have gone through an exhaustive process to ensure that we are presenting the most credible, the most reliable, the most honest estimates possible of our policies and their impact.

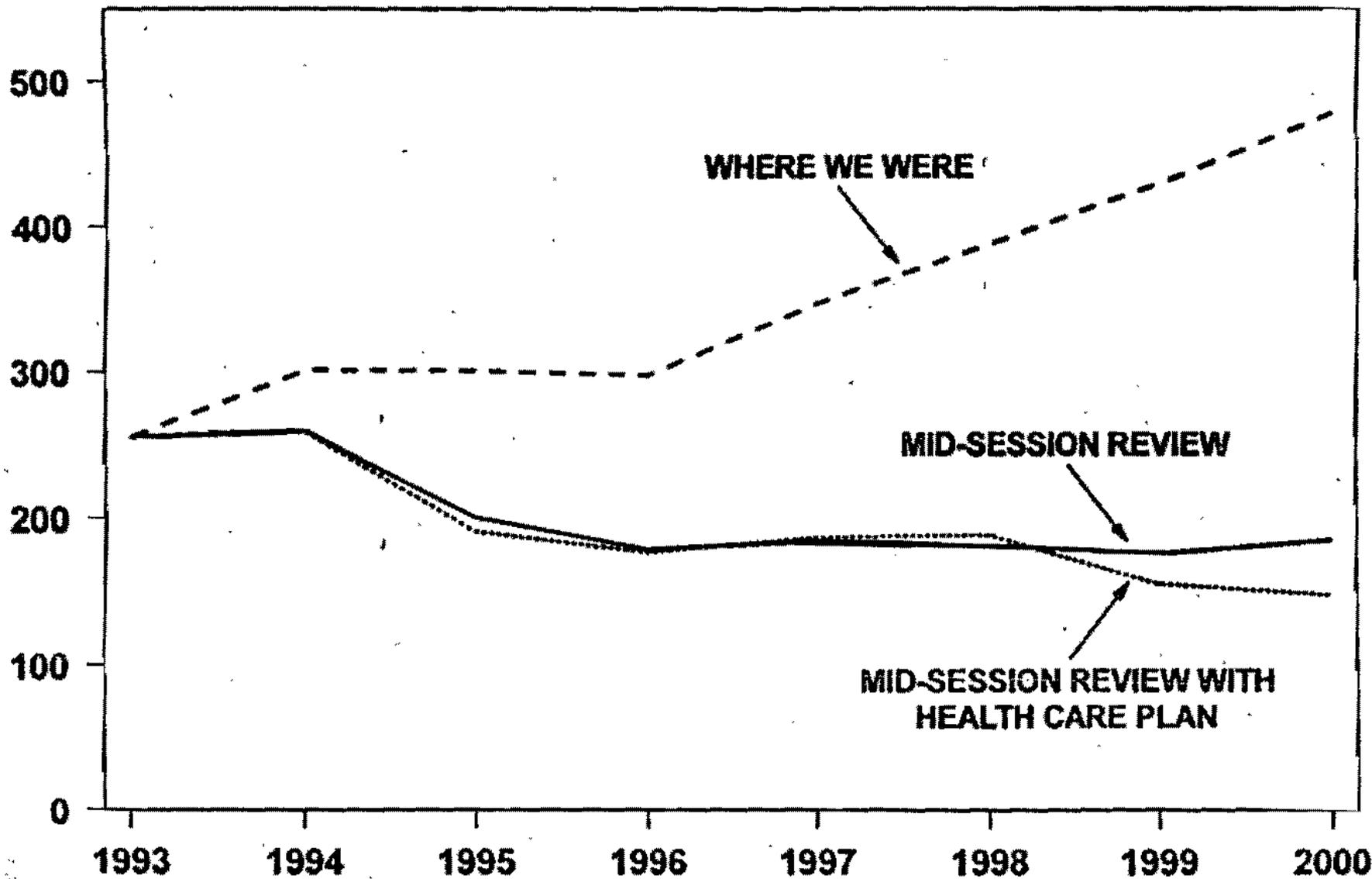
So as the great national debate proceeds, we expect to be challenged on policy; we expect a strenuous and far-reaching discussion of how best to achieve the goal of comprehensive health care reform. The Administration does not pretend to possess divine wisdom on this issue. We welcome alternative proposals and views.

