



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

Already Dist.

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August 19, 1993

Memorandum for Secretary Bentsen

From: Roger C. Altman *RA*

Subject: Health Care

Attached is a remarkably fiery memo from Donna Shalala to Mrs. Clinton on Medicare cuts in health care reform. It is worth reading.



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.
- o Hospitals are also major employers in rural America. Studies show that the presence of a hospital in a rural area guarantees an inflow of funds. If hospitals significantly cut back on staffing or close, rural areas especially could be hard hit by layoffs.

STATES WOULD SPEND MORE

- o Medicaid pays Medicare cost-sharing amounts for poor beneficiaries. If the Medicare cost-sharing is increased, the States would have additional liability. Each extra billion in beneficiary cost-sharing translates into \$470,000 more in State dollars.
- o Given the continued inadequacy of the Medicare benefit package compared to the comprehensive package under health reform, cuts of the Scenario 3 magnitude will make it impossible for any State to integrate Medicare beneficiaries into its system.

UNINTENDED CONSEQUENCES ON BENEFICIARIES

- o It is difficult to predict the effect of increasing beneficiary cost-sharing on beneficiaries, since cost-sharing amounts depend on the type of service provided and whether or not the beneficiary is covered by supplemental insurance. However, we have concerns that some beneficiaries may be negatively affected.
 - + For example, there are 240,000 elderly living in families with incomes \$200 or less above the poverty line. 290,000 live in families from \$200 to \$250 above poverty. Policies requiring beneficiaries to pay \$200 or \$250 more out-of-pocket per year could be detrimental to individuals teetering above the poverty line.

(\$'s in Billions)

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	<u>0</u>	<u>0</u>	<u>3</u>	<u>7</u>	<u>11</u>	<u>16</u>	<u>22</u>	<u>59</u>
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	<u>0</u>	<u>0</u>	<u>-9</u>	<u>-9</u>	<u>-9</u>	<u>-10</u>	<u>-10</u>	<u>-47</u>
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	<u>0</u>	<u>0</u>	<u>3</u>	<u>7</u>	<u>11</u>	<u>16</u>	<u>22</u>	<u>59</u>
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	<u>0</u>	<u>0</u>	<u>-9</u>	<u>-9</u>	<u>-10</u>	<u>-10</u>	<u>-11</u>	<u>-49</u>
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	<u>0</u>	<u>0</u>	<u>3</u>	<u>7</u>	<u>11</u>	<u>16</u>	<u>22</u>	<u>59</u>
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	<u>0</u>	<u>0</u>	<u>-9</u>	<u>-9</u>	<u>-10</u>	<u>-10</u>	<u>-11</u>	<u>-49</u>
Sub-total	-2	-2	-15	-21	-32	-43	-56	-167
Total, Scenario 3	-2	-2	1	0	-6	-11	-17	-33



DEPARTMENT OF THE TREASURY
WASHINGTON

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INFORMATION

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina
SUBJECT: NEC/CEA Analysis of Proposed Global
Budget Limits on Health Care Spending Growth
in Health Care Spending
DATE: August 25, 1993

As a follow-up to the Secretary Shalala memo, I thought you would find the attached of some interest.

Note especially the points raised on page 2 relative to the applicability of a GDP (gross domestic product) or GDP-1 rate of growth to health care spending in the U.S.

As you may know by now, Ira has apparently determined that the Cabinet opposition to a GDP or GDP-1 growth rate is sufficiently strong to warrant modification of his recommendation to the President. He has asked the HHS actuaries to model budget cuts in Medicare and Medicaid for several new scenarios using Consumer Price Index (CPI) instead of GDP. He adjusts for population change and then adds "x" percentage points as a cushion. In other words, he has staff modeling variations on CPI growth paths. For example:

good

1996	1997	1998	1999	2000
CPI+Population+2.5	CPI+Pop.+2	CPI+Pop+1.5	CPI+Pop+1	Etc.

o The good news is that CPI is a more appropriate index for health care, but could be improved by adjusting for real income (Brad DeLong and CEA/NEC view);

o The bad news is that Ira's preferred growth path, while CPI based, generates about the same level of savings assumed in his earlier proposal. In other words, we continue to feel that the restrictiveness of the global budget is too severe -- leading to the kinds of problems described by Secretary Shalala and in my cover note to her memo.

agree

July 30, 1993

MEMORANDUM TO CEA/NEC

FROM: DAVID CUTLER
SHERRY GLIED

SUBJECT: Budgetting Health Care Spending

Background: The health care reform task force has suggested that the growth rate of health care spending should be limited to the growth rate of nominal GDP minus 1 percentage point. The recent experience of other countries (especially Germany) is cited as evidence that it is possible to hold down costs.

International Evidence: The international evidence is not entirely persuasive on the possibility of holding costs to this rate:

- Figure 1 plots the annual growth rate of real health care spending and the annual growth rate of real GDP for OECD countries in the 1970-1980 period. The upper line in the figure is where health care growth equals GDP growth. Points above the line indicate health care increasing as a share of GDP, and points below the line indicate health care declining as a share of GDP. The lower line is where health care growth would equal GDP growth minus 1 percent.

 In the 1970-80 period, no country had a growth rate of health care below that of GDP. The United States actually had a low rate of health care cost increase, compared to other countries.

-  Figure 2 plots the same series over the 1980-90 period. Only four countries had health care spending growth below GDP growth (Germany, Denmark, Sweden, and Ireland), and only one country had health care spending growth over 1 percentage point below GDP growth (Ireland). The Irish data are sufficiently low that we suspect some form of misreporting, although we are not certain what is happening. The conclusion from the figure is that dramatic reductions in the share of GDP devoted to health care is not easily obtained, even in highly regulated countries like Canada and France.

The United States had the highest real growth rate in the 1980s. Note that real health care spending in the United States increased at roughly the same rate in the 1980s as in

the 1970s, however. The difference between the 1970s and 1980s is that other countries managed to control cost increases more effectively (although not at the GDP-1 target).

- Figure 3 plots the same relationship, for the 1985-1990 period. In the 1985-90 period, both Germany and Ireland meet the GDP-1 test, and Portugal is very close. This may be some evidence that over time, cost control measures can be made tighter, although it might also just be an aberration.

Applicability to the United States:

- In terms of the United States, a distinction should be made between short term growth rates and long term growth rates. Since the U.S. system is very inefficient, policies that encourage more efficient use of resources will result in reductions in health/GDP. In the short term, a GDP-1 budget is more tenable than in the long term, assuming appropriate incentives are given to reform the system.
- While efficiency improvements can lower the rate of growth in the short-run, health care reform aims to combine these efficiency improvements with a major expansion of coverage. None of the countries experiencing cost declines had major coverage expansions during the period of real cost decline.

