



DEPARTMENT OF THE TREASURY

WASHINGTON

May 26, 1993 1:22 PM

INFORMATION

93-122038

MEMORANDUM FOR DEPUTY SECRETARY ROGER ALTMAN
ASSISTANT SECRETARY ALICIA MUNNELL

*noted
RCA
5-26-93*

From: Brad De Long ^{BD}

Subject: **AHCPR ESTIMATES OF THE COST OF HEALTH CARE REFORM**

The AHCPR (Agency for Health Care Planning and Research) in Rockville has estimates of the cost of the level 2 health reform plan that are different from—and higher than—those produced by the HCFA (Health Care Financing Administration). The two sets of estimates are:

	<u>AHCPR</u>	<u>HCFA</u>	<u>Difference</u>
For individuals	\$1,682	\$1,193	\$489
For families	\$3,715	\$3,365	\$350

If the covered population contains approximately 70 million families and 35 million single individuals, health alliance spending for the level 2 program would be nearly \$42 billion a year more under the AHCPR estimates than under the HCFA estimates.

Under the per-person premium plan, the AHCPR estimates imply \$489 dollar a year rises in individual and \$350 dollar a year rises in family premiums, with a roughly 17 percent increase (on the order of \$10 billion a year) in the subsidy program.

Under the wage-based premium plan, the AHCPR estimates imply a nationwide average payroll rate of 8.8 as opposed to 7.2 percent. State payroll rates would vary from 6.4 percent in Maryland to 10.7 percent in Louisiana and Maine.

ESK

Edward S. Knight

<u>State</u>	State Payroll Premium Rate (AHCPR)	State Payroll Premium Rate (HCFA)
Alabama	10.00%	8.30%
Alaska	8.70%	7.10%
Arizona	8.00%	6.50%
Arkansas	9.80%	8.20%
California	9.60%	7.90%
Colorado	7.50%	6.20%
Connecticut	9.30%	6.00%
DC	9.80%	7.70%
Delaware	8.70%	7.10%
Florida	9.90%	8.00%
Georgia	8.20%	6.70%
Hawaii	7.70%	6.30%
Idaho	9.10%	7.60%
Illinois	8.80%	7.20%
Indiana	8.70%	7.20%
Iowa	7.50%	6.20%
Kansas	7.80%	6.50%
Kentucky	8.80%	7.30%
Louisiana	10.70%	9.00%
Maine	10.70%	8.80%
Maryland	6.40%	5.20%
Massachusetts	8.40%	6.70%
Michigan	9.40%	7.70%
Minnesota	7.60%	6.10%
Mississippi	10.00%	8.40%
Missouri	8.40%	6.90%
Montana	9.00%	7.50%
Nebraska	7.20%	6.00%
Nevada	9.20%	7.50%
New Hampshire	6.90%	5.60%
New Jersey	7.90%	6.40%
New Mexico	9.20%	7.70%
New York	9.30%	7.60%
North Carolina	7.90%	6.50%
North Dakota	8.90%	7.30%
Ohio	8.90%	7.30%
Oklahoma	8.60%	7.10%
Oregon	8.40%	6.90%
Pennsylvania	9.60%	7.90%
Rhode Island	8.10%	6.50%
South Carolina	7.50%	6.20%
South Dakota	8.10%	6.70%
Tennessee	8.90%	7.30%
Texas	8.70%	7.20%
Utah	8.90%	7.30%

Vermont	7.20%	6.00%
Virginia	7.90%	6.40%
Washington	7.80%	6.40%
West Virginia	9.90%	8.30%
Wisconsin	7.30%	6.00%
Wyoming	8.60%	7.20%
NATIONAL AVERAGE	8.80%	7.20%

93-122232



DEPARTMENT OF THE TREASURY
WASHINGTON

INFORMATION

TO: Deputy Secretary Altman
FROM: Marina L. Weiss
DATE: May 27, 1993
SUBJECT: Phase-in Schedules for Health Care Reform

Pursuant to your request, attached are copies of the slides used to brief the President and the Health Reform Task Force members on two alternative paths to reform.

Plan A begins with a spare "major medical" plan in 1996 and phases into a 20th percentile plan by the year 2000.

Plan B begins with a 20th percentile plan in 1996 and phases into a 70th percentile plan by the year 2000.

DESIGN STRATEGY FOR PLAN A

- COVER EVERYONE AS SOON AS POSSIBLE
- MINIMIZE THE IMPACT ON SMALL BUSINESSES, WORKERS, AND THE DEFICIT
- PHASE-IN COVERAGE ENHANCEMENTS SLOWLY, AS IN HAWAII
- PROVIDE HEALTH SECURITY BY ENDING ANXIETIES ABOUT:
 - FINANCIAL RUIN UPON SERIOUS ILLNESS
 - ACCESS TO HIGH QUALITY CARE FOR SERIOUS PROBLEMS
 - CONTINUITY OF COVERAGE IF JOB OR HEALTH STATUS CHANGES

BASIC FACTS ABOUT PLAN A

- **FEATURES THAT ARE LIKE PLAN B:**

- **HEALTH ALLIANCES IN EVERY STATE, SAME PHASE-IN SCHEDULE**
 - **CURRENTLY INSURED WILL BE GUARANTEED THE LEVEL TWO BENEFIT PACKAGE WITH 80% EMPLOYER SHARE**
 - **IN THE YEAR 2000, ALL AMERICANS WILL BE GUARANTEED A LEVEL TWO BENEFIT PACKAGE**
-
- **HEALTH SERVICES COVERED**

BASIC FACTS ABOUT PLAN A

- **FEATURES THAT DIFFER FROM PLAN B**

- **THERE ARE NO SUBSIDIES TO THE CURRENTLY INSURED**
 - **THE CURRENTLY UNINSURED WILL BE GUARANTEED THE LEVEL 1 BENEFITS PACKAGE**
 - **LOW INCOME UNINSURED WILL RECIEVE PREMIUM SUBSIDIES ONLY, NOT OUT-OF-POCKET SUBSIDIES**
-
- **EMPLOYER-EMPLOYEE SHARES ARE 50:50**
 - **DEDUCTIBLE AND ANNUAL OUT-OF-POCKET LIMITS ARE HIGHER (THESE COULD BE ADJUSTED)**

FUNDAMENTAL DIFFERENCES IN APPROACH BETWEEN PLANS A AND B

- **HOW MUCH COVERAGE FOR THE CURRENTLY UNINSURED DURING THE TRANSITION?**
 - **WHO WILL PAY HOW MUCH TO INSURE THE CURRENTLY UNINSURED DURING THE TRANSITION?**
-

PLAN A MEETS THE PRESIDENT'S MAJOR GOALS

- PROVIDES SECURITY
- CONTROLS COSTS
- MAINTAINS CHOICE
- IMPROVES QUALITY

ALL BY '97

NO BANKRUPTCIES

COVERAGE WILL FOLLOW AMERICAN THROUGH JOB

H.C.A.

LOWER INTEREST

~~THE~~

ACCESS TO CARE FOR EXPENSIVE PATIENTS

~~M.P. ...~~

PROFILE OF THE UNINSURED

- **85% OF THE UNINSURED LIVE IN HOUSEHOLDS WITH A WORKING HEAD OF HOUSEHOLD (70% FULL TIME)**
 - **83% OF UNINSURED HOUSEHOLDS EARN LESS THAN \$20,000**
 - **MOST UNINSURED ARE HEALTHY AND RELATIVELY YOUNG**
 - **35-40% HAVE NO VISITS AND NO EXPENDITURES**
 - **75% SPEND LESS THAN \$500**
-
- **THE UNHEALTHY UNINSURED ARE SICKER THAN AVERAGE**
 - **4% ACCOUNT FOR 64% OF ALL EXPENDITURES ON THE UNINSURED**
 - **THEY SPEND MORE THAN \$4000 EACH**

COVERING THE NEEDS OF THE UNINSURED

- **MOST UNINSURED INDIVIDUALS NEED A PLAN THAT PROTECTS AGAINST LARGE EXPENDITURES AT MINIMAL COST**
- **PLAN A DIRECTLY MEETS THE MOST PRESSING NEEDS OF THE UNINSURED WITHOUT AN UNDUE INCREASE IN FINANCIAL BURDEN ON ANYONE**
- **ABOUT 70% OF HOSPITAL UNCOMPENSATED CARE IS FOR AMOUNTS LARGER THAN THE DEDUCTIBLE OF PLAN A**
- **PROVIDERS, ESPECIALLY HOSPITALS, ARE THEREBY ALSO PROTECTED FROM LARGE LOSSES BY PLAN A**
- **WE COULD MODIFY THE SPECIFIC FEATURES OF PLAN A AND REMAIN CONSISTENT WITH THIS OVERALL DESIGN STRUCTURE**

IMPACT ON NATIONAL HEALTH COSTS

- **PLAN A INCREASES NATIONAL HEALTH EXPENDITURES BY ~~\$x~~ 2 BILLION LESS THAN PLAN B IN 1996, \$y LESS BY 1999**
- **IF EXPECTED SAVINGS FROM HEALTH REFORM FAIL TO MATERIALIZE, NATIONAL HEALTH EXPENDITURES COULD RAPIDLY ESCALATE. PLAN A MINIMIZES THE RISK OF THAT ESCALATION.**

PLAN A HAS A BETTER IMPACT ON THE ECONOMY

- **PLAN B WILL BE ACCUSED OF PUTTING 9.1 MILLION JOBS AT RISK**
- **LOWER PAYROLL TAXES OR PREMIUMS ENCOURAGE EMPLOYMENT RETENTION AND ECONOMIC GROWTH**

PLAN A HAS A BETTER IMPACT ON THE ECONOMY

- **PLAN A WOULD BE LESS DISRUPTIVE TO BUSINESSES NOT NOW PROVIDING INSURANCE**

REQUIRED EMPLOYER FAMILY PREMIUM PAYMENTS

	PREMIUM	EMPLOYER SHARE
PLAN B	\$3365	\$2692 (80%)
PLAN A	\$2463	\$1233 (50%)
DIFFERENCE		\$1459 PER WORKER

PLAN A HAS LOWER FEDERAL COSTS AND RISKS

- **COSTLY SUBSIDIES ARE MINIMIZED**

INCREASE IN GROSS SUBSIDIES (BILLIONS)

	1996	1998
PLAN A	\$ 2	\$11
PLAN B	\$59	\$69

PLAN A HAS LOWER FEDERAL COSTS AND RISKS

- **PLAN A REQUIRES LOWER NEW FEDERAL REVENUES**

ESTIMATED DEFICIT IMPACT WITHOUT NEW TAXES

(BILLIONS, WITHOUT CONTROLS)

	1996	1999
PLAN A	- 1	- 14
PLAN B	+ 54	+ 42

PLAN A HAS LOWER FEDERAL COSTS AND RISKS

- **RAPID EXPANSION OF A HEALTH CARE ENTITLEMENT IS AVOIDED**
- **ADMINISTRATIONS AND CONGRESS HAVE SERIOUSLY UNDERESTIMATED HEALTH CARE EXPENDITURES OF MAJOR NEW PROGRAMS IN THE PAST**
 - **THE ORIGINAL MEDICARE SPENDING ESTIMATE FOR 1970 WAS ROUGHLY HALF OF THE ACTUAL COST**
 - **ORIGINAL OUTYEAR ESTIMATES WERE MUCH WORSE**

PLAN A IS GENEROUS AND EXPANDABLE

- **PROVIDES NEW LONG TERM CARE AND MEDICARE DRUG BENEFITS**
 - **THESE BENEFITS ARE DESIRED BY MILLIONS OF AMERICANS INCLUDING CORE CONSTITUENCIES**
- **ONE COULD ACCELERATE THE TIMETABLE FOR AN UPGRADE TO A LEVEL 2 OR 3 BENEFIT PACKAGE**
- **ALLOWS STATES FLEXIBILITY TO INTRODUCE MORE GENEROUS COVERAGE ON THEIR OWN**

POLITICAL ADVANTAGES OF PLAN A

- **FULFILLS THE PRESIDENT'S PROMISE TO PROVIDE HEALTH SECURITY TO EVERY AMERICAN**
- **WILL NOT REQUIRE LARGE NEW TAXES NOR INFLATE THE DEFICIT**
- **PLAN B WOULD LEAVE THE PRESIDENT VULNERABLE TO THE OLD "TAX AND SPEND" LABEL**
- **PLAN A SHOWS THAT THE PRESIDENT IS A "NEW" DEMOCRAT — CARING AND REALISTIC**
- **PLAN A PROVIDES THE ACCESS AND COVERAGE THAT LIBERAL MEMBERS OF CONGRESS WANT**
- **THE LOWER PAYROLL CONTRIBUTION AND SLOWER PHASE-IN ATTRACTS MORE CONSERVATIVE DEMOCRATS AND MODERATE REPUBLICANS**