But let's make one thing clear. Let's be sure that when other plans are presented, they meet the same kind of rigorous analysis to which we have subjected this plan. Let's make sure that their numbers have been thoroughly examined and analyzed. That way, we can be sure that this is a discussion over policies and issues, not numbers and statistics.

The American people deserve that kind of debate as we address an issue that will directly affect every one of them every day of their lives.

# ALTERNATIVE DEFICITS 1993 - 2000

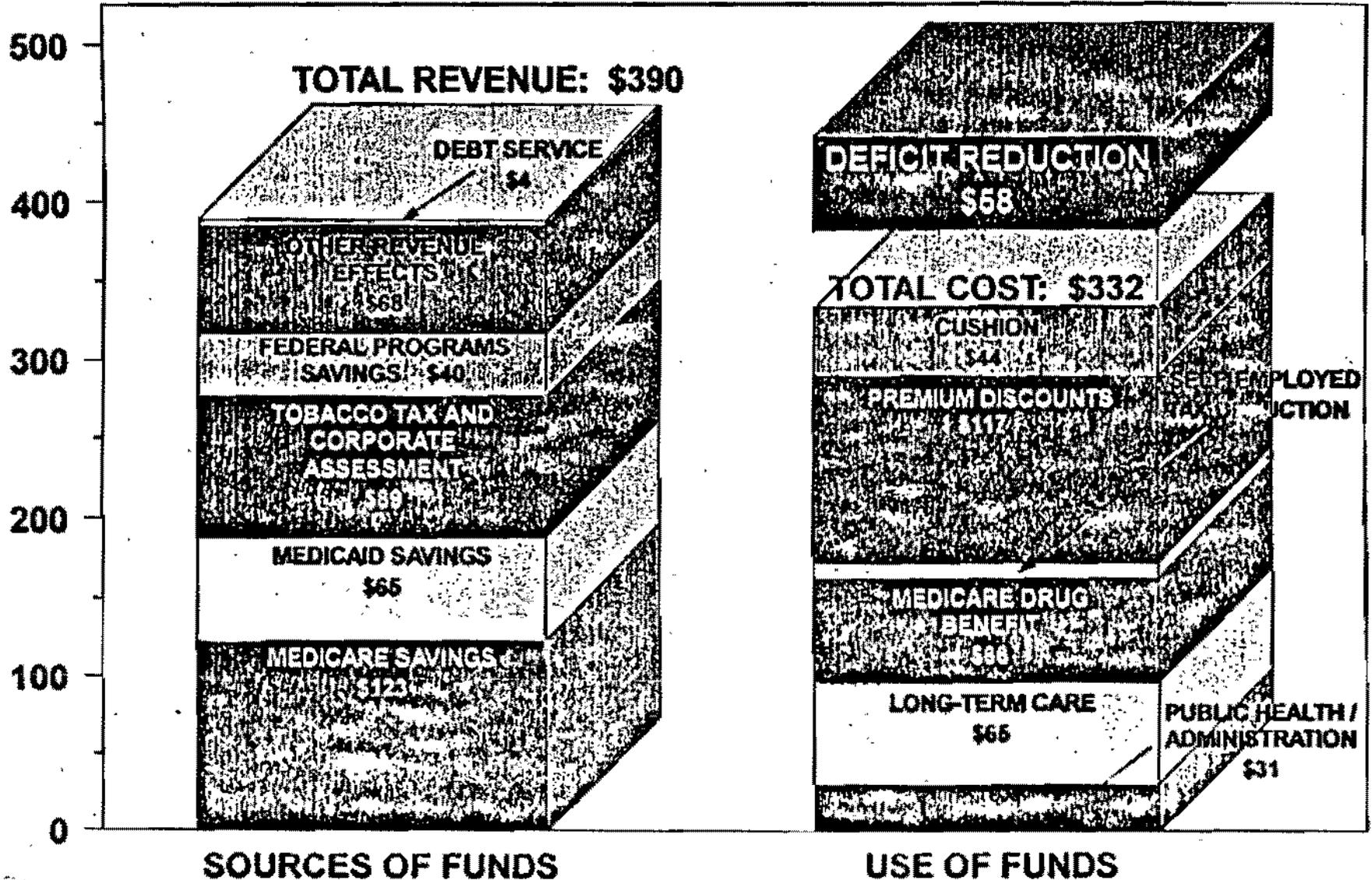
\$ BILLIONS



# FINANCING HEALTH CARE REFORM

TOTALS: 1995 - 2000

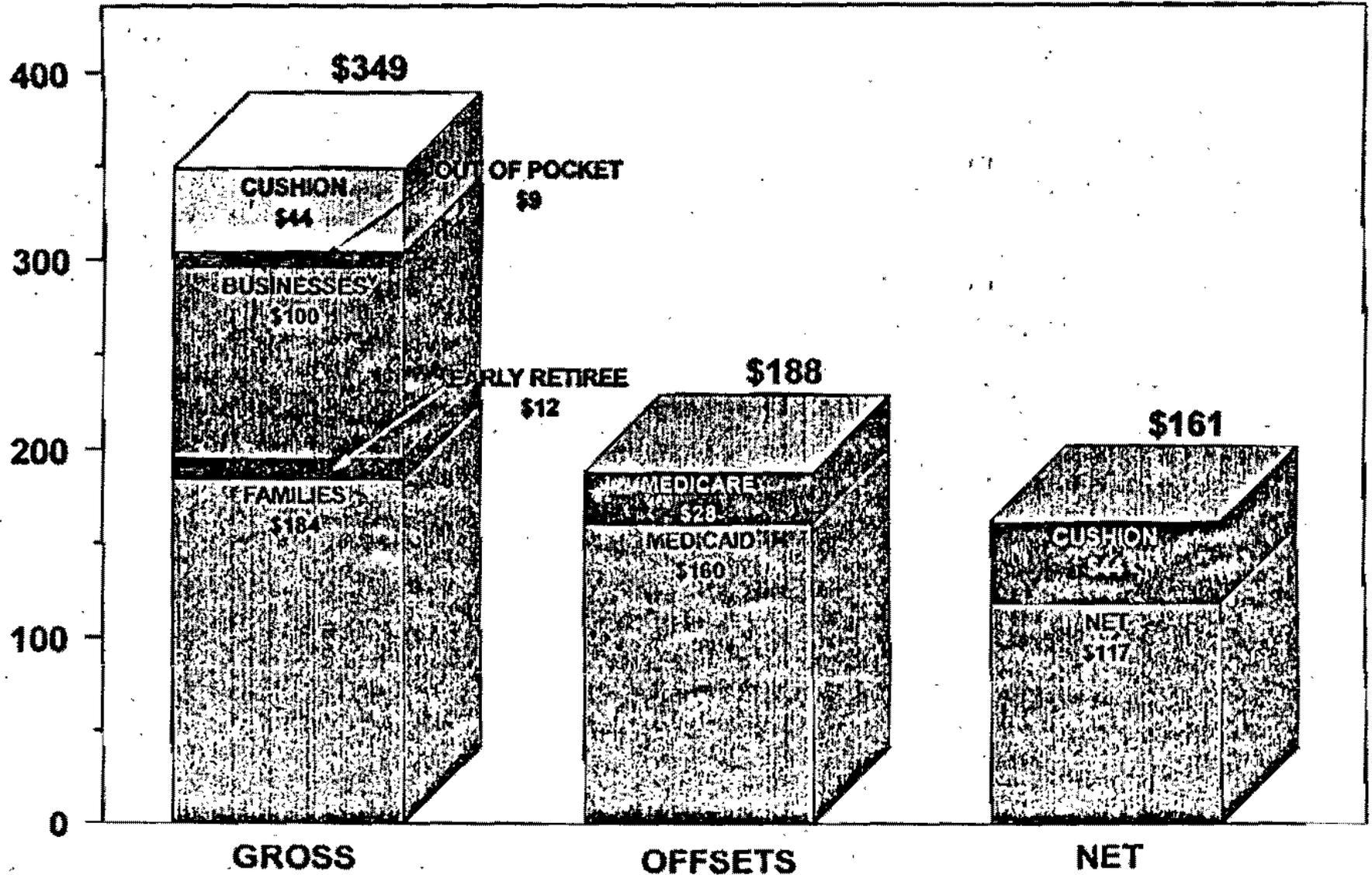
\$ BILLIONS