Appropriate Long Term Budget Rates: The "appropriate" growth rate of health care spending depends on several factors:

- General Inflation Rate. As the price of health care inputs rise, output prices must rise as well.
- Population Growth. Increase in population should also result in increases health care spending.
- Aging. Since older people use more health care than younger people, health care growth should reflect the age distribution of the population.
- Productivity Growth in Health Care and Other Sectors. As productivity increases in sectors outside of health care, the prices of products in these sectors will fall and the relative price of health care will naturally rise. If health care experiences little productivity growth (relative to the rest of the economy), economic theory suggests that its share of GDP should rise. Measured productivity growth

in health care is very low. Many argue, however, that this is because of the difficulty in measuring the output of the health care sector. For example, an increase in the number of operations performed per physician might be measured as a productivity increase even if all the patients died.

- Income growth. As people become richer, they demand more health care relative to other goods. From microeconomic data, we know the income elasticity of demand for health care (generally about 0.1). The income elasticity measured from cross country data is much larger. Some measure of income elasticity could be incorporated into the formula.
- Quality improvements. The budget might be adjusted to reflect technological innovations that, while costly, make significant improvements in the length or quality of life.

These considerations suggest the following type of formula for the optimal increase in health care spending over time:

$$\begin{aligned}
 \text{Health Care Expenditure} &= \text{General Inflation} + \text{Popn Growth} + \text{Aging} + \\
 & .1 * \text{Real Income Growth} + (\text{General Prod. Growth} - \text{Health Prod. Growth})
 \end{aligned}$$

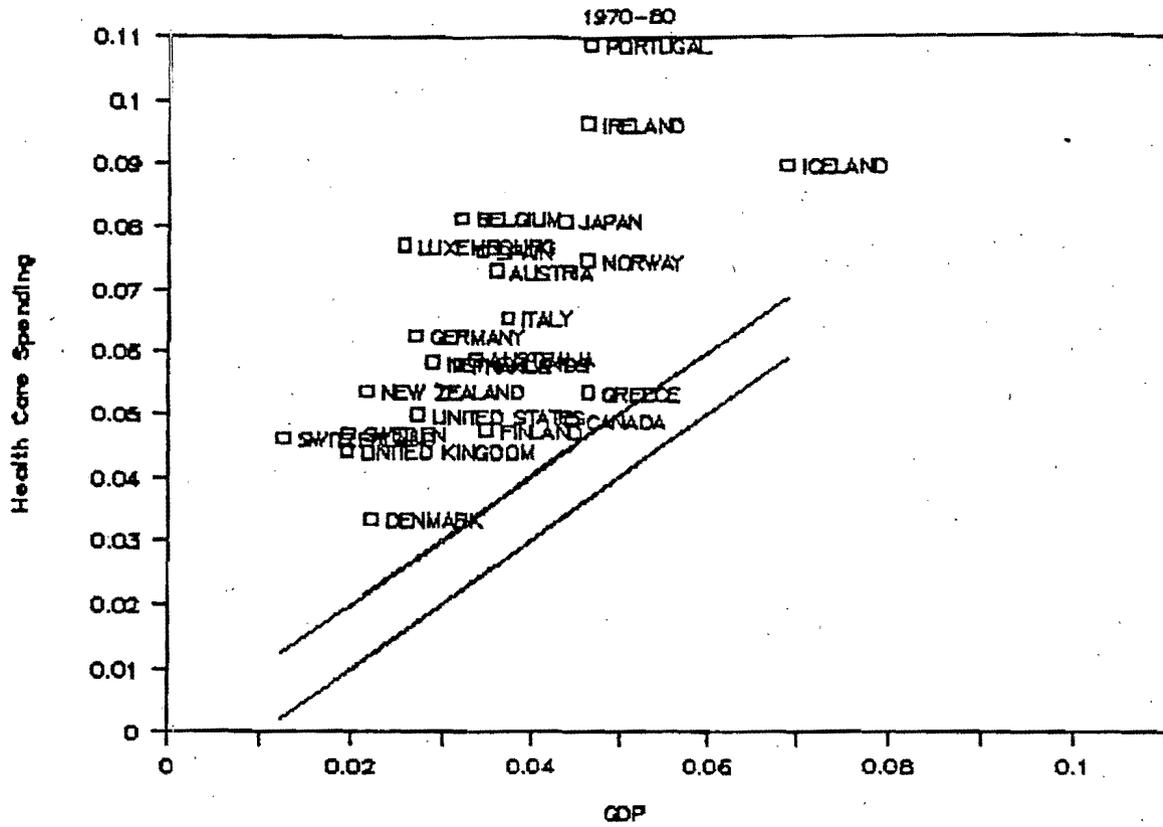
A Cautionary Note: In this plan, the budget serves four purposes:

- To encourage CBO to score substantial savings from the plan;
- To constrain the rate of growth in Federal programs;
- To send a strong signal to the private sector to keep cost growth down; and
- To trigger a regime change in case managed competition doesn't work.

Note that in order to achieve the first three targets (especially the first), the trigger for the regime change must be mandatory. The regime changes to one that is highly regulatory with premium controls, price regulation, and taxation of provider incomes.

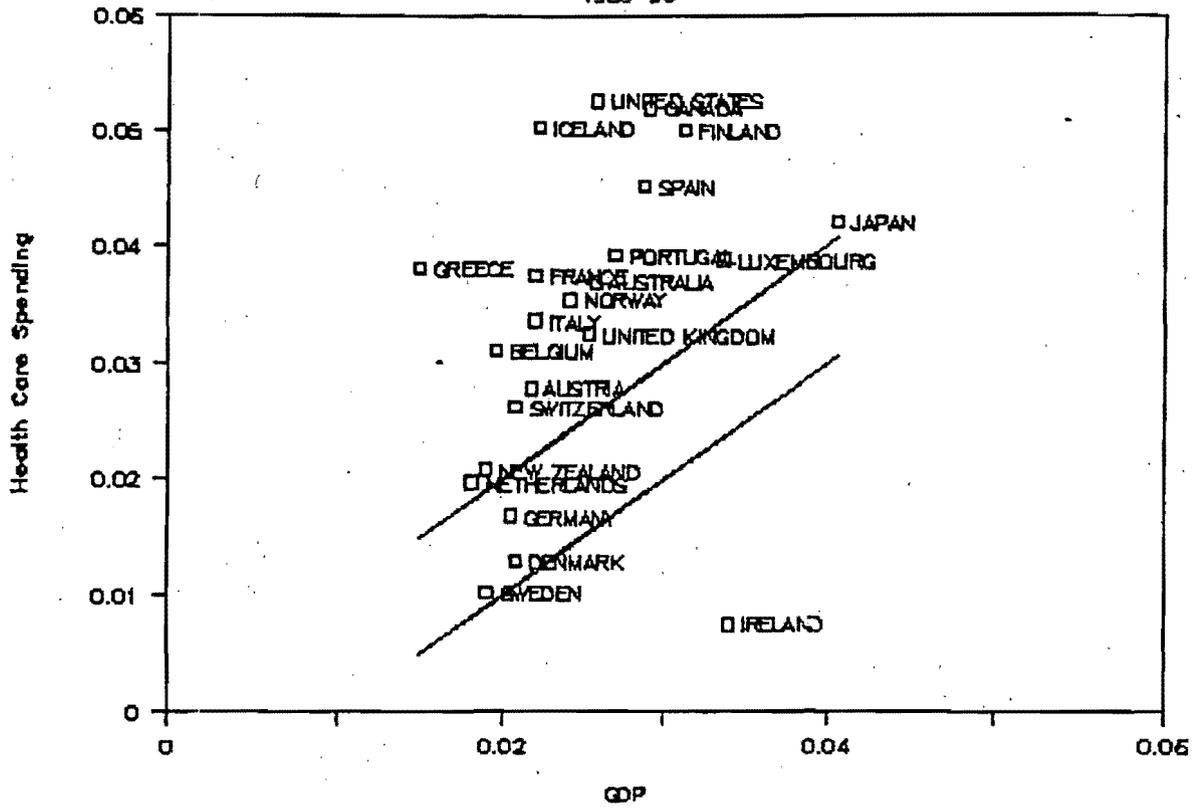
In setting the level of the budget, it is important to consider at what point the level of growth in health care spending would be so high that this regime change would be appropriate.