POLITICAL ADVANTAGES OF PLAN A

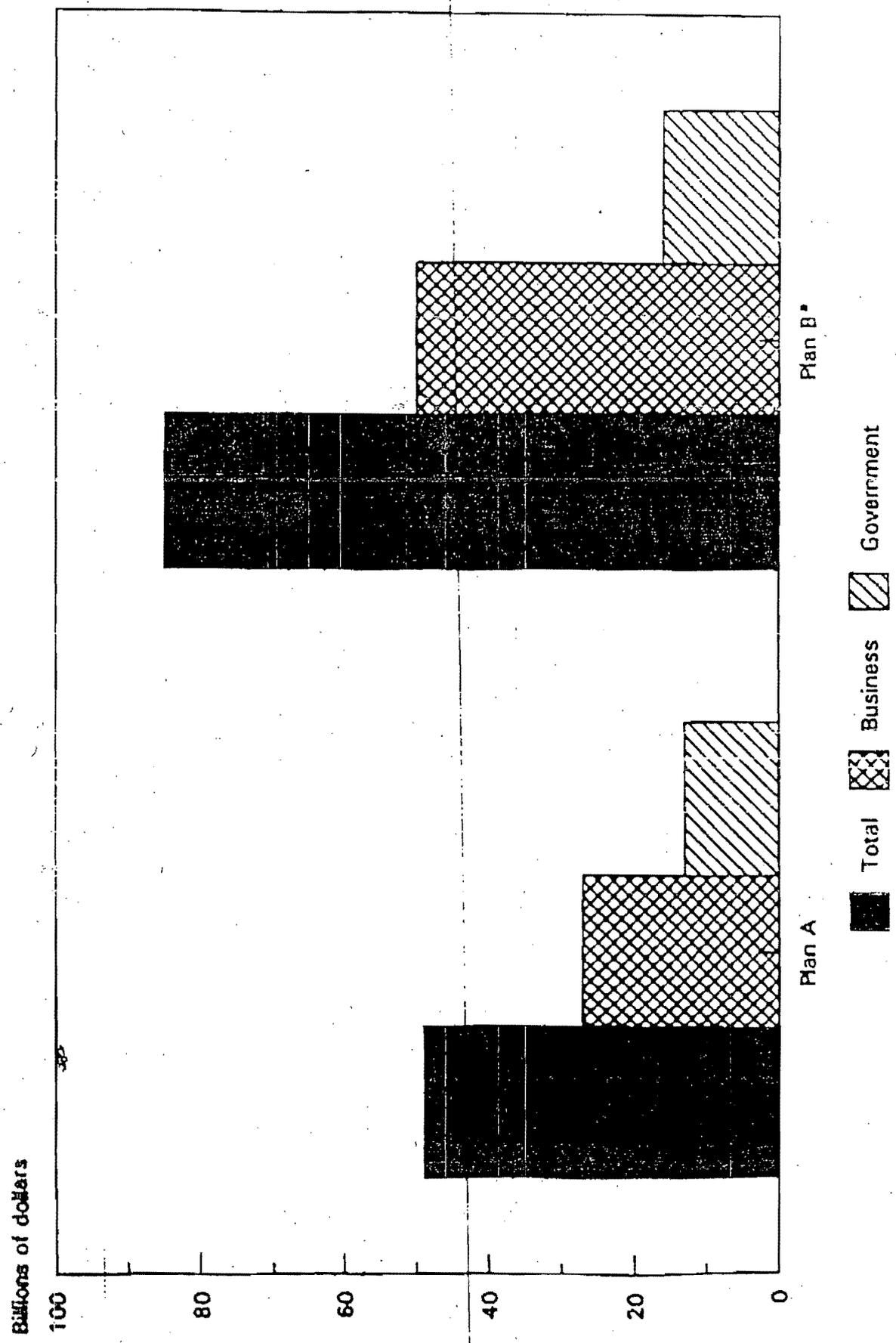
- **THOUGH SMALL BUSINESS WILL STILL BE OPPOSED, MANY MODERATE TO COSERVATIVE DEMOCRATS AND REPUBLICANS WILL CONCLUDE THAT THEIR CONSTITUENTS CAN ABSORB A LOW TAX DURING A SLOW TRANSITION**
- **PLAN A AVOIDS THE MISTAKES OF PREVIOUS LEGISLATIVE ATTEMPTS BY NOT LOADING UP THE PACKAGE WITH BELLS AND WHISTLES THAT PEOPLE DON'T WANT TO PAY FOR**
- **CONGRESS AND THEIR CONSTITUENTS WILL BE SKEPTICAL THAT COSTS CAN BE CONTROLLED**
 - **THEY FEAR THEY WILL BE ON HOOK TO RAISE EVEN MORE TAXES FOR A NEW HEALTH CARE ENTITLEMENT UNDER PLAN B**

POLITICAL ADVANTAGES OF PLAN A

- **PLAN A IS A BETTER SELL TO THE PUBLIC:**

- **THOSE WHO LACK INSURANCE TODAY ARE PREDOMINANTLY YOUNG AND HEALTHY. THEY DON'T WANT, NEED, OR WISH TO PAY FOR BENEFITS THEY WON'T USE**
- **PLAN A IS A "GO SLOW AND CORRECT THE COURSE AS WE GO ALONG" APPROACH. IT'S MORE APPEALING TO A CAUTIOUS PUBLIC**
- **PROMISING TOO MANY BENEFITS, TOO SOON, WILL RAISE EXPECTATIONS THAT CANNOT BE MET**
- **PLAN A AVOIDS A DOUBLE HIT OF LARGE TAXES (IN BOTH ECONOMIC AND HEALTH CARE PACKAGE)**
- **PROVIDES HEALTH SECURITY TO THE MIDDLE CLASS WITHOUT UNDULY TAXING THEM TO PAY FOR THE POOR**

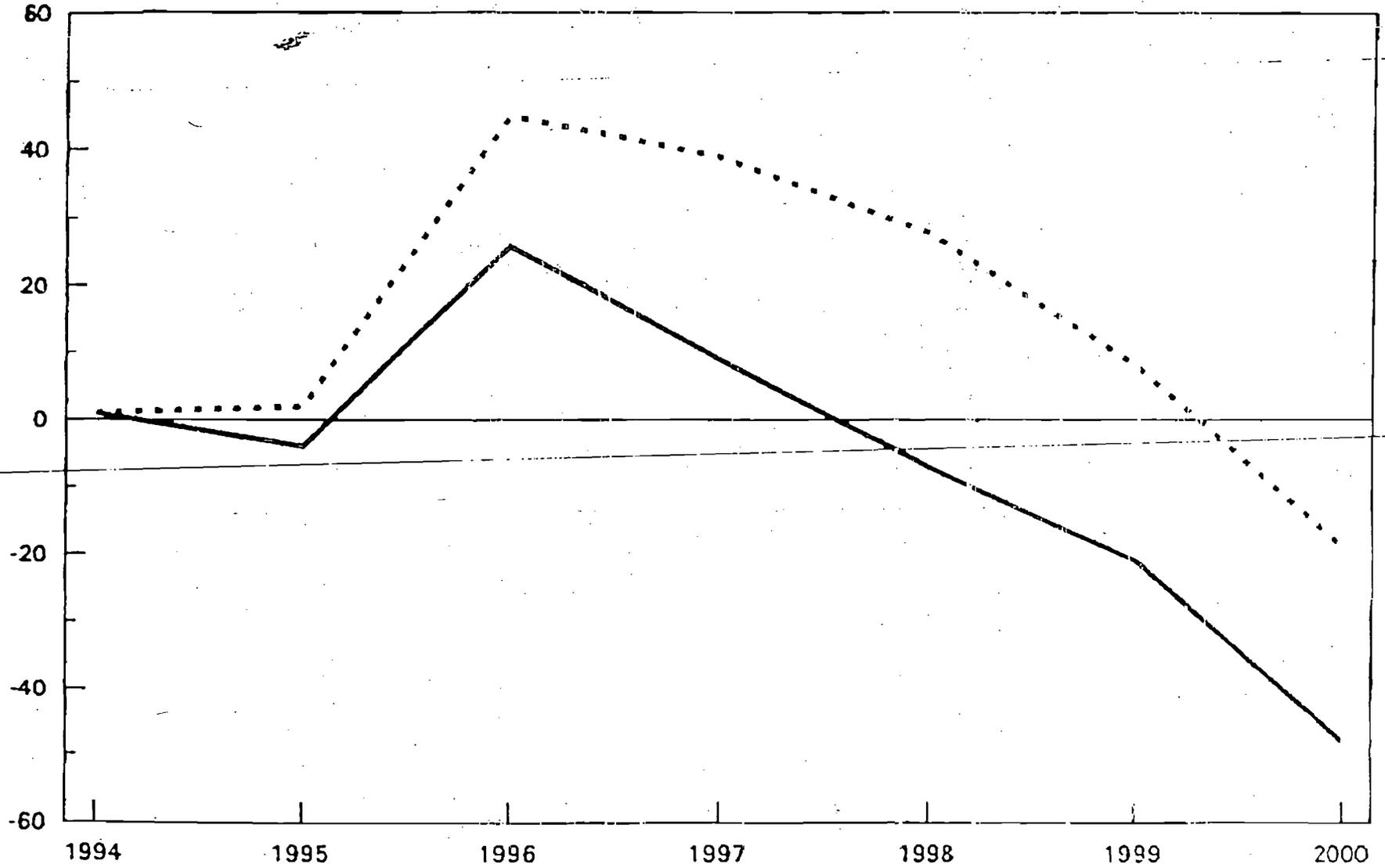
Change in Health Care Spending in 2000 (before upgrade)



* wage-based

Change in National Health Spending

Billions of dollars



Plan A

Plan B: Wage-Based

—————

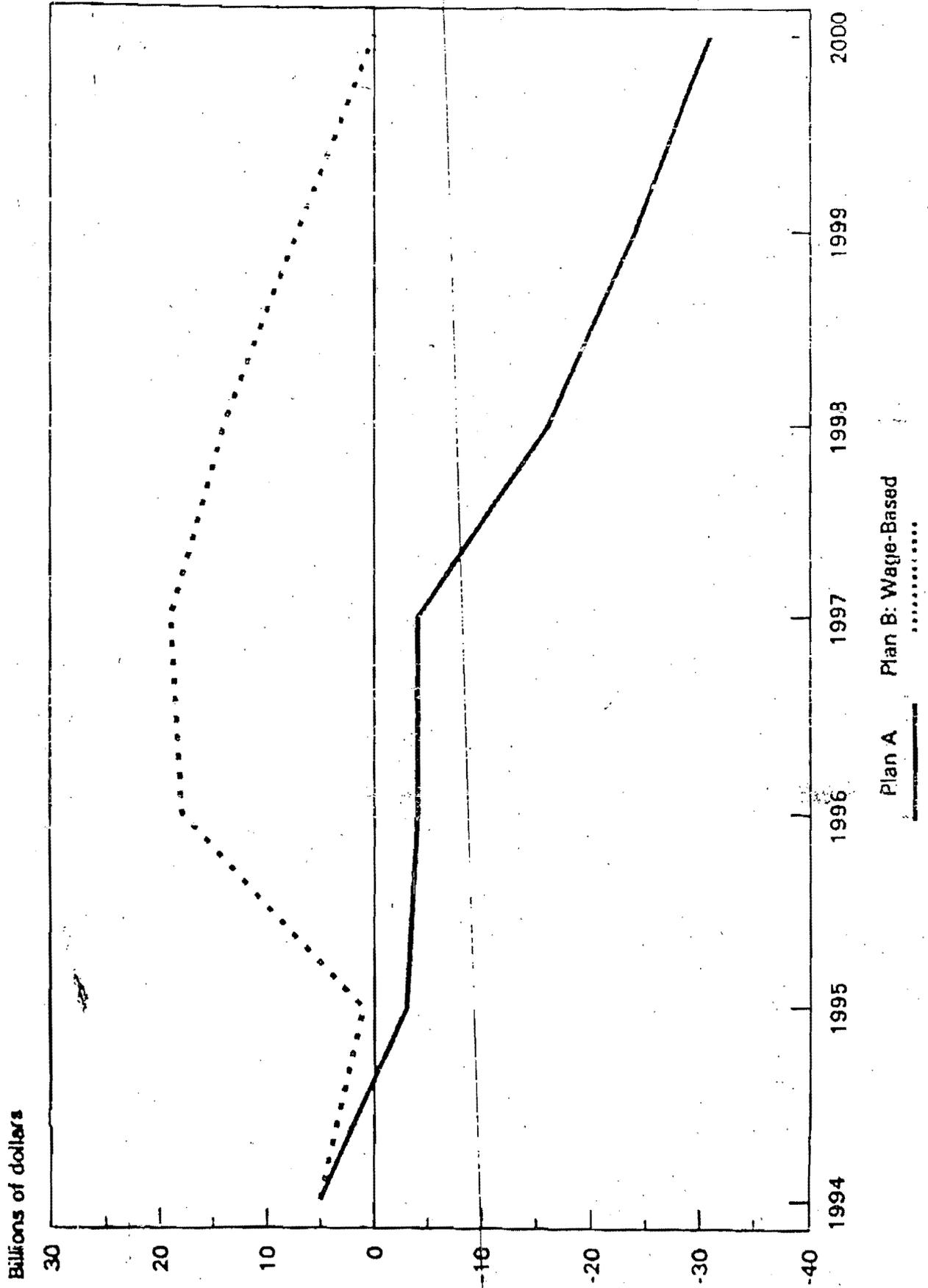
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05/27/93

Change in Federal Deficit



PLIN 5

**PLAN A IS QUESTIONABLE POLITICS AND
QUESTIONABLE POLICY**

● **SETS UP ARBITRARY, TWO-TIER SYSTEM**

- CURRENTLY INSURED PEOPLE WOULD BE GUARANTEED A GOOD PACKAGE OF BENEFITS, WHILE THE UNINSURED WOULD BE GUARANTEED LESS. PEOPLE WOULD CONTINUE TO GET WIDELY DIFFERENT COVERAGE BASED ON THEIR EMPLOYER.