# COST OF PREMIUM DISCOUNTS

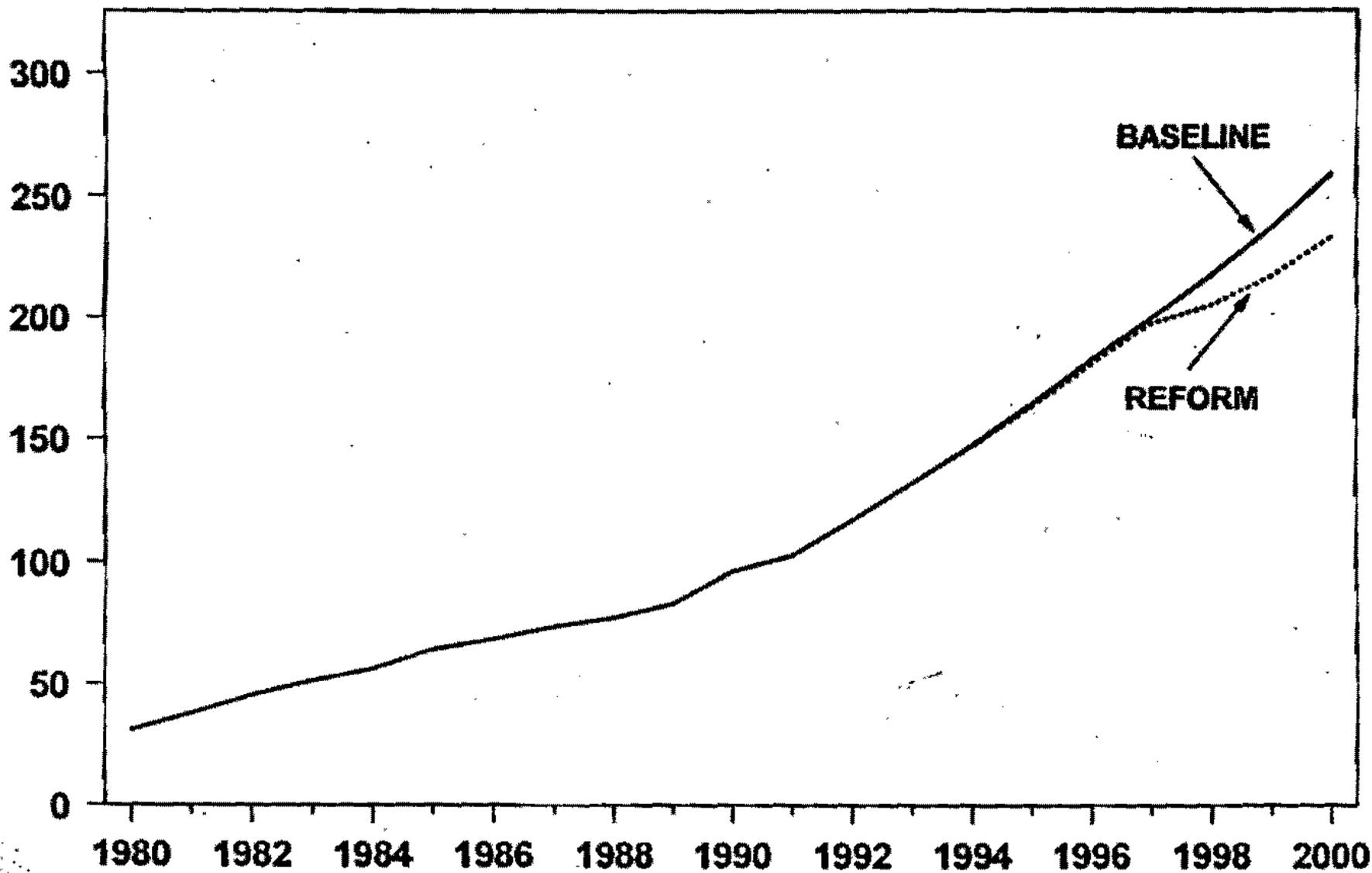
TOTALS: 1995 - 2000

\$ BILLIONS



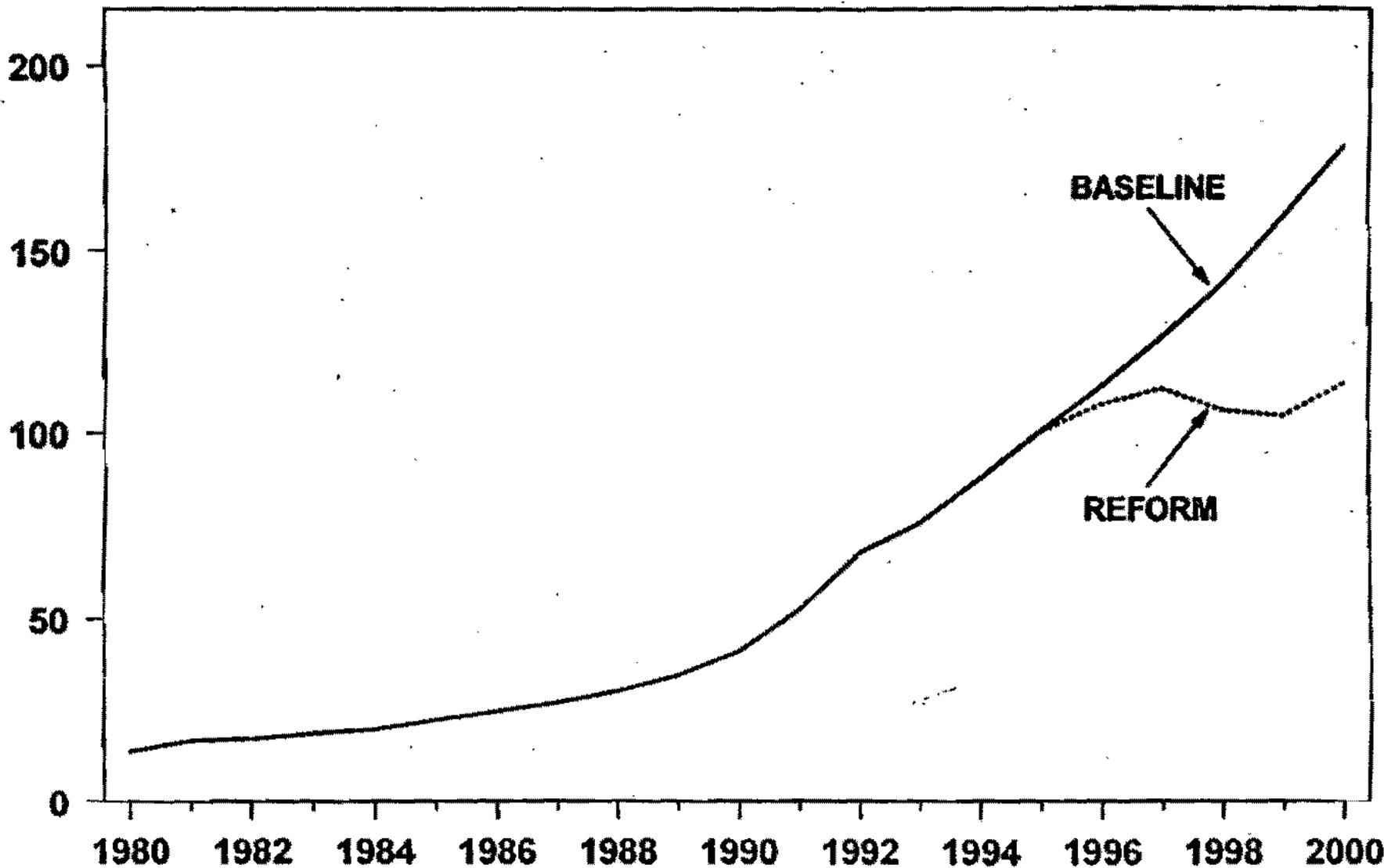
# MEDICARE SPENDING UNDER HEALTH CARE REFORM

\$ BILLIONS



# FEDERAL SPENDING FOR MEDICAID

\$ BILLIONS



LEON E. PANETTA  
DIRECTOR  
OFFICE OF MANAGEMENT AND BUDGET  
SPEECH TO THE CENTER FOR NATIONAL POLICY  
JUNE 20, 1994

TO: NEM  
5 PG  
SPEECH

I want to thank the Center for National Policy for providing me with this opportunity to speak to you today. The Center for National Policy has been an important focal point for debate on a broad spectrum of issues affecting our nation. You have made important contributions to these issues and have directly affected the course not only of debates but of decisions and actions.

It is therefore appropriate that we discuss today an issue that will certainly affect every citizen and taxpayer in this country -- health care reform. Today, I want to talk to you about health reform and focus not so much on the delivery of health care but rather on what the President believes, and what I believe, is an absolutely essential element of reform, and that is controlling the skyrocketing costs of our health care system.

The President was elected in 1992 on his promise to focus on fundamental changes in the nation's economy, in our government, and in the lives of America's families. That he has done. Working with the Congress, he has put in place an economic plan that has reduced budget deficits and increased investment in long-term economic growth and in the education, skills, and well-being of our workers and our children. He has implemented a trade policy that is already increasing exports and creating new opportunities and jobs throughout this country. He has signed into law the Family Leave Act, Goals 2000 education reforms, a historic national service program, and reforms in Head Start and other education programs. Last week, the President proposed a strong, measured reform plan to turn the nation's outdated and, in so many ways, counterproductive welfare system into a plan for work and responsibility.