Annual Growth of Health Care and GDP



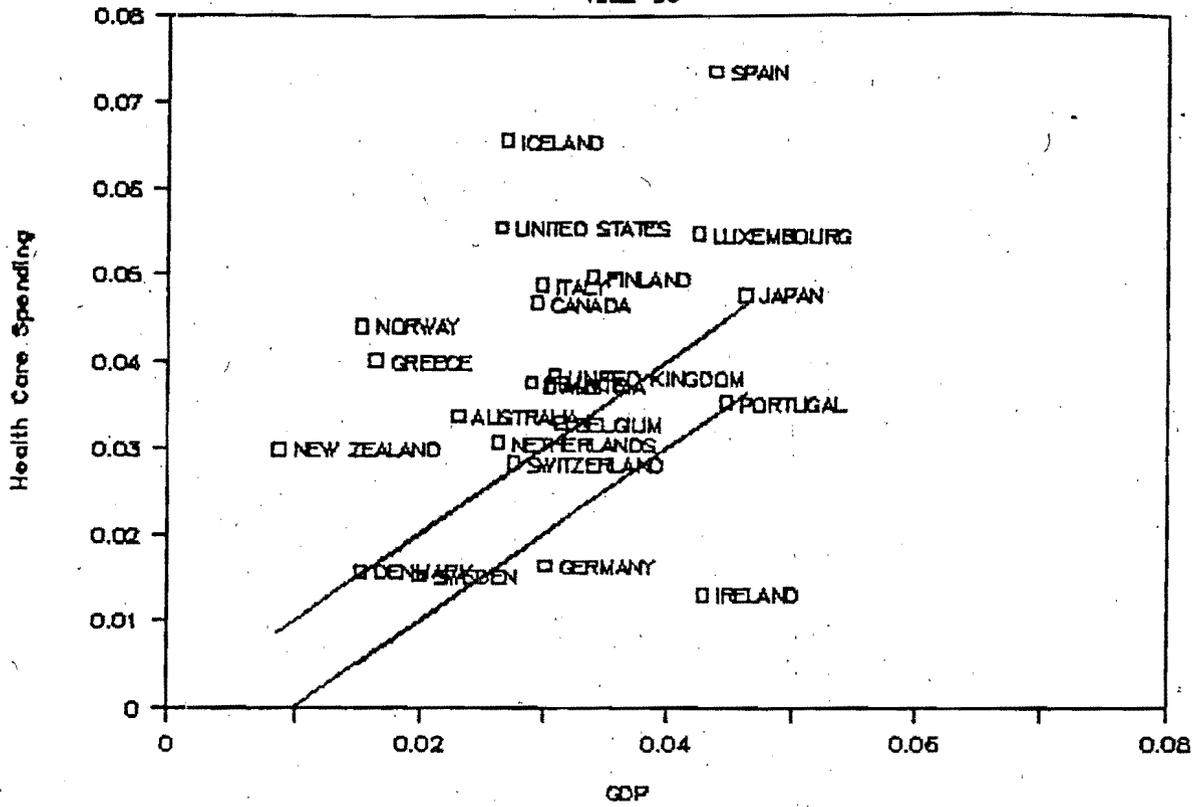
Annual Growth of Health Care and GDP

1980-90



Annual Growth of Health Care and GDP

1965-90





DEPARTMENT OF THE TREASURY
WASHINGTON

September 7, 1993

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INFORMATION

ASSISTANT SECRETARY

MEMORANDUM FOR DEPUTY SECRETARY ROGER ALTMAN

From: Alicia Munnell and Brad De Long

Subject: **COST OF HEALTH CARE**

If everyone believed that American consumers were making an informed and thoughtful decision about how much of their incomes to spend on health care, then we would not be concerned if the health care spending share of total GDP or of consumer spending was large. Consumers are likely to be good judges of their own well-being. And it is a free country.

But few believe that the level of health care spending is the result of such an informed decision: that each year Americans are collectively deciding, through the market, that they want to consume a little less in food, clothing, and housing and a little more in health care. Instead, we believe that the health care system treats additional tests, procedures, and practices as essentially free—that a great deal of unnecessary tests are run, unnecessary operations are performed, and unnecessary money is spent because consumers are not faced with the costs of the medical system, and therefore cannot calculate how their lives would be better if the resources wasted on unnecessary tests were devoted to some alternative use.

The suspicion that a great deal of American health spending is unnecessary, in the sense of taking a lot of people's worktime and money to perform and yet producing no measurable benefit in terms of health, is reinforced by looking at the contrast between the U.S. and other industrial countries. In the U.S.:

- health care spending is much higher.
- health care spending is a greater share of national product.
- yet the U.S. has no higher a life expectancy than other rich countries.

cc: Marina Weiss

TREASURY CLEARANCE SHEET

NO. _____
Date Sept. 7, 1993

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

FROM: Alicia Munnell and Brad De Long

THROUGH: _____

SUBJECT: Cost of Health Care

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TREASURY CLEARANCE SHEET

NO. _____
Date Sept. 7, 1993

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
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FROM: Alicia Munnell and Brad De Long
 THROUGH: _____
 SUBJECT: Cost of Health Care

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September 7, 1993

INFORMATION

MEMORANDUM FOR DEPUTY SECRETARY ROGER ALTMAN

From: Alicia Munnell and Brad De LongSM
Subject: **COMMENTS ON THE HEALTH CARE REFORM PLAN**
cc: Marina Weiss

This memorandum sets out our major concern about the health care reform plan: that it tries to do too many desirable, worthwhile, and expensive things at once—and that as a result it may not work as planned. A possible consequence is that the program may be much more expensive than the Administration anticipates, in which case its sources of funding may prove grossly inadequate. At the same time, attempts to control the national health care budget through spending caps precludes any of the efficiencies that might be generated through managed competition.

The Scope of the Benefit Package

The American Health Care Security Act (HCSA) proposes to provide all Americans with a comprehensive benefit package. The benefit package is somewhat more generous than low-option federal employee Blue Cross: it requires lower copayments, and provides substantially grater coverage of mental health, substance-abuse treatment, dental services, and clinical preventive services.