● **ADMINISTRATIVELY COMPLEX**

- THE DIFFICULTY OF IDENTIFYING WHICH EMPLOYERS HAVE WHICH RESPONSIBILITIES, THE HANDLING OF DUAL WORKER FAMILIES, AND THE FREQUENCY OF MOVEMENT BETWEEN LEVEL ONE AND LEVEL TWO PLANS COULD BE ADMINISTRATIVELY DIFFICULT, BLUNTING OUR GOAL OF ADMINISTRATIVE STREAMLINING.

● **DOES NOT PROVIDE SECURITY, PORTABILITY OR CONTINUITY**

- PEOPLE CHANGING JOBS AND MOVING IN AND OUT OF WORK COULD DROP FROM COMPREHENSIVE TO LIMITED COVERAGE, AND FROM PAYING 20% TO 50% OF PREMIUMS. CURRENTLY 70 MILLION PEOPLE MOVE BETWEEN INSURED AND UNINSURED STATUS OVER TWO YEARS. THEY WILL CONTINUE TO SEE MAJOR DISRUPTIONS IN THE COVERAGE AND CARE THEY RECEIVE WHEN INSURED.

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FRONT

00:56

MAY-11-1993

● **DOES NOT PROVIDE SECURITY, PORTABILITY OR CONTINUITY (cont'd)**

- **PEOPLE WILL FEAR BEING DROPPED TO LESSER COVERAGE, DISCOURAGING JOB MOBILITY AND CONTINUING LOSS OF HEALTH SECURITY FOR THOSE WHO LOSE THEIR JOBS.**
- **LEVEL 1 DOES PROVIDE THE UNINSURED WITH PROTECTION AGAINST CATASTROPHIC HEALTH EVENTS – THE CAR ACCIDENT, THE HEART ATTACK. BUT THE UNINSURED ARE NOT TURNED AWAY FROM CARE IN THESE EVENTS AND THEY ARE NOW EXPECTED TO PAY 50% OF A \$2463 PREMIUM FOR THIS COVERAGE.**

● **CREATES/MAINTAINS INEQUITIES**

- **FOR POOR FAMILIES ON MEDICAID, IT IS A STARK DIFFERENCE BETWEEN COVERAGE WITH A \$1000/2000 DEDUCTIBLE IF THEY GO TO WORK AND THE RICHER BENEFITS AND NO COST SHARING OF MEDICAID IF THEY DO NOT WORK.**
- **BY MANDATING CURRENTLY INSURING EMPLOYERS TO PAY 80% OF A BETTER PACKAGE AND NON-INSURING EMPLOYERS TO PAY 50% OF A LESSER PACKAGE, PLAN A REWARDS EMPLOYERS WHO HAVEN'T BEEN COVERING THEIR EMPLOYERS.**

11-11-1993 00:56 PM

● **DISCOURAGES SHIFT TO PRIMARY CARE**

- **THE LEVEL 1 PLAN CONTINUES THE FLOW OF DOLLARS TO HOSPITALS AND SPECIALISTS, PERPETUATING A SYSTEM OF "AFTER THE FACT" MEDICINE THAT DOES NOT ENCOURAGE PREVENTION AND PRIMARY CARE.**

● **FAILS TO BRING THE UNINSURED INTO ORGANIZED DELIVERY SYSTEMS**

- **THE DEDUCTIBLE REQUIREMENTS OF LEVEL 1 PLANS ARE NOT LIKELY TO ATTRACT MANAGED CARE PLANS TO COVER THE UNINSURED. THIS UNDERMINES AND DELAYS OUR GOALS OF ENCOURAGING DEVELOPMENT OF HEALTH PLANS THAT ORGANIZE CARE MORE EFFECTIVELY AND COMPETE TO CONTROL COST AND IMPROVE QUALITY.**

MHI-11-1953 00:57 FROM

**THE BENEFIT PACKAGE IS ONLY PART
OF THE DIFFERENCE BETWEEN PLANS**

COMPARING THE COSTS OF PLAN A AND PLAN B INVOLVES MORE THAN THE DIFFERENCE IN THE COSTS OF PROVIDING LEVEL 1 AND LEVEL 2 BENEFITS PACKAGES TO THE UNINSURED. OTHER POLICY DIFFERENCES BETWEEN THE TWO PLANS ADD TO THE DIFFERENCES IN NET COSTS.

- **PLAN A LOWERS EMPLOYERS COSTS IN PART BY SHIFTING MORE COSTS TO EMPLOYEES:**

PLAN A: EMPLOYERS AND EMPLOYEES SPLIT PREMIUMS 50/50

PLAN B: EMPLOYERS AND EMPLOYEES SPLIT PREMIUMS 80/20

- **SUBSIDIES ARE PROVIDED IN PLAN A BUT NOT IN PLAN B:**

- TO MAKE DEDUCTIBLES AFFORDABLE FOR LOW INCOME FAMILIES
- TO LOWER EMPLOYER PREMIUM COSTS FOR LOW WAGE WORKERS

- **LONG TERM CARE BENEFITS ARE GREATER IN PLAN B**

- COVERAGE IS NOT RESTRICTED TO THOSE IN POVERTY
- COVERS HOME CARE THROUGH A CAPPED ENTITLEMENT FOR THE SEVERELY DISABLED NOT LOW INCOME

- **A PORTION OF THE DIFFERENCE IN COST IS THE BENEFIT PACKAGE:**

- DIFFERENCE IN PREMIUMS: \$350 SINGLE / \$900 FAMILY

10
MAY-11-1993 00:57 FROM

THE ADDED INVESTMENT PROVIDES HEALTH CARE SECURITY

- **THE MANDATE PREMIUM IS SIGNIFICANTLY LESS FOR EMPLOYEES**

CURRENTLY UNINSURED FAMILY WITH \$32,000 EARNINGS	EMPLOYEE PREMIUM SHARE	EMPLOYER PREMIUM SHARE
PLAN A - PER FAMILY	\$1232	\$1232
PLAN B - PER FAMILY	\$ 673	\$2692
PLAN B - WAGE BASED	\$ 461	\$1848

- **PROTECTION IS PROVIDED FOR TYPICAL HEALTH NEEDS**

AVERAGE AMERICAN FAMILY'S HEALTH CARE SERVICES IN 1990 INCLUDED:

- 5-6 DOCTOR VISITS
- 7 PEDIATRIC VISITS (INCL. 1 ER VISIT FOR TODDLER)
- \$180 IN PRESCRIPTION DRUGS
- \$110 IN DENTAL SERVICES

1 IN 10 AMERICANS ARE HOSPITALIZED IN ANY YEAR. IF HOSPITALIZED, AVERAGE CHARGES ARE \$4,572.

35422033

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MAY-11-1993 00:58

THE ADDED INVESTMENT PROVIDES HEALTH CARE SECURITY

WHAT FAMILIES MUST PAY BEFORE THEY ARE COVERED:

	LEVEL 1	LEVEL 2 HMO	LEVEL 2 BLUE CROSS
PHYSICIAN CARE	\$2000 + 20%	\$10 PER VISIT	\$400 + 20%
RX DRUGS	\$500 + 40%	\$10 PER SCRIPT	\$50 + 40%
DENTAL CARE	NOT COVERED	NOT COVERED	NOT COVERED

- LEVEL 2 OFFERS GOOD FINANCIAL PROTECTION FOR TYPICAL NEEDS, BUT IT'S NOT A CADILLAC EITHER
- LEVEL 1 DOESN'T HELP WITH THE TYPICAL HEALTH NEEDS OF FAMILIES. THE COST IS LOW BECAUSE 94% ARE NOT EXPECTED TO NEED THIS PLAN'S COVERAGE IN A GIVEN YEAR.
- **AFFORDABILITY FOR LOW INCOME FAMILIES**
 - PLAN B SUBSIDIZES DEDUCTIBLES FOR THOSE BELOW 200% OF POVERTY ~~ASSURING AFFORDABILITY FOR THE LOW INCOME WORKER, EARLY RETIREE OR SELF-EMPLOYED PERSON.~~
- **MIDDLE AMERICANS WILL HAVE LONG TERM CARE PROTECTION**
 - ELIGIBILITY FOR HOME CARE BASED ON DISABILITY NOT INCOME

COSTS CAN BE ADJUSTED

- **JUST AS THE COSTS AND ATTRACTIVENESS OF PLAN A CAN BE RAISED SLIGHTLY BY ADDING BENEFITS OR LOWERING DEDUCTIBLES, THE COSTS OF PLAN B CAN BE LOWERED BY ADJUSTING ITS COMPONENTS. BUT THE CORE QUESTIONS REMAIN.**

IF WE ARE REQUIRING THE UNINSURED TO PURCHASE COVERAGE AND SETTING A MINIMUM GUARANTEE FOR THE INSURED:

- **WHAT IS THE THRESHOLD LEVEL OF PROTECTION THE BENEFITS PACKAGE SHOULD PROVIDE?**
- **WHAT LEVEL OF COST BURDEN IS ACCEPTABLE FOR FAMILIES, BUSINESSES AND GOVERNMENT?**

PLAN B OFFERS BALANCE IN POLICY TERMS AND POLITICAL TERMS THAT SHOULD BE THE BASIS FOR OUR CONTINUED WORK.



THE DEPUTY SECRETARY OF THE TREASURY
WASHINGTON, D. C. 20220

Health Care
93 1227 *dfb*
Spec Sec
Revised submission
sent page
me to OMB
now for one
action
upon

June 15, 1993

MEMORANDUM FOR: SECRETARY BENTSEN
FROM: ROGER ALTMAN *RA*
RE: Health Care

Attached is a provocative proposal from Alice Rivlin on the next steps in health care reform. She tells me that Leon Panetta and Bob Rubin are sympathetic.

I'm not particularly enthused because we could lose control of the legislative process. But, this will come up soon.

Attachment

cc: Alicia Munnell
Marina Weiss

Norma
This is a
replacement.
BeRnetts

EXECUTIVE OFFICE OF THE PRESIDENT

12-Jun-1993 03:56pm

TO: Leon E. Panetta
FROM: Alice M. Rivlin
Office of Mgmt and Budget
CC: Joseph Minarik
CC: Nancy-Ann E. Min
SUBJECT: Health Reform

Health reform seems to have dropped off the radar screen except that the press continues to carry stories about various aspects of the "Administration Plan" being described by "senior officials" to Congressional and health industry groups. There is a widespread perception that the Administration already has a firm plan (or is close to one), that it will be quite expensive, that substantial new taxes and/or mandates on business will be required to finance it. This perception, plus the general uncertainty caused by repeated delays and confusing leaks, is damaging the Administration's credibility on deficit reduction and reinforcing the "tax and spend" image when we can least afford it.

I gather, although no one has said this, that the current schedule is to reactivate the health reform decision process in time to propose a health reform bill in early September with still some hope of enactment this calendar year. I would like to propose an alternative; namely, that the Administration release a White Paper, entitled something like "Strategy for Health Reform," as quickly as possible, perhaps as soon as the first of August.

The "Strategy" should make the case for the Administration's approach to health reform as strongly as possible. It should describe what we think is wrong with the health delivery system and why its costs are so high and rising so rapidly. It should explain what managed competition is and why we favor it, what global budgets are, how they would work and why they are necessary, and why we believe considerable state flexibility is desirable.

It should show how costs are related to the level of the standard benefit, illustrating two levels similar to plans A and B. It should show several ways of financing and phasing in a desirable (but not too costly) plan, such as Plan B, but should not choose among them.

The message should be: (1) We have a strategy and a strong case for it; (2) We believe our type of reform can reduce

cost growth and provide better care and coverage; (3) We recognize that there will be initial costs of getting to the new system; (4) We want a full and frank debate about the merits of the plan and how to share the costs.

I believe such a White Paper would reduce the uncertainty, restore a sense of forward momentum on the health front, give the press something real to discuss--without precipitating the train wreck of a new tax proposal. This approach would necessitate recognizing that health reform will require a lot of in-put from the Congress and will not happen this year, but that's realistic.

Can we discuss?



THE DEPUTY SECRETARY OF THE TREASURY
WASHINGTON, D. C. 20220

Knights
93-122766

June 15, 1993

MEMORANDUM FOR: SECRETARY BENTSEN
FROM: ROGER ALTMAN *RA*
RE: Health Care

Attached is a provocative health care reform. I'm sympathetic.

I'm not particularly sympathetic to the legislative process. But

Cookie:

*Makes sure that
the process is
legislated*

1w.

ESM

steps in
the process

of the

Attachment

cc: Alicia Munnell
Marina Weiss

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

12-Jun-1993 03:56pm

TO: Leon E. Panetta

FROM: Alice M. Rivlin
 Office of Mgmt and Budget

CC: Joseph Minarik
CC: Nancy-Ann E. Min

SUBJECT: Health Reform

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Can we discuss?



DEPARTMENT OF THE TREASURY
WASHINGTON

93-122561
ES/C

INFORMATION

June 15, 1993

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Jim Duggan/Marina Weiss
SUBJECT: Health Care Reform Benefits Package
DATE: June 15, 1993

Headed the
with the [unclear] [unclear]
with cost & benefits
✓
MB

SUMMMARY: As you know, the cost of the guaranteed benefits package drives the overall cost of the health reform bill because it affects mandated costs to business [and therefore revenue losses to the Treasury], individual and business subsidies, and increases in Federal costs to upgrade public programs.