Fundamentally tied to all of these changes in government, in the economy, in the well-being of our families is the need to reform our health care system. There is a clear consensus that the nation cannot sustain the inadequacies, the bureaucracy, the waste, and the costs of the present system. Reform is essential to continuing deficit reduction, it is essential to our efforts to restore America's economic strength, and it is essential to the security, to the well-being, of every American family.

As health care has been debated in the Congress and in the press, one of the issues that has aroused controversy is whether to effectively contain mounting health care costs, a key goal of the President's legislation. But how can we provide affordable health care for all Americans and not deal directly with costs? The answer is, we cannot.

## THE STAKES IN COST CONTAINMENT

Without real cost control, health costs will continue to consume an ever-growing share of household, business, and government budgets, robbing national income that we need to save and invest now for a better future.

Some argue that we should just rely on the word of those in the health care system to hold down costs. But as one observer has written, the health care system has, on its own, become overbuilt, overused, and overpriced.

The United States devotes the highest proportion of its national income to health care of any industrialized country -- 14 percent -- yet insures the smallest percentage of its citizens. We pay more, but get less. If current trends continue, by the end of the decade 14 percent will rise to 18 percent, yet more than 40 million Americans will still have no health coverage. And government, businesses, and families will continue to face rapidly rising costs, with no end in sight.

How can we not control costs? The American people want real health care reform. But does anyone seriously think that they want the Congress to go through this process and end up not containing costs? The reality is, the stakes in not allowing national health spending to rise out of control are huge -- for families, for businesses, and for government.

Deficits. First, government. And for government, read the taxpayers, all of us. Last year, Congress and the President reversed the trend of rising budget deficits by making some very tough choices about spending and taxes. Even so, the reality is that without comprehensive health reform, deficits will rise again in the latter part of this decade. Why? Because there is one remaining area of the Federal budget that is out of control. It's not defense spending, and it's not foreign aid, and it's not social spending or even other entitlements. It is health care. The Congressional Budget Office projects that without reform, they will rise by over ten percent for ten consecutive years -- obviously well beyond the rate of overall inflation.

If you consider all of the spending increases expected over the next several years, 90 percent come in three areas. Third is interest on the debt. Second is Social Security, largely because of a growing senior population, although the Social Security trust fund continues to run a substantial surplus. In first place, and easily leading the pack, is health costs, which make up more than 50 percent of anticipated spending increases.

Of course, if revenues could keep up with that spending, then deficits would not grow, but even in a strong, growing economy, revenues simply will not keep up with the pace of health spending.

So controlling health costs is absolutely essential to maintaining the path of deficit reduction.

**Businesses.** It is equally essential to the nation's economy. Businesses face the same problem as government -- skyrocketing costs which take a greater share of profits and payroll, which force many to limit the insurance they provide their workers, and prevent all too many, as we know, from providing it at all.

Perhaps the best-known example is the automobile industry. Health costs for the Big Three automobile manufacturers average over \$1,000 per car, placing them at a massive disadvantage to Japanese carmakers. Every product we manufacture, every service we provide, contains a growing health care tax premium. And that is true regardless of the size of the business. Small businesses today are charged an average of 35 percent more than large businesses for the same insurance. Whether large or small, businesses desperately need predictable, affordable health costs.

**Families.** And finally, families, particularly middle-class families, are finding it more and more difficult to ensure that they have adequate health care. First, just like government and businesses, they are facing rising costs for insurance, for doctors' visits, for prescription drugs. In addition, though, efforts to control costs in today's marketplace result in families being denied insurance just when they need it most -- because of a serious illness or other long-term condition.

So families, again, especially middle-class families, today live with the knowledge that they are one serious illness or one job change away from losing their health insurance. And because protecting families is at the core of health care reform, one of the fundamental ways in which we need to protect them is not only to guarantee coverage but to control rising costs.

If someone had sought to design the highest-cost system possible, they would have come up with our current system. There are few incentives today to control spending: the consumer bears only a fraction of costs; patients do not have the information they need to make meaningful choices; and most consumers must pay whatever providers charge. We need to change that market fundamentally. We need to create real competitive pressures and then guarantee them with cost constraints.

## **UNIVERSAL COVERAGE IS ESSENTIAL**

But first, it is important to understand one fundamental point: we cannot hope to contain costs without universal coverage. The two are inextricably linked. All the experts agree that until all Americans are insured, billions of dollars will continue to be shifted onto those with insurance coverage.