The decision to adopt a relatively generous and comprehensive benefit package—a package significantly better than the average American currently receives—causes Treasury significant unease for three reasons.

First, there is a substantial gap between the alliance plans and Medicare. The elderly may see their 60-64 year old younger siblings receive significantly better health benefits, and wonder why this is so. This could create difficulties, one of which is the possibility that individuals will upgrade Medicare themselves on an *ad hoc* basis. If individuals turning 65 have the option of retaining their alliance status, many will not shift to Medicare. Workers in corporate alliances may retire early, may trade pension rights for cash to break their legal connection with their firm and join a regional alliance in their last pre-65 year.

Second, the generosity of the health care reform package being offered to low-income Americans contrasts sharply with the stinginess of other sources of assistance.

Low-income Americans today have a third-class diet, fourth-class housing, and fourth-class access to schools, clothing, other consumer goods, and American culture. The HCFA provides low-income Americans with an entitlement to first-class health care. It might be better to provide a less generous universal health benefit package, and devote the resources not spent on low-income health care to schools, clothing, housing, diet, and income support.

Third, and most important, the substantial benefit package is expensive. The high cost forces some decisions not because they are good policy but because they promise to reduce the official cost of the benefit package (never mind that they do not produce system savings). Of these the most serious is the retention of separate payment schedules for Medicaid.

The substantial benefit package is in tension with other goals of health care reform: the decision to eschew significant new revenue sources, the goal that health care reform reduce the deficit, and the goal of making the mandate rest lightly on firms that employ low wage workers. At the moment these goals appear consistent. But they rely on optimistic assumptions about cost growth, and about the effectiveness of global budgeting as a cost-control mechanism.

Optimistic spending growth estimates create a major public relations problem. In contrast to the debate over the budget, elite opinion makers may not be on the Administration side during the debate over health care. They will listen to what outside observers and analysts say—and the outside observers and analysts they trust will say that the cost containment assumptions are highly optimistic. Conventional wisdom may become that the Administration is relying on a rosy scenario to make its health care books balance.

The Need for Standby Funding Sources

In addition, the optimism about spending growth implicit in the plan creates a need for standby funding sources in case optimism is unwarranted. It is good to have a baseline scenario that is neither pessimistic nor optimistic: the risk that things will turn out worse than expected should be offset by the opportunity that things will go better than expected. If the baseline is an optimistic scenario, then it is also necessary to provide a strategy for handling the situation in the event of higher costs than forecast—for the balance of risk is then overwhelmingly on the negative side.

Possible sources of downside risk include:

- (1) HCFA premium estimates turn out to be too low; utilization is higher and the

previously uninsured demand more than HCFA expects.

- (2) The short-run increase in demand for medical care as the uninsured begin to use their coverage creates substantial excess demand for nurses, technicians, and other health-care professionals. Managed competition works against the plan: it does not reduce premiums but instead boosts wages.
- (3) A strong political reaction against health care rationing leads states to fail to enforce the global budget; confronted with a *fait accompli* the federal government backs down and does not apply sanctions.
- (4) The federal government fails to collect the \$17 billion or so a year to pay for subsidies that it expects from state "maintenance of effort."
- (5) Medicare and Medicaid cuts do not reduce system spending, but instead shift costs elsewhere.
- (6) Large firms divest themselves of all low-wage workers, setting up separate smaller supplier corporations that qualify for additional subsidies.
- (7) Administration estimates understate how many large firms with high-risk workforces enter the regional alliances.
- (8) The Urban Institute TRIM2 model understates the number of people who qualify for subsidies.

These eight sources of risk are not exhaustive. And they will certainly not all happen. But they are not balanced by an equivalent set of positive surprises that could lead spending to be less than projected.

There is no equivalent upside opportunity because the projected rates of growth of health care spending included in the plan are already extremely optimistic. They project that American spending on health care will, after reform, grow as or more slowly than total national product—any growth rate of "consumer price index plus population plus one percent" or lower sees health care spending shrink as a share of national product.

But as time passes and America becomes a richer country, Americans are almost sure to want more health care services, not fewer. In every industrial country, a larger share of national product was devoted to health care in 1980 than in 1970. And in every industrial country except four—Sweden, Denmark, Germany, and Ireland—health care was a larger share of the economy in 1990 than in 1980. Rates of increase in health care costs differ widely. But no matter what institutions are adopted, health care spending tends to grow as a share of economic activity. It is very optimistic to suppose that the U.S. can quickly go from being one of the worst in the OECD in terms of containing health care costs to one of the best.

How large is the risk, both to the system and to the federal budget? One

"pessimistic" scenario would be that (3), (4), and (5) above all come to pass—that Medicare and Medicaid cuts are shifted onto other spending, that for political reasons the global budget becomes a dead letter and spending continues on its baseline path, and that the federal government fails to finance subsidies out of state "maintenance of effort." In this case, making very rough and approximate estimates, the differences between the "pessimistic" scenario outcome and scenario 2 include by the year 2000:

- A \$110 billion a year subsidy program instead of an \$87 billion program.
- No \$17 billion a year inflow from state "maintenance of effort."
- Approximately \$82 billion a year in additional federal health program spending.
- Additional second-order ramifications not estimated.

In this "pessimistic" scenario, health care reform does not reduce the year 2000 budget deficit by \$49 billion a year. It increases the year 2000 deficit by \$73 billion a year. Why is the federal deficit impact so large? Because at the margin each \$1 increase in alliance health spending increases required subsidies by \$0.50 or more, and because federal programs (even with the mandate taking priority over Medicaid and Medicare) continue to be a very large share of health spending.

If the health care benefit package were less substantial—were a catastrophic insurance package, were the equivalent of Medicare, or even of federal employee Blue Cross—the balance of risk would be much more even. The net federal budget impact would be favorable even without optimistic assumptions about cost controls backed by stringent global budgets. If managed competition did in fact reduce health care spending to or below growth in national product, then there would be ample opportunity to expand the benefit package. On the other hand, it will be very difficult to cut back a benefit package once it is put into place.

The major risk, therefore, is that reform will demand significantly more money. The biggest single need of the health care reform plan is for additional funding sources. They need only be "backstop" or "emergency" funding sources, to be drawn on only if managed competition and the global budget fail to achieve the desired savings, or if random uncertainty fails to break in favor of the Administration. But additional "standby" funding sources must be identified and specified.

Implications of the Global Budget

The draft plan states that the HCSA "organizes the market for health care and creates mechanisms to control costs through enhanced competition, consumer choice,

administrative simplification, and increased negotiating power through health alliances. A national health care budget serves as a backstop to that system of incentives and organized market power."

As the plan stood four months ago, this appeared an acceptable summary description. Four months ago the caps on health care spending growth contained in the global budget were "loose." Savings proposed promised to drop the rate of growth of health care spending by one to two percentage points per year. The arguments that managed competition could reduce the rate of growth of spending to some extent appeared convincing. In May, it appeared that with moderate savings generated by managed competition the global budget caps would not or would rarely become binding. The global budget was a backstop.