In advance of the health reform meetings scheduled for later this week, we thought you might like to review the benefits package currently being considered. You should be aware that the specific provisions of the package [and therefore the costs] are being refined. Accordingly, the attached table should be read as illustrative only, and not as the final proposal. The table outlines the benefit design as of June 1 -- and compares it to the Federal Blue Cross/Blue Shield fee for service plan and to Medicare.

RECOMMENDATION: None, this memo is informational only.

DISCUSSION:

General Observations:

First, a few general observations. Ira Magaziner characterizes the plan under consideration by the Administration as the 20th percentile plan. What he means is that, by comparison with plans offered by a representative sample of 1,000 medium and large size firms, the proposal falls near the 20th percentile when the plans are arrayed according to two criteria -- scope of benefits covered, and cost sharing required by the beneficiary. Using these criteria, Medicare is somewhere below the 10th percentile, Medicaid and the autoworkers plans are above the 90th percentile. Note that since no small businesses are surveyed in establishing the 1,000 firm baseline used to compare plans, the benefits package under development by the health care reform group is probably more generous than the 20th percentile of plans offered by all businesses.

A second observation relates to the estimated cost of the 20th percentile plan. HCFA actuaries and AHCPR economists have been struggling to come to closure on estimates of the cost of this package. However, it is not the mission of these HHS agencies to estimate the cost of privately purchased policies, no one is certain what it will cost to insure the non-working uninsured

population [disabled, early retirees, etc.] and the impact of global budgets/managed care on expenditures is unclear. Therefore, the potential for error in these estimates is significant. You should be aware that staff working on health reform generally believe that the premium estimates displayed here are low.

Our third observation pertains to upgrades in protection against out of pocket costs, and improvements in mental health, dental, and vision coverage. Magaziner continues to refine the scope of covered benefits, focusing on these issues. As noted above, the attached table pertains only to the benefits package as described on June 1 and further expansions are likely.

Plan Comparison:

The major differences between the three plans can be summarized as follows:

1. Premiums: Note that the premiums quoted by HCFA [especially the individual premium] are low. Most analysts believe the number should be \$300 to \$500 higher, an issue that will have to be resolved before government and business costs of the Administration's plan can be properly estimated. The 20th percentile plan calls for a lower employee contribution than that required under the Blue Cross or Medicare plans. The Medicare Part B premium paid by beneficiaries is 25% of the actual premium cost, the remaining 75% is paid by the Federal government through general fund. [For low income elderly, Medicaid pays the 25% premium share.]
2. Coinsurance: Note that the general design cost sharing is more austere under the Blue Cross and Medicare plans than what is contemplated under the 20th percentile proposal.
3. Deductibles: The individual deductible under Medicare is more generous than that used by Blue Cross or in the 20th percentile proposal. However, the amount and frequency of the Medicare hospital deductible makes it far more austere than that of the Blue Cross or 20th percentile plans.
4. Annual Out of Pocket Limit: Part of the purpose of the Medicare Catastrophic Act was to create an annual out of pocket limit for the elderly and disabled. When Medicare Catastrophic was repealed, the out of pocket limit lapsed, leaving beneficiaries with open ended liability. You should be aware, however, that beneficiaries often purchase supplemental Medigap coverage which includes out of pocket limits [or such Medigap coverage is provided by their former employers].
5. Mental Health Coverage: Both Blue Cross and the 20th percentile plan require 40% coinsurance and a \$250 per admission deductible. Medicare policy is more restrictive, applying a 50% coinsurance requirement, an annual benefits limit of \$1,100 for

outpatient services, and a \$676 per admission deductible for inpatient care [up to 6 such deductibles annually]. In addition, Medicare applies a 190-day lifetime limit to mental health coverage.

6. Dental Services: Finally, Blue Cross provides limited dental services which are paid on the basis of a fee schedule. Neither Medicare nor the 20th percentile plan include dental coverage.

Upgrades to the 20th Percentile Plan:

As indicated above, Magaziner is contemplating modifications to improve the 20th percentile plan. As of June 1, the upgrades listed below are being evaluated for inclusion in the package. If approved, these upgrades will increase the cost of the benefit package and will expand its scope of coverage as compared to Medicare and the Blue Cross standard option.

<u>Benefit</u>	<u>Options Being Examined</u>
1. Preventive Care	A. Eliminate cost sharing altogether B. Add services not now covered
2. Prescription Drugs	A. Count coinsurance toward out of pocket limit B. \$200 deductible, 20% coinsurance countable toward out of pocket limit C. \$200 deductible, 20% coinsurance not countable toward limit
3. Durable Medical Equipment	A. Include in package
4. Hospital Services	A. Offer as substitute for hospital services: [1] 100 days extended facility care; [2] home care; [3] hospice care
5. Dental Services	A. Generous package: [1] no cost sharing for prevention, [2] \$200 deductible and 20% coinsurance for restorative services B. Modest package: [1] separate \$50 deductible, [2] 20% coinsurance on preventive services, [3] 40% co-insurance on restorative services
6. Other Services	Include in package: [1] ambulance services, [2] health education and promotion

**Basic Features of 1993 Blue Cross/Blue Shield (standard option),
20th Percentile Plan, and 1993 Medicare Benefits**

Plan Features	Blue Cross/Blue Shield	20th % Plan	Medicare
<i>General Design</i>			
Nonhospital Deductibles			
Individual	\$200	\$200	\$100 (Part B)
Family	\$400	\$400	
Coinsurance	25%	20%	20% (Part B); 25%-100% (Part A) after 60 days
Annual Out of Pocket Limit	\$3,000 per policy	\$3,000 per policy	none
Lifetime Limit	none	none	none
<i>Hospital Services</i>			
Inpatient	\$250 per admission deductible; no coinsurance	\$250 per admission deductible; no coinsurance	\$676 per admission deductible (up to 6/yr); 25-100% coinsurance after 60 days (Part A)
Outpatient	25% coinsurance	20% coinsurance	20% (Part B)
<i>Surgical Services; Physician Services</i>	25% coinsurance	20% coinsurance	20% (Part B)
<i>Preventive Care</i>	25% coinsurance	20% coinsurance	very limited coverage; 20% coinsurance
<i>X-Ray and Lab Tests</i>	25% coinsurance	20% coinsurance	no coinsurance
<i>Prescription Drugs</i>	\$50 per year deductible; 40% coinsurance	\$50 per year deductible; 40% coinsurance	immunosuppressive drugs only - 20% coinsurance
<i>Mental Health*</i>			
Inpatient	\$250 per admission deductible; 40% coinsurance	\$250 per admission deductible; 40% coinsurance	\$676 per admission deductible (up to 6/yr); 25-100% coinsurance
Outpatient	40% coinsurance	40% coinsurance	50% coinsurance (Part B); \$1,100 annual benefit limit
<i>Dental Services</i>	schedule of allowances for various services	none	none
<i>Vision Services</i>	none	none	20% (Part B) - covers eyeglasses after surgery
<i>Annual Premium</i>			
Individual	\$2,180	\$1,394**	\$2,652 (A); \$1,756 (B)
Family	\$4,580	\$3,931	
Employee/ Beneficiary Share	25%	20%	25% (Part B)

*For BC/BS, mental conditions/substance abuse have annual and lifetime benefit limits of \$8,000 and \$50,000, respectively. These limits may apply to the 20th % plan.

**Premium estimates are from HCEA and are under revision



DEPARTMENT OF THE TREASURY
WASHINGTON

INFORMATION

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina L. Weiss
SUBJECT: Health Care Reform/Global Budgets
DATE: June 30, 1993

SUMMARY: This memo summarizes current working group recommendations on the global budget provisions. In general, the role of the Federal government is to establish the framework and rules by which the States implement the budget. As you know, the global budget is scheduled to be in place by 1997. All outyear cost estimates of the plan assume the global budget is holding growth in health care spending to a rate of 5.7% (well below the 9% rate of growth projected if health reform is not enacted).

RECOMMENDATION/OPTIONS: None, this memo is informational only.

DISCUSSION: This memo is based on closely held documents which have not been shared with others on the Task Force.

As you know, the conceptual framework of the proposed health plan is an approach called "managed competition." Managed competition is essentially a generic term used to describe a wide array of techniques employed by insurance companies, HMO's and some large group practices to steer patients to the lowest cost level of treatment consistent with their health care needs. Since some of these techniques are relatively new and untested, CBO and the HCFA actuaries are skeptical about the extent of savings that can be achieved through their use. Therefore, the President has proposed that his reform plan -- while structured to take advantage of the managed competition mechanisms -- also include a "global budget" to ensure cost savings. In other words, you should think of the "global budget" as a cost containment redundancy that has been included only because the CBO and the actuaries will not "score" hard savings without it.

General Concept

The national health care budget centers on the use of the weighted average premium paid in each Regional Health Alliance (the State based organization responsible for implementing the reform plan). Through the budget, Alliances will be assigned a target for how much the average premium in their region can increase each year. For the first 3 years of plan implementation, the Federal government will have responsibility for enforcing the budget -- thereafter, the States will be the responsible party.

Covered Expenditures

Expenditures subject to the budget are all premiums paid for the standard benefit plan, irrespective of whether those premiums are paid by employers, employees, or individuals. Supplemental benefits beyond the standard plan are not included in the budget; nor are premiums for policies where cost sharing by the employee is required.

Medicare and Medicaid expenditures are not subject to the global budget. It is not clear from the materials developed thusfar whether other Federally financed health programs (such as CHAMPUS, VA, DOD) will be subject to the global budget. Presumably costs in these programs would be restrained by imposing an entitlement cap and/or limiting annual increases in appropriations.

Annual Increases

The reform legislation contemplates creation of a National Board which would determine, on an annual basis, the percentage by which health care premiums would be permitted to increase. (I will prepare another memo detailing the role and membership of the National Board).

However, CBO and HCFA will not "score" savings if the legislation does nothing more than create a board and assign it the task of setting a rate of growth for health care premiums. Therefore, the working group proposal details the following formula by which the Board would determine growth rates.

Consumer Price Index (CPI) + 1% (There would also be an additional adjustment equal to 2% in the first year and 1% in the second year).

The allowable percentage increase would be adjusted on an Alliance by Alliance basis to reflect demographic changes including age and gender of the covered population.

Baseline Budget Targets

The actual task of setting the budget begins with the Board calculating the amount of health care spending that occurs on a national basis and converting that total spending into a per capita number.

The second step in the process is for the Board to allocate Alliance-specific global budget targets which they calculate taking into account total national spending, geographic variations, and actual bids submitted to each Alliance by health plans (insurers) who wish to do business with the State agency.

Process For Making Adjustments in Targets Over Time

The National Board is instructed to appoint an Advisory Commission to recommend adjustments to the methodology for calculating Alliance premium targets over time.

The Board is also directed to provide States and Alliances with information about regional differences in health care costs and practice patterns of physicians and other providers. The Commission's charge is to work toward narrowing the variation in health spending across States due to differences in practice patterns. However, adjustments to targets cannot be made without Congressional action.

Federal Enforcement of the Budget

For the first three years of full implementation (1997-1999), the Federal government will assume responsibility for enforcing Alliance budgets.

Each year, Alliances submit for approval their proposed health plan premiums and fee schedules. Based on the proposed premiums, the Board would then calculate the average premium for each Alliance.

If an Alliance's average premium exceeds its assigned budget target, the National Board may take any of the following actions to control spending for the balance of the year:

1. Require the Alliance to re-negotiate premiums with participating health plans (insurers);
2. freeze new enrollment in high-cost plans;
3. impose a surcharge on high-cost plans and provide rebates to low-cost plans.

In addition, the Board would notify health plans participating in the Alliance that premiums will be re-negotiated or regulated at mid-year if interim steps do not bring spending under control.

At the end of the year, the Board calculates an updated average premium for each Alliance.

If the updated average premium exceeds the budget, the Board takes steps to ensure that premiums are brought into line with the allowable budget. Beginning mid-year, the Board requires the Alliance to adopt the lower set of premium rates by either re-negotiating premium rates or freezing premium rates at the prior year level (adjusted for the Alliance specific inflation factor).

To determine premiums for the following year, the Alliance again negotiates with its health plans and submits the results to the National Board for approval. If the expected average premium is within the allowable budget, the Alliance follows normal

procedures for determining future budgets and premiums. If, however, the average premium exceeds the budget target, the Board continues to supervise the setting of premiums for the health plans in that Alliance.

NOTE: When an Alliance exceeds its budget, the Board holds the authority to regulate rates paid to providers.

Enforcement When a State is Responsible for the Budget

A State may assume responsibility for the budget any time after universal coverage through the Alliances begins. However, by the year 2000 all States must assume budget responsibility.

States have a financial incentive to hold premiums below the target established by the Board. Specifically, States can retain 50% of any Federal savings in subsidies paid to low income families if the average premiums across all health plans in the Alliance total less than the budget target.

Conversely, if actual premiums paid total more than the Alliance target, then the State is financially responsible for the additional subsidy costs.

The annual budget for spending on health care in an Alliance is the inflation factor plus a band of 1%. A State is permitted to roll forward one half of the band unused in a given year, but cannot accumulate more than a maximum of 5% over time.

If a State exceeds the band in one year, then it must submit to Federal enforcement action in the following year. In that circumstance, the Board sets a maximum allowable premium for each health plan in the State's Alliance.

When a State is under Federal enforcement, the Board also holds the authority to regulate rates paid to individual providers. In addition, any health plan in the Alliance can submit a request to the Board to regulate providers' rates.