And without an approach that requires universal coverage, as CBO points out, it is the middle class -- not the poor -- who largely end up without insurance. If we do not achieve universal coverage, Americans numbering in the tens of millions, more than two-thirds of them in middle-class working families, will remain uninsured because they will not be able to afford it.

If we fail to cover every American, we won't fail the rich, who will get covered anyway; we won't fail the poor, who will receive subsidies. The people who we will fail are the hard-working middle class -- and that is wrong. Real reform must be universal. It must include middle class Americans.

## **PRIVATE SECTOR COMPETITION**

Our primary strategy for cost containment is private sector competition -- creating the right economic incentives to provide choices, bring costs in line, and encourage health plans to compete on price and quality. This will slow down costs, but we also need to build some discipline and certainty into our system. It would be irresponsible not to back up health security with cost security.

Indeed, what seems to get lost in the debate over specific cost-containment mechanisms is that we need to design a system that is inherently more cost conscious than the one we have today. We can debate forever about which specific cost containment mechanisms to use, but the fact is that most consumers, providers, and insurers do not now have adequate incentives to spend our health care dollars wisely -- and that is one market failure that health reform must correct.

The President's plan gives most consumers more choice of plans than they have in today's system, where so many employers offer only one plan. And consumers will be provided with information about the plans from which they are choosing, in a form they can use to compare health plans -- which most people don't have today. Plans will provide a standard benefits package, so the system will allow consumers to make an apples-to-apples comparison based on price, on quality of care, on previous customer satisfaction, on experience.

And because the plan stresses responsibility by requiring consumers to pay a portion of their premiums, they will have a financial stake in choosing the plan that best meets their individual needs. And they will be given an annual opportunity to switch plans if their plan does not live up to their expectations.

The plan also strengthens competition in health care by requiring providers and insurers to provide care to all who seek coverage, and to continue to provide quality care within a set premium. A key element of that is the choice of plans provided to consumers. Choice is essential to competition. To be competitive in the reformed health marketplace, providers will have to continue to provide high-quality care and to do so in a cost-effective way. This is how the President's plan uses the instruments of competition to squeeze excess costs out of the system.

## **FURTHER PROTECTIONS AGAINST RISING COSTS**

These policies are the building blocks of incentive-based cost containment in a reformed health care system. But we need to build accountability into the system as well. So, in addition to encouraging real competition, the President's plan uses three additional

protections to control costs: short-term protection in the first year of reform; long-term protections; and protections to control budget deficits.

**Short-term protection.** Setting an accurate premium level in the first year is a critical step towards real cost containment. Today, millions of uninsured individuals cannot pay when they use the health care system. Doctors and hospitals set their fees -- and insurers set their premiums -- about 25% higher for those who do pay to cover these uncompensated costs. That, of course, is one of the fundamental arguments in favor of universal coverage.

With universal coverage, all Americans would be insured, so there would be virtually no uncompensated costs. Therefore, we need to set an appropriate premium ceiling in the first year of health reform; otherwise, the health industry will reap a huge windfall because they will effectively be paid twice for the uninsured -- once when the uninsured get insurance and pay their premiums and again when everyone else still gets charged more. This windfall, worth ~~hundreds of~~ billions of dollars to insurance companies over the next several years, would come straight out of our pockets.

The costs of the system are high enough. The health industry should not be permitted to collect fees and premiums twice for the same care. To prevent that, setting an appropriate first-year premium is essential.

**Long-term protection.** To provide the long-term protection that American businesses and families demand, the President's plan ties the future growth in health insurance premiums to a reasonable scale of increases.

This protection makes sense. Limits on premium increases are preferable to direct Federal micro-management of health care costs -- for example, through a system of Federal price controls for specific procedures. The Federal government should not set prices for all of the tens of thousands of private health transactions that take place every day. The President rejected that approach in favor of broad limits on the rate at which insurance companies may raise premiums. The President's plan leaves it to those who know the system best -- health plans, doctors, and nurses -- to eliminate waste while improving the quality of care.

We believe that by reforming the way the health care market works -- permitting providers to compete efficiently and giving consumers the information they need to make prudent and cost-effective choices -- health care cost increases will be slowed. But if competition does not hold premium growth within reasonable targets as quickly as expected, then premium caps will be triggered.