In recent weeks the caps on health care spending growth contained in the global budget are extremely tight. The growth rate of medical care spending (both private and public sector) is projected to settle below the rate of increase of national product.

Such a stringent global budget raises four significant problems: that of convincing Congress and others that the stringent budget is in fact attainable, that of improving the efficiency of the system, that of enforcing the global budget after reform, and that of dealing with the residual risk left in case of the global budget's failure.

First, Congressional leaders and outside opinion makers must be convinced that such a stringent restriction on post-reform health care growth is attainable, and is sound policy. This will be very difficult. For example, many of them are strongly attached to economist William Baumol's theory that health care spending inevitably must grow significantly more rapidly than spending on other types of goods: as Americans become richer they seek more health care services, but the labor intensive nature of the industry forces its costs to rise more rapidly than the average. They are unlikely to credit the proposed spending growth estimates at all, and if they do credit them will attribute them to the effects of rationing: if prices rise yet total provider revenue cannot rise, services provided will fall. If the global budget savings are produced not by increased efficiencies but because consumers "pay" for them through diminished access to services, then the policy appears less attractive.

Second, the shift from managed competition to the global budget as the primary cost-containment mechanism may well lead to a less efficient system. Managed competition is an extremely elegant system that promises to improve efficiency by making consumer choice easy. Little in the experience of government-run price controls lends confidence that the global budget will produce many gains in efficiencies. And it is not clear how managed competition can be effective if all providers are bound by such a tight budget.

Third, states must be convinced that the federal government will in fact apply stringent sanctions in the event that they fail to enforce the global budget. It is not clear who applies the ultimate sanctions—the President or the National Health Board. It is not clear that if a state does fail to enforce the global budget that the federal government will find it worthwhile to impose sanctions.

Fourth, if states do come under so much political pressure to avoid health care rationing that they fail to enforce the budget, and if the federal government then blinks and avoids imposing sanctions, residual risk appears to fall more or less equally on alliance members and on the federal budget. For each dollar that alliance spending exceeds targets, close to fifty cents comes from the federal budget.

Subsidy Schemes and the Economic Impact of Health Care Reform

Assessments of the economic impact of the HCSA inform us that the current low-wage subsidy scheme is flawed. As a result of reform, the cost to an employer of hiring a minimum-wage worker goes up by 32 cents an hour in a relatively large firm, and by approximately 16 cents an hour in a small firm.

Minimum-wage workers who find their jobs at risk as a result of this increase in employer costs have few courses of action open to them. They cannot volunteer to accept a reduction in take-home pay as higher-paid workers might. Employment of minimum-wage workers is likely to decline substantially: perhaps 300,000 or so will be the central estimate under the current subsidy scheme when the economic impact assessments are completed, with uncertainty ranging from 100,000 to 800,000.

Other "job losses" generated by reform are by and large not serious defects. Today many workers find it desirable to work because it is the best or the only way to obtain or continue health insurance. After reform, health insurance will be an entitlement: such workers will have little desire to remain in the labor force. Many of the "jobs lost" from health care reform are ultimately generated by this shrinkage in the labor force.

But minimum-wage workers are different. Those who lose their jobs still want them as much as ever—but their former employers no longer find their labor worth the higher cost of the \$640 or \$320 dollars a year that they must pay to the Health Alliance. A better subsidy scheme would minimize the impact on minimum wage workers—elsewhere workers can lower their take-home pay to compensate for the effects of the employer mandate should it put their jobs at risk, and neither employers (their costs do not rise) nor workers (they have lower take-home pay, but something extremely valuable, health care, in exchange) suffer. But minimum-wage workers cannot voluntarily adjust their wages should the employer mandate place their jobs at risk.

The cleanest way to fix the subsidy system would be to exempt the first \$4.25 of every employee's hourly wage from the required employer contribution. The employer contribution would be capped at the lower of (a) 80% of the premium, and (b) a percentage (which would have to be considerably higher than 7.6%) of the difference between the employee's earnings and the earnings of a minimum wage employee who worked the same hours.

Subsidy schemes should be tuned to have as little impact as possible on all minimum wage workers: those who work in large firms with high average wages are as much at risk as those who work in small firms. At the very least, Congressmen and Senators fearful of negative employment impacts should be given a menu: if minimum-wage employment reductions (the ones that are the subject of the most concern) are to be eliminated, here is a way to do it—but extra money is needed to accomplish this.

Residual Risk

At many points in the plan, the ultimate payer is presumably the federal government. When an HMO goes bankrupt in the middle of a year, who pays for the coverage of its former enrollees? If the IRS discovers in 2002 that a regional alliance used the wrong subsidy formula in 2000 and grossly overqualified beneficiaries for subsidies, how does the federal government recover, and from whom? It is worrisome that the federal government has delegated so much control over spending—and on the right to draw on the federal Treasury—to other entities.

Treatment of Medicaid

Today Medicaid reimbursements do not cover the full cost of treating Medicaid patients. Hospitals and doctors "cost shift"—charge other, insured, fee-paying patients more than the full cost of their care in order to recover the gap left by Medicaid. A reasonable goal for health care reform is to eliminate this cost shifting: reimburse providers for the full cost of treating their Medicaid patients.

The current version of the HCSA does not pay for health care provided Medicaid patients at standard rates. Medicaid patients' care will still be paid for at low Medicaid rates. Cost shifting will still continue: hospitals and other providers that serve the Medicaid population will make up the difference by charging their other customers more than full cost.

Incentives for geographical cherry picking will be substantial. A provider serving

the D.C. Alliance, for example, could face a substantial incentive to locate as many offices as possible in upper Northwest, and as few as possible in Anacostia. Any health plan that does serve a substantial proportion of Medicaid clients might well appear unattractive to the bulk of alliance purchasers: either it has high premiums, because it must cost shift onto its non-Medicaid clientele, or it is cutting substantial corners on service.

It is important to recognize that the retention of separate Medicaid rates for service does not, by itself, reduce system health care costs. Should Medicaid patients wind up served by a segregated group of providers without a non-Medicaid client base, the retention of separate Medicaid rates saves money by devaluing Medicaid benefits. To the extent that Medicaid patients are served by providers that serve broader populations, cost-shifting continues: there are no system savings.

What is the rationale for preserving separate Medicaid reimbursement rates? It appears to be a peculiarity of the cost estimating process: paying for Medicaid patients at full rates raises outlays on such patients, and this is captured in cost estimates. But paying for Medicaid patients at full rates reduces the fees that others pay. There is then no incentive for cost shifting; this reduction in fees charged other clients as a result of higher Medicaid reimbursement rates does not appear to show up in cost estimates.

After this month, the most important cost estimates will no longer be those of executive branch agencies. Instead, they will be legislative branch assessments of the sums required for different policies. When the HCSA is sent up to Capitol Hill, it should at the very least include an option to fold Medicaid patients into the Alliances at full rates, along with an explanation that there is no substantive cost-saving reason to treat Medicaid patients any differently from others.