Tools Available to States and Alliances to Meet Premium Targets

Alliances have the authority to control costs through premium negotiations and to refuse to contract with a plan whose premiums are too high. Specific tools available to States to contain costs include:

1. Premium negotiation and regulation;
2. limiting enrollment in high-cost plans to reduce the average premium (limits can be imposed by freezing enrollment, surcharging high cost plans, or rebating low cost plans);
3. setting or regulating provider rates; and
4. controlling the supply and allocation of resources (health planning).

Budgeting Corporate Alliances

Firms of some as yet indeterminate size (1,000 employees or 5,000 employees are the two thresholds most often discussed) would be permitted to remain outside of the Regional Alliance and would, instead, self-insure as a "Corporate Alliance."

However, if a large employer plan fails to meet Federal budget goals, that employer would be required to join the Regional Health Alliance.

The inflation factor for health spending in the Corporate Alliances will be calculated using the following formula:

CPI + 1% (a three year moving average would be used to calculate the CPI)

There would be a phase-in adjustment equal to 2% in the first year and 1% in the second year.

The National Board would develop a methodology for calculating the annual premium equivalent per employee within the Corporate Alliance. Three years after implementation, every Corporate Alliance would be required to report to the Department of Labor its average premium equivalent per employee.

If the increase in the reported average premium exceeds the allowed inflation factor in two of any three year period, the Department of Labor may require the employer to purchase its health coverage through the Regional Alliance.

No penalties for failure to comply have been articulated as yet.

TREASURY CLEARANCE SHEET

NO. 93-123135
 Date June 30, 1993

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Marina L. Weiss

THROUGH: _____

SUBJECT: Health Care Reform/Global Budgets

REVIEW OFFICES (Check when office clears)

- Under Secretary for Finance
 - Domestic Finance
 - Economic Policy
 - Fiscal
 - FMS
 - Public Debt

- Under Secretary for International Affairs
 - International Affairs

- Enforcement
 - ATF
 - Customs
 - FLETC
 - Secret Service
 - General Counsel
 - Inspector General
 - IRS
 - Legislative Affairs
 - Management
 - OCC

- Policy Management
 - Scheduling
 - Public Affairs/Liaison
 - Tax Policy
 - Treasurer
 - E & P
 - Mint
 - Savings Bonds
- Other _____

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Weiss, Marina	<i>MW</i>	6/30/93	DAS for Health Policy	2-0090
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date



DEPARTMENT OF THE TREASURY
WASHINGTON

93124010

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina L. Weiss
SUBJECT: July 26, 10:00 a.m. Roosevelt Room Meeting
DATE: July 23, 1993

SUMMARY: Staff have not received a detailed agenda for the 10:00 a.m. meeting, however informal discussion in the health care reform working groups suggests the focus of the meeting is likely to be timing of the release of three initiatives: health care reform, NAFTA and reinventing government.

All have been described to the press as ready for release in mid-September, and White House staff are anxious to work out a schedule to maximize media coverage.

RECOMMENDATION: I recommend strongly that every effort be made to meet the President and First Lady's promise of a September release date for the health care reform plan. However, I would also recommend that the actual proposal be released in the form of a 100-125 page "white paper," rather than as detailed legislative specifications.

Health staff with other NEC members are uniform in their support of this approach -- however, not all health staff are aware of the agenda for the July 26 meeting. Therefore, if you were to propose a "white paper" approach, NEC members may not know that their staff would recommend they speak in support of the proposal. The information outlined below is highly sensitive and confidential.

OPTIONS:

 LW Agree with recommendation, will so advise those at the Monday meeting

___ Prefer not to take a position on this issue at this time

___ Other:

DISCUSSION: As you know, Ira Magaziner has prepared briefing papers on a health care reform proposal for the First Lady and the President. Staff working on the health plan have been told that the briefings were scheduled for this weekend. However, in light of the President and First Lady's unexpected trip to Little Rock, it is not clear whether the briefings will actually be held.

Working group staff do not have copies of the briefing materials -- including the financing section and the cost estimates. Ira disaggregated tasks for the agencies involved, so that although individual agencies took part in the estimating exercise, no one agency had access to the full set of data. Based on the assumptions provided Treasury for revenue estimating purposes and cross-agency consultations, however, staff have been able to piece together the following information about what we believe the plan to include:

1. The premiums were calculated as though the plan was fully implemented by 1994. Premiums range from a low of \$1619 per year for a single individual whose employer functions as its own "corporate alliance" to \$4184 for 2 parents with children where insurance is purchased through the State-based alliance.

2. Growth in health care spending is held, via the global budgeting assumptions, to growth in the overall economy during the early years of the plan -- and to GDP minus 1% in the outyears. In other words, growth is reduced from the currently projected levels of 8.5% to about 3% by the year 2000.

3. The system is based on an employer mandate. New spending by the Federal government is estimated to be \$89b in 1996 -- rising at a rate of GDP in 1997-98, thereafter the rate drops to GDP-1. The \$89b is composed of: \$17b in Medicare drugs, \$50b in subsidies, \$6b in public health, \$3b in administrative funding, \$5b to begin expanding long term care coverage.

Spending cuts in Medicare and Medicaid fund the lion's share of these expansions -- \$50b in 1996, reaching a total of \$140b in the year 2000.

4. Aside from the employer mandate [described by Magaziner as a premium], revenue increases in this proposal appear to be limited to an increase in the tobacco tax and a "recapture" or provider tax penalty of 12% that triggers when a State alliance fails to meet its budget target.

not realistic *How much?*
Relying on Medicare cuts and recapture of funds from State Medicaid programs as the principal sources of funding for this initiative is potentially very explosive. Moreover, the details of the Federal mandate on business, the Alliance structure, and the global budget are certain to provoke opposition from employers, States, insurers and providers. In fact, it is not clear to me where support for the plan as currently drafted might be found.

Therefore, in order to meet the President and First Lady's stated goal of a mid-September release, while preserving the Administration's options for modifying the plan as we go along, I recommend that a narrative description of 100-125 pages in length be prepared and released to the public. The draft can be described as a working document. This approach will enable the

12/2000

Administration to solicit the views of interested parties [including members of Congress]; to gauge the intensity and direction of criticism; and to refine its position on issues where re-alignment seems reasonable without appearing to have "lost" on important provisions. ✓

This approach has another advantage that should be attractive to those who wish to turn to NAFTA and reinventing government initiatives. If a "white paper" or working draft of health reform is released in September, it will be obvious that the Administration intends to work with interested parties over a several week/month period. In fact, the Administration could work with congressional committees of jurisdiction to ensure that a hearings schedule is announced immediately following the release of the draft plan.

The Administration could then launch its NAFTA and reinventing government proposals which could be brought to closure in a process parallel to hearings on health reform.

Jan. - more probable

The critical issue here is to press for an approach that acknowledges at the time of release that the Administration views its health proposal as a dynamic document, a working draft which it will refine over the course of the Fall as it consults with Members of Congress and others interested in the initiative.



DEPARTMENT OF THE TREASURY
WASHINGTON

124400

TO: Secretary Bentsen
FROM: Marina L. Weiss
SUBJECT: Health Care Reform Meeting
DATE: August 8, 1993

SUMMARY: Ira Magaziner has scheduled a health care reform meeting for 11:30-2:00 today. In addition to yourself, participants in the meeting include Bob Rubin, Laura Tyson, Secretary Shalala, and Alice Rivlin. In addition, some staff will be present. No written materials have been provided for use at the meeting. However, I have outlined below the list of items I believe Ira is interested in discussing this week. As you may know, the President has asked for recommendations by the end of this week. It is my understanding that there will be health reform meetings each day this week.

RECOMMENDATION: I recommend strongly that you and others insist on access to written materials. Secretary Shalala has had such materials for some weeks, it seems only reasonable that others who are being asked to develop recommendations for the President have access to the same materials. You may be offered a 20 page narrative on the proposal -- that is a summary for use with the press. What you need is the 250 page policy book (you have seen some excerpts regarding global budgets, short term cost controls, and administration). You have not yet seen the financing section of the policy book.

DISCUSSION: I spoke with Ira by telephone this weekend and learned that he is interested in discussing the following provisions of the proposal:

1. Size of the program and phase-in schedule. On this issue, I recommend focusing on size, since phase-in will be automatically delayed by the need for States to create the necessary infrastructure (alliances), and for the Federal government to develop programs and to deploy staff (global budgets, Medicare drug benefit, National Board, long term care coverage). Bob Rubin will argue for controlling the size of the program by beginning with a catastrophic plan only -- and phasing in the more extensive coverage as funding permits. While this is certainly a reasonable approach, he is likely to be turned down by the First Lady and others.
2. Budget level -- global budgets. As you know, Secretary Shalala learned of the plan to impost a baseline limit of GDP and GDP-1 on the Medicare and Medicaid programs as a way of financing new public expenditures for health care reform. She objected and

has been able to move the debate to GDP+1%. Without reform the cost of health care is expected to grow at a rate of more than 8% (nearly 10% when adjusted for aging of the population), GDP+1 still produces substantial outyear savings. The trick here is to find a reasonable budget path -- but even more importantly, to focus on the enforcement mechanism. The most recent budget documents suggest that Magaziner is interested in extinguishing health related tax deductions and other preferences for businesses located in States where a nationally set budget limit is exceeded. Tax Policy staff are deeply concerned about this option.

3. Funding of the mandate. Magaziner will propose a compromise between the current policy of a per capita premium based system and shifting to a new payroll based system. His compromise calls for a limit or "cap" on percent of payroll that a low wage employer would pay (3.2% has been discussed). In addition, he proposes to cap the overall amount an employer would have to pay if the employer has 50 or fewer employees (4% is the latest figure I have heard).

Nevertheless, employers would be mandated to contribute to the cost of insuring their workforce -- the basic rule would be 80% of the cost of the overall premium.

4. Size of the Alliance. This issue continues to influence the debate. The tension is between wanting a large pool of employers in the regional alliance (State based group) in order to spread risk and lower premiums -- especially for small companies -- and the large self-insured employers' opposition to being included in the regional pool.

Currently, the First Lady is pressing for a threshold of 5,000 employees (firms with fewer would be required to enroll in the State alliance, those of more than 5,000 would be permitted to remain outside the State alliance and would instead be deemed a "corporate alliance"). The Chamber of Commerce would prefer to keep the threshold at 100 employees.

5. Short Term Cost Controls. This issue is of greatest concern to the CEA because it involves the potential for wage and price controls on the health industry. In truth, the single most difficult issue here is that global budgets will not be operational before 1997, thereby leaving the health care industry ample opportunity to drive up their prices before the global budget takes effect. The First Lady has been working with the AMA, American Hospital Association and others on a possible compromise involving "voluntary" price restraint with "back-up" legislative authority for the President to invoke wage and price controls if the industry exceeds legislatively established budget targets.

II. In addition, Ira may raise the issue of timing with respect to NAFTA and Vice President Gore's "Reinventing Government"

initiative. As recommended in your talking points for "Face the Nation," staff suggests delaying the Gore initiative until later in the year and double teaming NAFTA and health reform.

Since NAFTA is further along and faces a 1-1-94 deadline, it seems reasonable to handle that issue at the full committee level (trade staff are not needed on the health care proposal). A narrative description of the health reform initiative can be sent up to the Hill in September and appropriate subcommittees can begin the hearings process. Given the scope of the health initiative, more than 40 Committees and subcommittees can be expected to want to participate in the development of a bill.

124491



DEPARTMENT OF THE TREASURY
WASHINGTON

August 9, 1993

MEMORANDUM

TO: MARINA WEISS

FROM: SECRETARY BENTSEN'S SCHEDULING OFFICE
Kevin Varney *KV*

MEETING: White House Health Care Meetings

DATE: Tuesday, August 10, 1993

TIME: 2:30 p.m.

LOCATION: Indian Treaty Room, OEOB

DURATION: approximately 3 hours

PARTICIPANTS: Secretary Bentsen
Ira Magaziner
Roger Altman
Secretary Reich
Secretary Shalala
Alice Rivlin
Bob Rubin
Laura Tyson
Nancy Min
Carol Rasco

REMARKS REQUIRED: No

BRIEFING REQUIRED: To be prepared by Marina Weiss

MEDIA COVERAGE: No

CONTACT: Marjorie 456-6406

cc: Secretary's Office
Chief of Staff
Exec. Sec. ~~XXXXXX~~
Josh Steiner
General Counsel
Public Affairs
Legislative Affairs
USSS



DEPARTMENT OF THE TREASURY
WASHINGTON

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina L. Weiss
SUBJECT: 2:30 Health Reform Meeting
DATE: August 9, 1993

SUMMARY: Attached for your use is a copy of yesterday's memo. Also attached is an earlier memo on global budgets. At our staff meeting this morning, Ira indicated that today's agenda item would be the global budget. The Secretary's question of 8-8-93 about the global budget enforcement mechanism was never fully answered. This is a critical issue because the Federal government's ability to control its costs depends almost entirely on the effectiveness of the global budget.

If discussion of the global budget does not take the full amount of meeting time, I would recommend you move to a discussion of the enforcement mechanism associated with the employer mandate. It is my understanding that Ira's current thinking is that the mandate be enforced with some form of a tax penalty on non-compliance employers.

RECOMMENDATION: Considerable staff work has been done on the issues of global budgeting and employer mandates. However, Ira has not discussed the nitty-gritty compliance mechanisms with NEC members. Since these two mechanisms are central to the success of the program, I would recommend strongly that you press for a step by step walk-through, focusing on who has responsibility for the following aspects of the new program: (1) the new entitlement to health coverage; (2) financing of the coverage and subsidies to individuals/employers; and (3) enforcement of the global budget under which costs are controlled.