Some argue that these limits are too stringent to maintain the high quality of care that Americans receive today. This is simply untrue. First, the ceilings allow for regional variations and demographic shifts. But more fundamentally, in 2004, even with these limits, the U.S. health industry would have revenues of \$2.1 trillion. The average annual growth in national health spending between 1996 and 2004 would be 7.3 percent per year instead of 8.4 percent as now projected -- an important achievement but one that would more than allow the

health sector to continue the high-quality care and medical advances which are the hallmark of our system.

**Deficit protection.** Finally, the President's plan assists small businesses and low-income families and individuals in paying their share of the cost of insurance. However, the President rejected the notion of creating another runaway entitlement program. Therefore, the plan sets a cap on total discounts. If costs rise beyond that level, Congress and the Administration must revisit the program and fix the problem.

We are all too familiar with the problem of exploding entitlement programs, established without limits and coming back to haunt Congresses and Administrations. The cap on aggregate subsidies is a backstop that we do not expect to use. But just as we are asking the private sector to control its health costs, we are also requiring the Federal government to be held to a measurable standard of cost containment, and we are protecting the taxpayer as well as our commitment to deficit reduction.

### **COST CONTAINMENT CRITICAL TO REFORM**

Regardless of the means, we need to put an end to the fantasy that we can reform the nation's health system and provide coverage to every American without containing health costs. Let me point out just how bizarre the debate over cost containment has become. When the Administration said that health care spending would rise to 19 percent of GDP by 2004 without reform, everyone agreed with us that 19 percent was too high and that it would crowd out important investments in the economy. But when the Administration produced a plan to reduce health's share of GDP to 17 percent by 2004, some claimed we were too ambitious -- even though all of our industrial competitors spend less than 10 percent of their output on health today while insuring all of their citizens.

If 10 percent is enough for other industrialized nations to provide universal health coverage, why should 17 percent and another \$1 trillion-plus in health industry revenues not be sufficient to continue to provide high-quality care in this country? And if the uninsured are now receiving care -- even if it is expensive care -- why should giving them health coverage, much of which would prevent disease, drive costs higher than they are today? The Administration should not have to defend 17 percent. It is opponents of cost containment -- largely those who profit from the excesses of today's system -- who have some explaining to do.

If we enact health care reform that does not provide for universal coverage and control costs -- whether through the mechanisms proposed by the Administration or by some other means -- this effort will have failed.

This is a debate that is taking place not only in the committee rooms and the chambers of the Congress but in newspapers, in meeting halls, and over kitchen tables throughout our country. For 16 years, I served as a member of Congress. And for 16 years, the health care issue became a bigger and bigger problem. It was ignored until it became a crisis, as costs for families, businesses, and government spiraled out of control, as

the number of uninsured Americans grew, and as more and more families came to fear the loss of their insurance coverage.

We saw a lot of suggestions, a lot of ideas, a lot of concepts proposed. We tried. But we failed. The truth is, until this President, nobody presented the kind of specific, comprehensive, responsible, detailed, paid-for plan that the Congress has been considering.

As this great national debate has proceeded, we have been challenged on policy, as we expected, and there has been a strenuous and far-reaching discussion of how best to achieve the goal of comprehensive health care reform. The Administration does not pretend to possess divine wisdom on this issue. We have welcomed alternative proposals and views.

But as the legislative process moves forward, let's make one thing clear. Let's be sure that as the various plans are considered, they meet the tests that we have sought to meet -- first, universal coverage, and also choice, quality, cost containment. And let's try -- to the extent possible -- to be sure that the debate proceeds on the substance, not the politics and not the personalities. The American people deserve that kind of debate because this is an issue that will directly affect every one of them every day of their lives.

As you know, the legislative process is well under way. House and Senate Committees are hard at work on their versions of health care reform. Cost containment is a critical element of their deliberations. We all know that the legislative process is sometimes not very pretty. We are in for a roller coaster ride with even steeper twists and turns than last year with the enactment of the President's economic plan.

But the fact is, we have already crossed an important threshold of this debate. There is no turning back. If Congress produces a minimal plan that fails to meet the principles established by the President, it will have failed, the problems will continue to grow, and future Congresses will have no alternative but to return to the task again and again until it is completed.

If, on the other hand, Congress succeeds in putting this nation on a new course toward real health reform, then we and our children and their children will know that destiny was truly ours.

In the end, I am convinced that Congress will pass a plan that guarantees coverage for every American and that controls health costs. And that is absolutely essential to the future of our economy, our country, and our people.

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