Treatment of Fee-for-Service Providers

The American Health Security Act requires states to set schedules for fee-for-service reimbursement, and prohibits balance billing. The rationale for requiring states to set rates appears to be as follows: Suppose that a regional alliance qualifies three fee-for-service insurance plans, each of which states that it allows free choice of doctor. And suppose that each insurance company sets different reimbursement rates. Fee-for-service doctors, prohibited from balance billing, might then say "I take patients with Aetna, but not with Prudential insurance." And people who have signed up for Prudential then do not have free choice of doctor.

Thus to ensure that those who sign up for fee-for-service plans do have free choice of doctor, the American Health Security Act must mandate that:

- Any doctor who accepts some fee-for-service patients must accept all fee-for-service patients.
- All insurance companies must reimburse doctors the same state-set amount for fee-for-service claims.

Treasury does not find this argument convincing. People who sign up for fee-for-service plans today are not guaranteed free choice of doctor: if a consumer finds that a given doctor imposes excessively onerous balance billing, or simply has a distaste for the reimbursement forms of a particular insurance company, then the consumers's ability to "choose" that doctor is illusory. After reform, people who sign up for fee-for-service plans are not guaranteed free choice of doctor: some doctors will remain completely outside the system, taking no insurance at all, seeing whomever they please, and charging whatever they wish.

Requiring states to set reimbursement rates imposes on states a needless burden that they may well lack the administrative capacity to successfully bear. Insurance companies should set reimbursement rates. And health alliances should disseminate information on whether doctors are refusing to accept patients with any one particular fee-for-service insurance plan.

In addition, stringent state rate-setting may have the unanticipated side effect of undermining the fee-for-service sector. Doctors may well prefer to be their own bosses to being employees of an HMO. Fewer would prefer to be piece-rate contractors for an exceptionally large, distant, and bureaucratic HMO, which is what the state rate-setting boards may become. A doctor who works for one HMO could quit and go to work for another. A doctor who accepts three insurance companies could drop one if it became too stingy. But a fee-for-service doctor has no bargaining power against a state rate-setting commission.

One of the principal goals of the HCSA is to retain a vibrant fee-for-service sector: Americans value freedom to choose their own doctor highly. It would be unfortunate if the HCSA were to lead to an anemic fee-for-sevice sector.

Conclusion

The HCSA appears unlikely to work in practice as well as Administration scenarios project. The balance of risk appears to be that costs will be higher, savings through efficiency gains lower, and implementation more difficult than officially projected. As a result, the chief need is for additional funding sources in particular, and in general a backup strategy in case not everything works as well as anticipated.

TREASURY CLEARANCE SHEET

NO. _____
Date Sept. 7, 1993

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

FROM: Alicia Munnell and Brad De Long

THROUGH: _____

SUBJECT: Comments on the Health Care Reform Plan

REVIEW OFFICES (Check when office clears)

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SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date

TREASURY CLEARANCE SHEET

NO. _____
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MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
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Review Officer

Date

Executive Secretary

Date



DEPARTMENT OF THE TREASURY
WASHINGTON

September 21, 1993

ASSISTANT SECRETARY

MEMORANDUM FOR DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell *AM*

SUBJECT: The Insurance Industry and Health Care Reform

Health care reform's expected transformation of the insurance market has split the life-health insurance industry into two groups. The first group, The Health Insurance Association of America (HIAA), represents the majority of health insurers, including Mutual of Omaha. Many of its members would be losers if, as expected, health care reform leads to a major consolidation of the industry and many smaller companies specializing in traditional fee-for-service insurance become extinct. A number of industry analysts expect as much as a 90% reduction in the number of companies offering health insurance.

The second group, The Alliance for Managed Competition (AMC), is a newly-formed trade association comprised of five of the largest health insurance companies - Aetna, CIGNA, MetLife, The Prudential, and The Travelers. Those five companies have taken the lead in operating managed care networks and expect to prosper under the new health care system.

This memo summarizes the views on health care reform of these two groups, as reflected in published statements. The memo also contains some background discussion on the potential impact of health care reform on the insurance industry.

Also attached is Secretary Bentsen's briefing memo for his September meeting with CEOs from Aetna, MetLife, and The Travelers to discuss the President's health care reform plan. You should also be aware that Mutual of Omaha fashioned a small insurance market reform plan after Secretary Bentsen's insurance reform bill, S. 1872.

The Health Insurance Association of America (HIAA). Health insurance is provided by over 600 life-health insurance companies. HIAA is the principal lobbying arm for these companies; former Congressman Bill Gradison is the president. On March 29, 1993 Gradison presented the views of HIAA on health care reform before President Clinton's Health Care Reform Task Force. HIAA emphasizes the following viewpoints.

Consistent with the President's plan, HIAA favors:

- A nationally defined guaranteed benefits package for all Americans.
- Requiring employers to contribute to costs of coverage for their employees.

- Individual mandate to purchase health insurance.

Inconsistent with the President's plan, HIAA opposes:

- Mandatory purchasing cooperatives.
- Community rated insurance premiums.
- Regulation of insurance premiums.
- Separate reimbursement schedules for Medicare, Medicaid and the health alliances.

Alliance for Managed Competition (AMC). In 1992, five of the largest health insurance companies - Aetna, CIGNA, MetLife, The Prudential, and The Travelers - terminated their membership with HIAA and formed an ad hoc coalition working for comprehensive health care reform. These companies more strongly support managed health care delivery than the remaining HIAA membership, which puts a greater emphasis on traditional fee-for-service insurance. AMC promotes a managed competition model for health care reform that closely follows the Jackson-Hole Group's proposal, many elements of which are in the President's plan.

Consistent with the President's plan, AMC favors:

- A managed competition model for health care reform, including the following:
 - a nationally defined standard benefits package.
 - community rated premiums.
 - an employer requirement to *offer* health insurance.

Inconsistent with the President's plan, AMC opposes:

- Global budgets.
- Premium rate regulation.
- Individual mandate to purchase insurance (universal coverage is a goal rather than a requirement).

Though health insurance companies will experience the biggest changes as a result of health care reform, property-casualty companies will also encounter a change in business activity if workers' compensation and auto liability insurance are integrated into the new health care system. The American Insurance Association (AIA) and the Alliance of

American Insurers (AAI) represent the property-casualty sector of the insurance industry.

Consistent with the President's plan, AIA and AAI favor:

- A coordinated approach in which the insurance companies would retain their current role of carrying the risk for workers' compensation and auto accident liabilities. In this approach, workers' compensation and auto insurance companies contract with the health plans that provide individuals with general health care needs.

The Impact of Health Care Reform on the Insurance Industry

In the President's health care reform plan, health care delivery would be organized around "Health Alliances" (HAs) and Health Plans (HPs). HAs are state level quasi-public agencies that act as intermediary purchasing agents of health care services for small employers and individuals in a geographic area. HAs would negotiate with organized networks of providers (HPs) and select those networks from which consumers would choose for their own plan.