DISCUSSION: As currently structured, the reform proposal gives every U.S. citizen under the age of 65 a new Federal entitlement to health care coverage. In addition, low income citizens have a Federally guaranteed right to receive subsidies intended to help them pay their 20% portion of the premium cost -- they are also entitled to help in paying any co-payments required at the point of service. (In addition, there is a Federal guarantee of subsidies to certain businesses.) As you know, the cost to the Treasury of the subsidies increases as the cost of the benefit package goes up.

The Federal guarantee of coverage is to be paid for largely through an employer/employee mandate which is enforced ultimately by the Federal government. However, the most recent round of estimates assumes that the Federal government is liable for

something on the order of \$50b to \$60b in subsidies for individuals and certain employers. The entitlement is administered at the State level by a non-profit regional alliance (or by corporate alliances where an individual is employed by a firm of more than 5,000 employees). Note that the regional alliances are not at financial risk for the cost of these entitlements, yet Ira envisions them as the bargaining mechanism through which lowest cost insurance is obtained.

It is therefore critical to explore the degree to which the Federal government may be at financial risk if the alliances are unable or unwilling to keep costs down. If one believes in "managed competition," then the marketplace should perform that role. However, neither the actuaries nor CBO credit managed competition with significant savings. Instead, the estimates that have been made of the cost of the proposal assume that the global budget is the tool through which Federal financial exposure is limited.

Attached for your review is an earlier memo on the global budget. Note that the ultimate enforcement mechanism, as described by Ira yesterday, has been modified. The new fail-safe mechanism involves an assessment (tax) on premiums when the regional alliance fails to live within the budget target specified by the National Board. The rationale is that a tax on insurers will encourage alliances to negotiate more aggressively for lower prices with hospitals, doctors and other providers of care.



DEPARTMENT OF THE TREASURY
WASHINGTON

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina L. Weiss
SUBJECT: Health Care Reform Meeting
DATE: August 8, 1993

SUMMARY: Ira Magaziner has scheduled a health care reform meeting for 11:30-2:00 today. In addition to yourself, participants in the meeting include Bob Rubin, Laura Tyson, Secretary Shalala, and Alice Rivlin. Some staff will be present. No written materials have been provided for use at the meeting. However, I have outlined below the list of items I believe Ira is interested in discussing this week. As you may know, the President has asked for recommendations by the end of this week. It is my understanding that there will be health reform meetings each day this week.

RECOMMENDATION: I recommend strongly that you and others insist on access to written materials. Secretary Shalala has had such materials for some weeks, it seems only reasonable that others who are being asked to develop recommendations for the President have access to the same materials. You may be offered a 20 page narrative on the proposal -- that is a summary for use with the press. What you need is the 250 page policy book (you have seen some excerpts regarding global budgets, short term cost controls, and administration). You have not yet seen the financing section of the policy book.

DISCUSSION: I spoke with Ira by telephone this weekend and learned that he is interested in discussing the following provisions of the proposal:

1. Size of the program and phase-in schedule. On this issue, I recommend focusing on program size (scope of benefits), since phase-in will be automatically delayed by the need for States to create the necessary infrastructure (alliances), and for the Federal government to develop its portion of the program and to deploy staff (global budgets, Medicare drug benefit, National Board, long term care coverage). Bob Rubin will argue for controlling the size of the program by beginning with a catastrophic plan only -- and phasing in the more extensive coverage as funding permits. While this is certainly a reasonable approach, he is likely to be turned down by the First Lady and others. Note that it is the intention of the group to make coverage universal by 1-1-96.

2. Budget level -- global budgets. As you know, Secretary Shalala learned of the plan to impose a baseline limit of GDP and GDP-1 on the Medicare and Medicaid programs as a way of financing new public expenditures for health care reform. She objected and

has been able to move the debate to GDP+1% (though you should be aware that Shalala would like to reach GDP+1 over several years - she is concerned about an excessively abrupt reduction in rate of growth). Without reform the cost of health care is expected to grow at a rate of more than 8% (nearly 10% when adjusted for aging of the population), GDP+1 still produces substantial outyear savings. The trick here is to find a reasonable budget path -- but even more importantly, to focus on the enforcement mechanism. The most recent budget documents suggest that Magaziner is interested in extinguishing health related tax deductions and other preferences for businesses located in States where a nationally set budget limit is exceeded. Tax Policy staff are deeply concerned about this option.

In the alternative, Magaziner may offer an enforcement mechanism that calls for automatic limits on premium increases (accomplished by imposing a tax on insurers). Note that the Federal government is responsible for enforcement if States are unwilling or unable to do so.

3. Funding of the mandate. Magaziner will propose a compromise between the current policy of a per capita premium based system and shifting to a new payroll based system. His compromise calls for a limit or "cap" on percent of payroll that a low wage employer would pay (3.2% has been discussed). In addition, he proposes to cap the overall amount an employer would have to pay if the employer has 50 or fewer employees (4% is the latest figure I have heard).

Nevertheless, employers would be mandated to contribute to the cost of insuring their workforce -- the basic rule would be 80% of the cost of the overall premium.

4. Size of the Alliance. This issue continues to influence the debate. The tension is between wanting a large pool of employers in the regional alliance (State based group) in order to spread risk and lower premiums -- especially for small companies -- and the large self-insured employers' opposition to being included in the regional pool.

Currently, the First Lady is pressing for a threshold of 5,000 employees (firms with fewer would be required to enroll in the State alliance, those of more than 5,000 would be permitted to remain outside the State alliance and would instead be deemed a "corporate alliance"). The Chamber of Commerce would prefer to keep the threshold at 100 employees.

5. Short Term Cost Controls. This issue is of greatest concern to the CEA because it involves the potential for wage and price controls on the health industry. In truth, the single most difficult issue here is that global budgets will not be operational before 1997, thereby leaving the health care industry ample opportunity to drive up their prices before the global budget takes effect. The First Lady has been working with the

AMA, American Hospital Association and others on a possible compromise involving "voluntary" price restraint with "back-up" legislative authority for the President to invoke wage and price controls if the industry exceeds legislatively established budget targets.

II. In addition, Ira may raise the issue of timing with respect to NAFTA and Vice President Gore's "Reinventing Government" initiative. As recommended in your talking points for "Face the Nation," staff suggests delaying the Gore initiative until later in the year and double teaming NAFTA and health reform.

Since NAFTA is further along and faces a 1-1-94 deadline, it seems reasonable to handle that issue at the full committee level (trade staff are not needed on the health care proposal). A narrative description of the health reform initiative can be sent up to the Hill in mid-September and appropriate subcommittees can begin the hearings process. Given the scope of the health initiative, more than 40 Committees and subcommittees can be expected to want to participate in the development of a bill.



DEPARTMENT OF THE TREASURY
WASHINGTON

INFORMATION

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina L. Weiss
SUBJECT: Health Care Reform/Global Budgets
DATE: June 30, 1993

SUMMARY: This memo summarizes current working group recommendations on the global budget provisions. In general, the role of the Federal government is to establish the framework and rules by which the States implement the budget. As you know, the global budget is scheduled to be in place by 1997. All outyear cost estimates of the plan assume the global budget is holding growth in health care spending to a rate of 5.7% (well below the 9% rate of growth projected if health reform is not enacted).

RECOMMENDATION/OPTIONS: None, this memo is informational only.

DISCUSSION: This memo is based on closely held documents which have not been shared with others on the Task Force.

As you know, the conceptual framework of the proposed health plan is an approach called "managed competition." Managed competition is essentially a generic term used to describe a wide array of techniques employed by insurance companies, HMO's and some large group practices to steer patients to the lowest cost level of treatment consistent with their health care needs. Since some of these techniques are relatively new and untested, CBO and the HCFA actuaries are skeptical about the extent of savings that can be achieved through their use. Therefore, the President has proposed that his reform plan -- while structured to take advantage of the managed competition mechanisms -- also include a "global budget" to ensure cost savings. In other words, you should think of the "global budget" as a cost containment redundancy that has been included only because the CBO and the actuaries will not "score" hard savings without it.

General Concept

The national health care budget centers on the use of the weighted average premium paid in each Regional Health Alliance (the State based organization responsible for implementing the reform plan). Through the budget, Alliances will be assigned a target for how much the average premium in their region can increase each year. For the first 3 years of plan implementation, the Federal government will have responsibility for enforcing the budget -- thereafter, the States will be the responsible party.

Covered Expenditures

Expenditures subject to the budget are all premiums paid for the standard benefit plan, irrespective of whether those premiums are paid by employers, employees, or individuals. Supplemental benefits beyond the standard plan are not included in the budget; nor are premiums for policies where cost sharing by the employee is required.

Medicare and Medicaid expenditures are not subject to the global budget. It is not clear from the materials developed thusfar whether other Federally financed health programs (such as CHAMPUS, VA, DOD) will be subject to the global budget. Presumably costs in these programs would be restrained by imposing an entitlement cap and/or limiting annual increases in appropriations.

Annual Increases

The reform legislation contemplates creation of a National Board which would determine, on an annual basis, the percentage by which health care premiums would be permitted to increase. (I will prepare another memo detailing the role and membership of the National Board).

However, CBO and HCFA will not "score" savings if the legislation does nothing more than create a board and assign it the task of setting a rate of growth for health care premiums. Therefore, the working group proposal details the following formula by which the Board would determine growth rates.

Consumer Price Index (CPI) + 1% (There would also be an additional adjustment equal to 2% in the first year and 1% in the second year).

The allowable percentage increase would be adjusted on an Alliance by Alliance basis to reflect demographic changes including age and gender of the covered population.

Baseline Budget Targets

The actual task of setting the budget begins with the Board calculating the amount of health care spending that occurs on a national basis and converting that total spending into a per capita number.

The second step in the process is for the Board to allocate Alliance-specific global budget targets which they calculate taking into account total national spending, geographic variations, and actual bids submitted to each Alliance by health plans (insurers) who wish to do business with the State agency.

Process For Making Adjustments in Targets Over Time

The National Board is instructed to appoint an Advisory Commission to recommend adjustments to the methodology for calculating Alliance premium targets over time.

The Board is also directed to provide States and Alliances with information about regional differences in health care costs and practice patterns of physicians and other providers. The Commission's charge is to work toward narrowing the variation in health spending across States due to differences in practice patterns. However, adjustments to targets cannot be made without Congressional action.

Federal Enforcement of the Budget

For the first three years of full implementation (1997-1999), the Federal government will assume responsibility for enforcing Alliance budgets.

Each year, Alliances submit for approval their proposed health plan premiums and fee schedules. Based on the proposed premiums, the Board would then calculate the average premium for each Alliance.

If an Alliance's average premium exceeds its assigned budget target, the National Board may take any of the following actions to control spending for the balance of the year:

1. Require the Alliance to re-negotiate premiums with participating health plans (insurers);
2. freeze new enrollment in high-cost plans;
3. impose a surcharge on high-cost plans and provide rebates to low-cost plans.

In addition, the Board would notify health plans participating in the Alliance that premiums will be re-negotiated or regulated at mid-year if interim steps do not bring spending under control.

At the end of the year, the Board calculates an updated average premium for each Alliance.

If the updated average premium exceeds the budget, the Board takes steps to ensure that premiums are brought into line with the allowable budget. Beginning mid-year, the Board requires the Alliance to adopt the lower set of premium rates by either re-negotiating premium rates or freezing premium rates at the prior year level (adjusted for the Alliance specific inflation factor).

To determine premiums for the following year, the Alliance again negotiates with its health plans and submits the results to the National Board for approval. If the expected average premium is within the allowable budget, the Alliance follows normal

procedures for determining future budgets and premiums. If, however, the average premium exceeds the budget target, the Board continues to supervise the setting of premiums for the health plans in that Alliance.

NOTE: When an Alliance exceeds its budget, the Board holds the authority to regulate rates paid to providers.

Enforcement When a State is Responsible for the Budget

A State may assume responsibility for the budget any time after universal coverage through the Alliances begins. However, by the year 2000 all States must assume budget responsibility.

States have a financial incentive to hold premiums below the target established by the Board. Specifically, States can retain 50% of any Federal savings in subsidies paid to low income families if the average premiums across all health plans in the Alliance total less than the budget target.

Conversely, if actual premiums paid total more than the Alliance target, then the State is financially responsible for the additional subsidy costs.

The annual budget for spending on health care in an Alliance is the inflation factor plus a band of 1%. A State is permitted to roll forward one half of the band unused in a given year, but cannot accumulate more than a maximum of 5% over time.

If a State exceeds the band in one year, then it must submit to Federal enforcement action in the following year. In that circumstance, the Board sets a maximum allowable premium for each health plan in the State's Alliance.

When a State is under Federal enforcement, the Board also holds the authority to regulate rates paid to individual providers. In addition, any health plan in the Alliance can submit a request to the Board to regulate providers' rates.

Tools Available to States and Alliances to Meet Premium Targets

Alliances have the authority to control costs through premium negotiations and to refuse to contract with a plan whose premiums are too high. Specific tools available to States to contain costs include:

1. Premium negotiation and regulation;
2. limiting enrollment in high-cost plans to reduce the average premium (limits can be imposed by freezing enrollment, surcharging high cost plans, or rebating low cost plans);
3. setting or regulating provider rates; and
4. controlling the supply and allocation of resources (health planning).

Budgeting Corporate Alliances

Firms of some as yet indeterminate size (1,000 employees or 5,000 employees are the two thresholds most often discussed) would be permitted to remain outside of the Regional Alliance and would, instead, self-insure as a "Corporate Alliance."

However, if a large employer plan fails to meet Federal budget goals, that employer would be required to join the Regional Health Alliance.

The inflation factor for health spending in the Corporate Alliances will be calculated using the following formula:

CPI + 1% (a three year moving average would be used to calculate the CPI)

There would be a phase-in adjustment equal to 2% in the first year and 1% in the second year.

The National Board would develop a methodology for calculating the annual premium equivalent per employee within the Corporate Alliance. Three years after implementation, every Corporate Alliance would be required to report to the Department of Labor its average premium equivalent per employee.

If the increase in the reported average premium exceeds the allowed inflation factor in two of any three year period, the Department of Labor may require the employer to purchase its health coverage through the Regional Alliance.

No penalties for failure to comply have been articulated as yet.



DEPARTMENT OF THE TREASURY
WASHINGTON

INFORMATION

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina
SUBJECT: Republican Health Care Statement
DATE: August 19, 1993

Attached for your review is a copy of the "manifesto" issued by Senate Republicans. Particularly striking are the similarities between the Republican statement and many of the features of the health plan being developed for the President [universal coverage, insurance reform, subsidies, health cooperatives, etc.].

AMB

Very interesting

Senate Republican Health Care Task Force Consensus Principles for Health Care Reform

SIGNATORIES

Robert F. Bennett (UT)	Judd Gregg (NH)
Christopher S. Bond (MO)	Orrin G. Hatch (UT)
Conrad Burns (MT)	Mark Hatfield (OR)
John H. Chafee (RI)	Nancy Landon Kassebaum (KS)
Bill Cohen (ME)	Dirk Kempthorne (ID)
John C. Danforth (MO)	Richard Lugar (IN)
Bob Dole (KS)	Frank Murkowski (AK)
Pete Domenici (NM)	Larry Pressler (SD)
Dave Durenberger (MN)	Alan Simpson (WY)
Lauch Faircloth (NC)	Arlen Specter (PA)
Slade Gorton (WA)	Ted Stevens (AK)
Charles E. Grassley (IA)	John W. Warner (VA)

Statement of Principles

We believe that the following three goals are fundamental to a successful health care reform effort:

1. Quality of care must be maintained;
2. Every citizen must be covered;
3. The growth of health care costs must be restrained.

As members of the Senate Republican Health Care Task Force, we have been working to devise a proposal for comprehensive reform to achieve these goals. Health care reform will not and should not be forced on the American people by one political party. If we are to restructure a large part of our economy, we must do so together, Republicans and Democrats, with the participation of consumers, providers, and the American people.

The United States offers the finest health care in the world. For the eighty-five percent of Americans who are currently insured, our system offers the world's highest quality and most technologically-advanced care. For the seriously ill, our skilled providers and state-of-the-art

treatments offer greater hope than any other system in the world. And those employed by large companies are often able to choose from a variety of health insurance options with reasonable premiums.

The health care industry represents one-seventh, or fifteen percent, of our economy. Hospitals, physicians' offices, visiting nurses, nursing homes, medical schools, equipment manufacturers, research institutions and many other health care-related endeavors employ some 12 million people -- over twice the number employed by the defense industry.

On the other hand, families, businesses, and governments are struggling to keep pace with ever-increasing health-related costs. Currently, Americans spend more for health care than any country in the world. Our federal deficit grows larger and larger, driven to a considerable extent by spiraling health costs.

Yet, despite this spending, even those with insurance fear that their coverage, or that of their loved ones, is not secure. For those not employed by a large company, the cost of insurance is often out of reach. And, for the fifteen percent of Americans without insurance, getting treatment for an illness is an uncertain proposition, while preventive care is frequently unavailable and often underutilized.

Our challenge is to solve these problems, provide coverage for everyone and preserve the elements of our system that all Americans value. The following are the concepts upon which our reform proposal will be based.

Right of Choice and Flexibility

The primary goal of reform should be to give all Americans an equal opportunity to influence the cost and quality of the health care they receive. The centerpiece of any plan must not be government micro-management. Instead, we believe the rules by which insurers, purchasers and providers operate must be changed in order to put all three on equal footing.

Large businesses today can constrain their health care costs by exercising their marketplace purchasing power. Thus, their employees often have the benefit of generous family insurance coverage with low cost-sharing requirements.

By helping them to join together, we can give small businesses and

individuals the same opportunity. We believe a system of private-sector purchasing cooperatives for small businesses and individuals could provide the solution. These cooperatives should not be government-run bureaucracies, but rather, non-regulatory facilitators -- owned and operated by the members they serve.

Insurance plans would be offered through the purchasing cooperatives to individuals and the employees of small businesses. All plans would be required to meet certain standards to protect consumers.

The current practice of "cherry picking" (attracting the healthiest people with low premiums, while refusing to cover those who are sick) is wrong. Today we have a system where one is only a heart attack away from losing his or her health insurance. We believe insurers should be prohibited from canceling any policy or raising the cost of premiums when someone becomes ill.

We also favor changes to ensure that anyone who moves from one area to another, or changes jobs, can continue to get insurance coverage.

In addition, defined comparable benefit packages should be established, and required to be offered by all plans, to prevent another way of gaming the insurance system -- offering a package of benefits that is attractive only so long as a person is healthy.

We believe that, in combination, these changes would foster an environment in which consumers could exercise choice among plans that are challenged to excel in quality of care and service at an attractive price. We also believe that Medicare beneficiaries should be given real opportunities to choose a health plan with better benefits -- such as drug coverage -- which is also more cost-effective. Likewise, Medicaid beneficiaries, who now have a difficult time finding care, should be able to choose an alternative plan.

Containing Costs

This new environment will give consumers much greater power to ensure that health care providers and insurers provide high quality care and make efficient use of our health care resources. We believe a significant decrease in the rate of growth for health care spending will be achieved in both private and public programs.

In addition, we firmly believe that reform of our medical liability laws is essential to bringing the cost of our system under control. Excessive medical tests and procedures performed defensively by doctors, continue to drive up health care costs.

agree

We believe another area that offers tremendous hope for improving quality and reducing costs is building a computerized health care information infrastructure. The costs of manual processing and paper shuffling inherent in our insurance claims system today adds \$135 billion a year to the cost of care -- in addition to bedeviling consumers with complex forms.

With uniform standards and strong statutory protection to ensure privacy and confidentiality, every American could have a personal health card -- like an ATM bank card -- to provide vital health information electronically to their doctor. For travelers such a system might mean the difference between life and death. A computerized system like this would help with outcomes research, and would eliminate fraud and unnecessary health procedures.

agree

Finally, we believe consumers must all be given an equal financial stake in the cost of care. One way to achieve this goal is to reform the tax code.

Our tax system has inequities which permit corporations to deduct the full cost of providing expensive gold-plated health coverage to their employees. On the other hand, farmers, ranchers, truck-drivers and other self-employed persons can deduct only 25% of their health insurance premium.

Furthermore, employees of large corporations receive their health benefits tax-free, while those who purchase their own insurance with no employer assistance, pay for such coverage with after-tax dollars. Consequently, a large proportion of the tax benefits for purchasing health insurance go to those with gold-plated insurance plans.

We believe everyone should be treated equally. All Americans should be eligible for the same health care tax deductions. One option might be to change the tax system so that the amount individuals or corporations can deduct would be limited. Under such an option, premium costs above the limit would not be deductible by the employer and would be taxable income to the employee. The savings derived from this change could be used to allow others to deduct 100% of their health insurance premiums up to this limit.

agree

We believe that, within this reformed and functioning system consumers would have choice, as well as the motive to be cost-conscious. Americans would keep their right to choose the insurance plan that best fits their needs -- from staff model HMOs to a traditional fee-for-service system with no restrictions. But, those who choose the higher cost plans will no longer be subsidized fully by those less fortunate.

Universal Coverage

We believe that all Americans should have access to a broad range of affordable insurance plans, and that the principles outlined herein will expand access greatly. The ability to deduct the cost of coverage, combined with more affordable premiums, will allow many who are uninsured today to purchase coverage with no additional federal assistance. For those who still cannot afford coverage, we believe federal financial assistance should be made available. Our proposal will provide such assistance.

Financing

During our examination of this issue, we have found that health care cost estimates and projections vary considerably. We believe any reform plan should reflect this fact, and take into account that no one can be certain of how reform will affect health spending.

Thus, we believe there should be a two-pronged approach to financing the coverage of the uninsured. First, reductions in federal spending should be made and those savings should be used immediately to finance coverage for those most in need. Second, we believe that the structural changes outlined earlier will yield additional savings in government health spending. Actual (rather than projected) savings should be assessed and a schedule of further expansions over the following years should be outlined in statute. If actual savings were greater or lesser than needed to pay for the scheduled expansion, the schedule would be sped-up or delayed until the two were in balance.

In attempting to solve health care problems we must be mindful of the first principle of medicine--"Do no harm." Any financing mechanism should, for example, avoid taxes on payrolls, which would discourage employment and cost jobs, jeopardizing coverage for even more Americans.

Too often, government tries to do too much, too quickly at too great

a cost to taxpayers. As our reforms cut health costs and produce savings, we can afford to phase in new coverage. This approach would squeeze health costs and cut wasteful spending first. Providing coverage up front while promising to cut costs later is irresponsible.

Individual Responsibility

Once the system has been improved so that everyone has access to affordable health insurance and federal assistance has been fully phased in, we believe individuals must assume responsibility for securing their own insurance. As long as there are adequate subsidies to make health insurance affordable for the poor and the unemployed, everyone must take responsibility for preparing for an unexpected health crisis.

Recently, the Senate took a bipartisan step to encourage individual responsibility by passing an amendment by Senator Bumpers to permit states to withhold welfare payments when parents have failed to get their child immunized. This is the type of individual responsibility that must be present in our reformed health care system.

Rural, Frontier, and Urban Areas

There are significant parts of the United States which have limited health care services available. We believe communities in rural, frontier (especially Alaska) and urban America face unique health care delivery and access challenges. Any reform plan must recognize that these areas may be the last to enjoy the benefits of change, and therefore must directly address their special needs in the short term.

State Flexibility

We believe any reform proposal must give states maximum flexibility to enact their own health care reforms. Citizens of a state should be allowed to join together to develop innovative new ways to deliver health care without being hampered by an inflexible federal system.

What Won't Work

We are greatly concerned by talk among some health reformers of government regulations and mandates. Like so many federal "solutions" they may appear neat and simple on paper, but will lead to disaster when implemented. Chief among these magical cures are arbitrary government-micromanaged global budgets, and bureaucratic price controls. Price controls do not work and encourage efforts to "game the

system."

A cursory look at the past ten years of statutory and regulatory changes in Medicare and Medicaid bears this out. Mandated reductions in Medicare reimbursement have only shifted higher costs to businesses and workers, without stopping a 12% annual increase in program costs.

We are also concerned about the breadth and scope of some proposals. We believe we should make the changes consistent with our principles over a 5-7 year time frame. In addition we should not tinker with federal programs such as the Indian Health Service, Department of Veteran affairs and CHAMPUS until we are certain that the reforms are working.

Finally, we are extremely concerned about proposals mandating that all small businesses provide their employees with health insurance. We believe such an action would force many employers to reduce their payrolls to meet this increased cost. These mandates could even force some small businesses to shut down. Everyone loses -- particularly the workers who have lost their jobs, their income, and have no health care insurance, despite the false promise of full coverage by employer mandates.

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Summary

We stand ready to work on a bipartisan basis to achieve major reforms consistent with the principles outlined above. The health care delivery system in our country is extremely complex and there are many details which must be carefully considered. A major overhaul will not happen overnight, but clearly we must move forward as quickly as possible. Our approach does not call for massive new taxes, but instead would cut costs and waste first, and direct these savings toward resolving the access problem responsibly for all Americans. We believe the government's role is to facilitate the transition through health care reform, and to police the system -- not to impose new regulatory or administrative burdens upon Americans.

We look forward to working with others in the Congress and the Administration to iron out the details and put in place a solid, workable plan that will match the quality of our current system with the availability of affordable health care coverage for all Americans.

93-124844



DEPARTMENT OF THE TREASURY
WASHINGTON

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina
SUBJECT: Memo from Secretary Shalala
DATE: August 19, 1993

Attached for your use is a copy of a memo prepared by HHS staff for the Secretary and Mrs. Clinton. This memo was shared with Treasury at the direction of Secretary Shalala who would appreciate your support of her arguments.

In sum, the memo details HHS objections with the global budget baseline assumptions that are proposed to control the rate of growth in spending for Medicare and Medicaid.

As you know, Treasury staff is concerned that the limits are too aggressive, making them essentially unreliable as a source of funding for health care reform. We are worried that expensive new entitlements to coverage will come on line with enactment of the bill and that the on-budget savings assumed in the global budget will not materialize -- resulting in either the need for a large tax increase to cover the deficiency or a significant deepening of the deficit.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MEMORANDUM FOR THE FIRST LADY

From: Donna E. Shalala

Subject: Medicare Cuts Under Reform

Background

We understand the necessity of significantly reducing health care inflation for health care reform financing, but we are convinced that the level of Medicare cuts Scenarios 1 and 2 call for would be bad policy and worse politics. The first impression of the health plan will be crucial to its success; the first impression of either Scenario 1 or 2 as applied to public programs will be deadly. Even Scenario 3 runs some serious risk of alienating our friends at the onset.