The role of insurance companies in the provision of health insurance will be transformed significantly. HPs most likely to be approved will be those with a relatively large network of providers under contract and those with the capacity to satisfy stringent information requirements on treatment outcomes and enrollee satisfaction. In addition, HPs with the largest capitalization will be best able to absorb the new risks associated with enrollment rules under the new system: enroll all individuals regardless of preexisting conditions, hold annual open enrollment, severely limit terminations (to nonpayment of premiums or fraud), and accept individuals from failed plans outside of the HA area.

In recent years, many of the large insurance companies have invested in the development of managed care facilities (e. g., the AMC group discussed above), putting them in a relatively good position to participate in the HA structure. In contrast, small companies with limited market share and those that have specialized in providing indemnity insurance coverage will find entry into the new market very difficult or impossible. Companies unable to compete within the HA structure will look to specialized products such as long-term care and claims administration. The opportunities will depend in part on the employer size threshold adopted for inclusion in the HA. The President's plan contains significant new tax preferences for long-term care insurance purchases which would stimulate the growth in that market. Some small companies may focus on the supplemental market, the extent of which will depend on the comprehensiveness of the standard benefits package in the new system.

If the health components of workers' compensation and auto insurance are integrated into the new health care system then many property-casualty insurance companies stand to lose a substantial amount of underwriting business. Again, small companies with a majority of revenues derived from either workers' compensation or auto could either go out of

business or be forced to merge with a larger company.

In summary, in contrast to the current health insurance industry, health care reform is likely to bring about a smaller number of large firms, dominated by Health Maintenance Organizations, Preferred Provider Organizations, and other integrated health care networks. In addition, health care reform legislation will likely contain new rules for the operation and governance of these firms, some of which will apply to firms both inside and outside of the HA structure. The health care legislation also will very likely address solvency requirements for health plans both inside and outside of the HA.



DEPARTMENT OF THE TREASURY
WASHINGTON

BRIEFING

TO: Secretary Bentsen
FROM: Marina Weiss
SUBJECT: 3:00 Meeting with Insurance CEO's
DATE: September 15, 1993

SUMMARY: You are scheduled to meet with 3 of the 5 CEO's of the nation's largest health insurance carriers. These five companies have created a new trade association which they will refer to as the "Managed Care Alliance." The purpose of the meeting is to discuss the President's health care reform plan. Present at the meeting will be:

Edward Budd, of the Travelers;
Ronald Compton, Chairman and CEO of the Aetna
Harry Kamen of Metropolitan Life; and
William (Bill) Oldaker who represents the group here in
Washington.

Earlier this year you met with Ronald Compton and Robert Winters of the Prudential (also representing the Health Task Force of the Business Roundtable). You will recall that Van McMurtry works for Compton.

RECOMMENDATION: That you commend them for their willingness to support important portions of the President's proposal: employer mandates, restructuring of the delivery system [HMO's] and insurance market reform. On this last issue, you may wish to thank them for their work with you in developing S.1872, the bill you wrote and guided through the Senate last year. (Only the Travellers was a little soft in supporting your bill -- because only the Travellers still writes a substantial amount of small group insurance].

You may also wish to tell them that S.1872 was written with the objective of obtaining President Bush's signature, and that with President Clinton in the White House it is now possible to go further -- particularly with respect to improving access to coverage for the uninsured. The leaked plan is a "work in progress" and they should assume changes will be made. Since they have much expertise to offer, their visit with you and others who are working with the President and First Lady is extremely useful.

DISCUSSION:

Special Role of These Companies: To fashion a health care plan that meets the President's objective of maintaining a private sector role for health insurance, the Administration will need

the support of this group. In particular, the 5 largest carriers will play an important role in validating the insurance reform changes sought by the White House (to bar preexisting condition exclusions and other "cherry picking" techniques, to ensure portability of coverage, to stabilize premium increases by moving toward community rating, etc.). They can also bring along the employers for whom they provide health insurance services. As you know, they write insurance for many of the large corporations that are calling for health care reform.

Price Controls: You may want to pose the following dilemma. If the President does not include a global budget in this bill, the actuaries at HCFA and the CBO will not "score" savings because they are skeptical about the effectiveness of "managed competition." Yet, if we don't produce scorable savings in the bill it will be necessary to either raise taxes or cut Medicare/Medicaid deeper to find the funds needed to provide universal coverage and subsidies. What would be their recommendation for resolving this dilemma?

They may suggest a reasonably aggressive tax cap [taxing employees for some amount of the cost of insurance], but of course you are aware that such a cap is anathema to the AFL-CIO because they believe their members have forgone pay increases to secure non-taxable health benefits. Given the make-up of the House of Representatives, an aggressive tax cap may not be feasible. The President's plan contemplates using a mild cap which, over time, could become more stringent. But the cap which the Administration might propose will not raise much revenue.

On the issue of limiting premiums to 7.9%, that proposal is intended to accomplish two objectives: (1) to bring along big business; and (2) to begin to arrest the growth of health care spending -- a very major part of the President's economic agenda.

They may tell you that the premium cap of 7.9% will force insurance companies to be the instrument through which provider prices are kept in check. They do not relish being viewed as the "black hats" of health reform.

Single Payer and State Regulation: As you know, some on the White House staff are outspoken in their support of eliminating the role of the insurance industry altogether. The First Lady leans toward this point of view, and has stated publicly her expectation that "some insurance companies will survive in a Darwinian struggle" for continued viability. Clearly the 5 companies that form the "Managed Care Alliance" believe they are best positioned to "survive" and to capture increased market share if there is to be any role for the private insurance industry. They will seek your reassurance that the Administration does plan to allow them to continue to exist under the new system, and they will assert their support for reforming the insurance industry in ways that will have the effect of driving some of the smaller companies out of business.

Interestingly, with the possible exception of the Travellers, this group is not particularly concerned about a stronger Federal role in insurance regulation [the President's plan sets some Federal standards but leaves much to the States -- the Federal role is likely to be strengthened in Ways and Means and in the Energy and Commerce Committees of the House].

Regional Alliances: The insurance industry would like to see the State based Alliances function only as pooling mechanisms for small employers (fewer than 100 as opposed to 5,000). As you know, proponents of a Canadian style "single payer" system view the alliances as a step toward elimination of the private insurance industry. This group may argue that, in order for the private insurance companies to be able to compete, the alliances should not be allowed to negotiate with providers of care on behalf of employers. This is likely to be a contentious issue during deliberations over health care reform because some governors, notably Governor Dean of Vermont, are interested in driving insurance companies out of their states and see the new alliances as a reasonable substitute.



DEPARTMENT OF THE TREASURY
WASHINGTON

September 28, 1993 5:12 PM

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INFORMATION

ASSISTANT SECRETARY

**MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN**

From: Alicia Munnell 
Subject: **POST-TRANSITION HEALTH CARE COST INCREASE FORECASTS**

SUMMARY

Ira Magaziner has now stated that the tight caps on health-care spending growth in the global budget apply only to the transition to the new system, and that after the transition spending growth is likely to resume at a somewhat higher pace. This appears to be a substantial shift in the Administration's position, and appears to be the result of pressure from Senator Moynihan. Recognition that the caps on growth cannot remain at their very tight 1996-2000 levels indefinitely means that health care expenditures may well continue to grow as a percentage of GDP, and health care programs will account for a rising proportion of government outlays.