Serious further cuts in Medicare are necessary to make health reform work, provided these cuts are captured for reform purposes as opposed to deficit reduction. We can then use savings rather than substantial new revenues to help form the centrist coalition of Democrats and Republicans necessary to pass health reform. If Medicare cuts can serve the dual purpose of meeting entitlement caps and financing a portion of reform, the liberal Democrats could be mollified somewhat. The lesson of budget reconciliation is that a balanced financing package is essential. As Exhibit 1 shows, however, Scenario 1 Medicare cuts would exceed the cost of expanded Medicare benefits by \$88 billion; Scenario 2 cuts exceed expansion by \$62 billion. We believe both numbers are much too high.

The danger is that a proposal to use Medicare to finance so large a part of reform will raise a firestorm of immediate protest from our strongest supporters. Supportive physician groups such as the American College of Physicians and the American Academy of Family Physicians will face enraged members who view further Medicare payment cuts as another broken government promise. Members of the American Hospital Association will see themselves as unable to survive the twin onslaught of aggressive pricing from qualified health plans and continued Medicare erosion. The elderly will raise the very legitimate question of why they are paying more for reform than they will receive in benefits to themselves. A major change in the current positions of any of these supporters could doom the plan at the onset.

Provider and beneficiary response will greatly influence the Hill's reaction. Senator Moynihan and the Ways and Means members will be inclined to protect teaching and urban hospitals if they appear to be in danger. Both House and Senate rural caucuses will focus on the impact on providers, particularly hospitals, in their districts. Mr. Waxman will be sympathetic to the protests of physician groups.

In choosing the amount of financing to come from Medicare, we are operating in the context of new savings from Reconciliation, which have yet to take effect, that will total \$56 billion over 5 years. Scenario 3 cuts in Medicare are more stringent than the entitlement caps in the Nunn/Domenici proposal and will be very difficult to achieve both technically and politically. If we move to Scenario 1 cuts we will be asking the Medicare program to provide, in new savings, an amount equal to four times the savings already achieved under the Reconciliation bill. Even Scenario 3 cuts would require almost three times the Reconciliation savings.

This is not just a political problem, but a technical one as well. Public programs simply cannot provide the same savings to support the plan as can the private sector, which has operated largely unchecked during a decade of Medicare restrictions. It would be inappropriate, from a policy point of view, to impose the same degree of expenditure limitation on Medicare and the private sector when the number of persons covered by Medicare is growing more rapidly than the rest of the population. Equal total growth rates for the two segments will mean lower per capita growth for Medicare. In addition, our strategy for achieving the targets for private sector savings relies very heavily on one time reductions in administrative costs, savings which are not available in Medicare.

One result of ten year's worth of cost containment efforts in Medicare is that provider payments under the program are already fully one third less than the private sector's with the result that the better group model HMOs are increasingly reluctant to accept Medicare capitation rates. In fact, bringing the private sector to current levels of Medicare spending, age and risk adjusted, by itself would save tens of billions of dollars.

The attached document reviews some of the most pertinent facts with respect to proposed Medicare savings.

Attachment

MANY RURAL AND INNER CITY HOSPITALS COULD GO OUT OF BUSINESS

- o Almost 2/3 of all hospitals currently have negative Medicare margins -- that is, they spend more on Medicare patients than Medicare pays them. In 1991, Medicare losses nearly equaled losses for uncompensated care. Some hospitals make up these losses by charging private payers more. Under health care reform, however, hospitals will be experiencing cutbacks from private payers as well. Hospitals that are squeezed from all sides are likely to respond by reducing staff and/or services -- or closing altogether.
- o About 30 percent of sole community hospitals, 39 percent of small rural hospitals, and 24 percent of large urban hospitals are currently operating in the red overall. Another 25 percent of large urban hospitals are teetering on the edge -- their margins are only .1 percent. While operating efficiencies may be possible, many hospitals will not be able to respond quickly enough. The additional Medicare payment cuts along with private reductions may force closures.
- o Many inner-city hospitals, particularly public hospitals, are facing crumbling infrastructures. Taken together, the Medicare and private sector cuts will mean less capital to invest and rebuild. Given their deteriorating structures, quality problems will eventually surface. Such hospitals cannot compete in the health care market.

PROMISES TO PHYSICIANS, ESPECIALLY PRIMARY CARE PHYSICIANS, WILL BE BROKEN

- o We are committed to increasing Medicare payments for primary care services. Significant cuts in Medicare physician payments under health care reform (on top of billions in reconciliation cuts) will prove politically very difficult to deliver if all physician fees must be reduced to the extent required to meet Scenario 1 or 2 levels.
- o Further significant cuts in physician payments could allow gaps in access to develop in certain areas. Reconciliation essentially froze Medicare physician fees in real dollar terms and will lead to substantial geographic redistribution in order to keep our promises with respect to primary care. Reductions needed to reach Scenarios 1 or 2 would require substantial reductions in Medicare payment levels. While access to physicians by Medicare beneficiaries may not be a problem immediately or in all areas, pockets of problem areas are sure to crop up.

EMPLOYMENT COULD SUFFER

- o Almost 4 million individuals are employed by community hospitals. The annual payroll (including fringe benefits) of these employees is about \$140 billion year. Cuts in Medicare hospital payments could jeopardize the jobs of many of these workers and negatively affect the economy in their communities. Hospitals are now the largest employers in many distressed cities; their employees are disproportionately women and minorities so the job loss will worsen the effects of the current economy on the most vulnerable individuals and communities.
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Scenario 1

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-7	-17	-30	-45	-62	-161
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-9	-10	-10	-47
Sub-total	-2	-2	-18	-28	-42	-58	-75	-221
Total, Scenario 1	-2	-2	-2	-7	-16	-26	-36	-87

Scenario 2

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-6	-13	-25	-38	-52	-134
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-17	-24	-38	-51	-66	-196
Total, Scenario 2	-2	-2	-1	-3	-12	-19	-27	-62

Scenario 3

	1994	1995	1996	1997	1998	1999	2000	1996-2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-4	-10	-19	-30	-42	-105
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-15	-21	-32	-43	-56	-167
Total, Scenario 3	-2	-2	1	0	-6	-11	-17	-33

*** ACTIVITY REPORT ***

TRANSMISSION OK

TX/RX NO. 3178

CONNECTION TEL 86197590851

CONNECTION ID

START TIME 08/23 10:39

USAGE TIME 04'41

PAGES 7

RESULT OK



FAX TRANSMITTAL SHEET

DATE: 8/23/93

NUMBER OF SHEETS TO FOLLOW: 6

TO: Secretary Bentzen

ADDRESSEE'S FAX #: _____

ADDRESSEE'S CONFIRMATION #: _____

FROM: Roger Martin (202-622-0064)

SENDER'S FAX #: 202-622-0073

SENDER'S CONFIRMATION #: 202-622-1700

SPECIAL INSTRUCTIONS/COMMENTS:



Noty EP

7/12/77
Let me have
your comments
on this
AUG 3

MEMORANDUM FOR THE FIRST LADY

From: Donna E. Shalala
Subject: Medicare Cuts Under Reform

Background

We understand the necessity of significantly reducing health care inflation for health care reform financing, but we are convinced that the level of Medicare cuts Scenarios 1 and 2 call for would be bad policy and worse politics. The first impression of the health plan will be crucial to its success; the first impression of either Scenario 1 or 2 as applied to public programs will be deadly. Even Scenario 3 runs some serious risk of alienating our friends at the onset.

Serious further cuts in Medicare are necessary to make health reform work, provided these cuts are captured for reform purposes as opposed to deficit reduction. We can then use savings rather than substantial new revenues to help form the centrist coalition of Democrats and Republicans necessary to pass health reform. If Medicare cuts can serve the dual purpose of meeting entitlement caps and financing a portion of reform, the liberal Democrats could be mollified somewhat. The lesson of budget reconciliation is that a balanced financing package is essential. As Exhibit 1 shows, however, Scenario 1 Medicare cuts would exceed the cost of expanded Medicare benefits by \$88 billion; Scenario 2 cuts exceed expansion by \$62 billion. We believe both numbers are much too high.

The danger is that a proposal to use Medicare to finance so large a part of reform will raise a firestorm of immediate protest from our strongest supporters. Supportive physician groups such as the American College of Physicians and the American Academy of Family Physicians will face enraged members who view further Medicare payment cuts as another broken government promise. Members of the American Hospital Association will see themselves as unable to survive the twin onslaught of aggressive pricing from qualified health plans and continued Medicare erosion. The elderly will raise the very legitimate question of why they are paying more for reform than they will receive in benefits to themselves. A major change in the current positions of any of these supporters could doom the plan at the onset.

Provider and beneficiary response will greatly influence the Hill's reaction. Senator Moynihan and the Ways and Means members will be inclined to protect teaching and urban hospitals if they appear to be in danger. Both House and Senate rural caucuses will focus on the impact on providers, particularly hospitals, in their districts. Mr. Waxman will be sympathetic to the protests of physician groups.

In choosing the amount of financing to come from Medicare, we are operating in the context of new savings from Reconciliation, which have yet to take effect, that will total \$56 billion over 5 years. Scenario 3 cuts in Medicare are more stringent than the entitlement caps in the Nunn/Domenici proposal and will be very difficult to achieve both technically and politically. If we move to Scenario 1 cuts we will be asking the Medicare program to provide, in new savings, an amount equal to four times the savings already achieved under the Reconciliation bill. Even Scenario 3 cuts would require almost three times the Reconciliation savings.

This is not just a political problem, but a technical one as well. Public programs simply cannot provide the same savings to support the plan as can the private sector, which has operated largely unchecked during a decade of Medicare restrictions. It would be inappropriate, from a policy point of view, to impose the same degree of expenditure limitation on Medicare and the private sector when the number of persons covered by Medicare is growing more rapidly than the rest of the population. Equal total growth rates for the two segments will mean lower per capita growth for Medicare. In addition, our strategy for achieving the targets for private sector savings relies very heavily on one time reductions in administrative costs, savings which are not available in Medicare.

One result of ten year's worth of cost containment efforts in Medicare is that provider payments under the program are already fully one third less than the private sector's with the result that the better group model HMOs are increasingly reluctant to accept Medicare capitation rates. In fact, bringing the private sector to current levels of Medicare spending, age and risk adjusted, by itself would save tens of billions of dollars.

The attached document reviews some of the most pertinent facts with respect to proposed Medicare savings.

Attachment

MANY RURAL AND INNER CITY HOSPITALS COULD GO OUT OF BUSINESS

- o Almost 2/3 of all hospitals currently have negative Medicare margins -- that is, they spend more on Medicare patients than Medicare pays them. In 1991, Medicare losses nearly equaled losses for uncompensated care. Some hospitals make up these losses by charging private payers more. Under health care reform, however, hospitals will be experiencing cutbacks from private payers as well. Hospitals that are squeezed from all sides are likely to respond by reducing staff and/or services -- or closing altogether.
- o About 30 percent of sole community hospitals, 39 percent of small rural hospitals, and 24 percent of large urban hospitals are currently operating in the red overall. Another 25 percent of large urban hospitals are teetering on the edge -- their margins are only .1 percent. While operating efficiencies may be possible, many hospitals will not be able to respond quickly enough. The additional Medicare payment cuts along with private reductions may force closures.
- o Many inner-city hospitals, particularly public hospitals, are facing crumbling infrastructures. Taken together, the Medicare and private sector cuts will mean less capital to invest and rebuild. Given their deteriorating structures, quality problems will eventually surface. Such hospitals cannot compete in the health care market.

PROMISES TO PHYSICIANS, ESPECIALLY PRIMARY CARE PHYSICIANS, WILL BE BROKEN

- o We are committed to increasing Medicare payments for primary care services. Significant cuts in Medicare physician payments under health care reform (on top of billions in reconciliation cuts) will prove politically very difficult to deliver if all physician fees must be reduced to the extent required to meet Scenario 1 or 2 levels.
- o Further significant cuts in physician payments could allow gaps in access to develop in certain areas. Reconciliation essentially froze Medicare physician fees in real dollar terms and will lead to substantial geographic redistribution in order to keep our promises with respect to primary care. Reductions needed to reach Scenarios 1 or 2 would require substantial reductions in Medicare payment levels. While access to physicians by Medicare beneficiaries may not be a problem immediately or in all areas, pockets of problem areas are sure to crop up.

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(in billions)
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DEPARTMENT OF THE TREASURY
WASHINGTON

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina
SUBJECT: Memo from Secretary Shalala
DATE: August 19, 1993

Attached for your use is a copy of a memo prepared by HHS staff for the Secretary and Mrs. Clinton. This memo was shared with Treasury at the direction of Secretary Shalala who would appreciate your support of her arguments.

In sum, the memo details HHS objections with the global budget baseline assumptions that are proposed to control the rate of growth in spending for Medicare and Medicaid.

As you know, Treasury staff is concerned that the limits are too aggressive, making them essentially unreliable as a source of funding for health care reform. We are worried that expensive new entitlements to coverage will come on line with enactment of the bill and that the on-budget savings assumed in the global budget will not materialize -- resulting in either the need for a large tax increase to cover the deficiency or a significant deepening of the deficit.

*Sympathetic to Shalala's
analysis*

*Prepare talking point
on less benefits at start -
comparable to standard
Blue Cross / Blue Shield or
Mitchel Kennedy
Room to adjust after
Sept 22 plan submitted.*