DISCUSSION

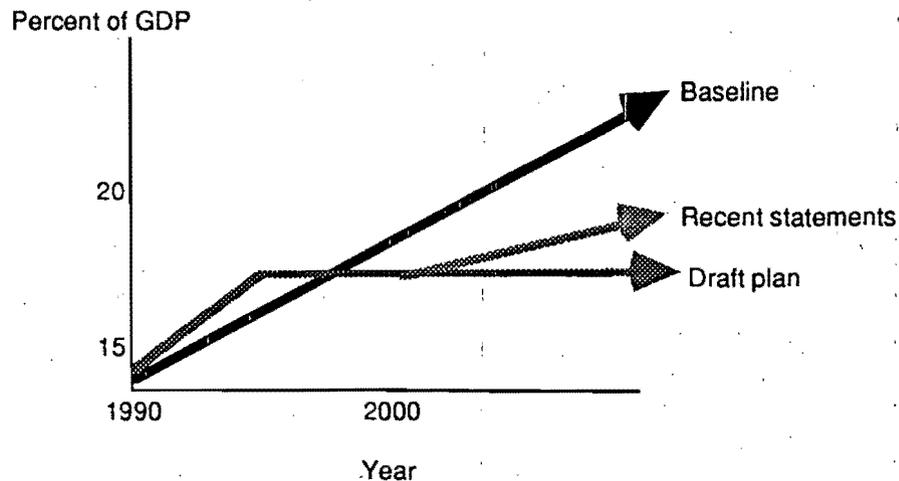
The past week has seen a significant shift in the Health Care Task Force's long-run cost projections. Before last week, the health care task force projected that after 2000 *per capita* health care spending—health care inflation plus real growth of demand—would grow no faster than CPI inflation. Health care costs, which had been growing much more rapidly than the CPI, would be slowed so that by 1999-2000 they would be growing less rapidly than the CPI. Before last week, this reduction in the rate of growth was seen as a long-run shift in health care cost inflation. The "Budget Development and Enforcement" sections of the draft plan refer to a 1996 growth rate, a 1997 growth rate, a 1998 growth rate, and then to premium increases limited to "[p]rojected increase in the CPI for each year thereafter." Administration officials had gone on record with the declaration that the purpose of health care reform is to stabilize health care spending at 17 percent of GDP.

Last week Ira Magaziner conceded to Senator Moynihan that the Administration projects that after the transition to the new system is completed health-care spending growth might well reaccelerate. Boston *Globe* stories paraphrase Senator Moynihan as saying that "...the White House acknowledged that costs would resume their growth in the [post-2000] decade after one-time savings in paperwork, fraud, and other wasteful practices were achieved. They go on to quote the Senator: "The administration now says the drop to

zero growth represents [a] one time effect of savings from less paperwork and fraud, and that after the year 2000 the growth resumes." I have been unofficially informed that New York University economist William Baumol (an advisor to Senator Moynihan, and a coauthor of Alan Blinder) are drafting what they believe will become a joint statement by both Ira Magaziner and Senator Moynihan to the effect that post-2000 growth is likely to be more rapid than the 1999-2000 growth rate cap.

This shift in post-2000 projections appears an attempt by Mr. Magaziner to mollify Senator Moynihan, who believes that in the long run health-care inflation is sure to rise faster than general inflation: as people become richer they want to spend more and more of their rising incomes on health care, and cost-reducing technological progress is very difficult to achieve in labor-intensive industries like health care. This shift appears to have been adopted by Ira Magaziner with minimal consultation inside the Administration. George Stephanopolus is on record saying that the Administration plan will stabilize health-care spending at seventeen percent of GDP on the same day that Senator Moynihan announced that the Administration did not envision indefinite continuation of the 1999-2000 growth rate.

If Senator Moynihan is correct in his understanding of Ira Magaziner's current position, the chart below gives a qualitative picture of the different forecasts of health care spending growth, as a share of GDP. The draft plan projected a shift from a baseline path of continued rapid increase in the share of national product devoted to health care spending to stabilization of spending at 17 percent of GDP. The more recent positions anticipate some—although it is not certain how much—renewed growth after 2000 in the health care spending share of GDP.



This shift is a step in the direction of greater prudence, and should be applauded. But abandoning the belief that health care costs can be indefinitely reduced fast enough to keep spending growing less rapidly than GDP points up some vulnerabilities in the proposed system:

- After 2000, the federal budget is at risk from rising Medicare (and, possibly to a lesser extent, Medicaid) spending. After 2000, the federal budget is also at risk from rising private-sector health-care costs: recall that fifty cents or more of every additional dollar spent on Alliance-system health care comes from the federal government through the subsidy program.
- Thus the possibility of more rapid increases in health-care costs after 2000 makes the creation of additional funding mechanisms more urgent. Otherwise post-2000 health care spending growth might once again place an enormous additional burden on the federal budget.

TREASURY CLEARANCE SHEET

NO. _____
Date September 28, 1993

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

FROM: Alicia Munnell

THROUGH: _____

SUBJECT: Post-2000 Health Care Cost Increase Forecasts

REVIEW OFFICES (Check when office clears)

- | | | |
|--|--|--|
| <input type="checkbox"/> Under Secretary for Finance
<input type="checkbox"/> Domestic Finance
<input type="checkbox"/> Economic Policy
<input type="checkbox"/> Fiscal
<input type="checkbox"/> FMS
<input type="checkbox"/> Public Debt | <input type="checkbox"/> Enforcement
<input type="checkbox"/> ATF
<input type="checkbox"/> Customs
<input type="checkbox"/> FLETC
<input type="checkbox"/> Secret Service
<input type="checkbox"/> General Counsel
<input type="checkbox"/> Inspector General
<input type="checkbox"/> IRS
<input type="checkbox"/> Legislative Affairs
<input type="checkbox"/> Management
<input type="checkbox"/> OCC | <input type="checkbox"/> Policy Management
<input type="checkbox"/> Scheduling
<input type="checkbox"/> Public Affairs/Liaison
<input type="checkbox"/> Tax Policy
<input type="checkbox"/> Treasurer
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<input type="checkbox"/> Mint
<input type="checkbox"/> Savings Bonds
<input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Under Secretary for International Affairs
<input type="checkbox"/> International Affairs | | |

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
De Long, Brad	AD	9/28/93	DAS for Economic Policy	2-0563
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer _____ Date _____ Executive Secretary _____ Date _____

TREASURY CLEARANCE SHEET

NO. 93-125873
 Date September 28, 1993

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

FROM: Alicia Munnell

THROUGH: _____

SUBJECT: Post-2000 Health Care Cost Increase Forecasts

REVIEW OFFICES (Check when office clears)

- | | | |
|--|--|---|
| <input type="checkbox"/> Under Secretary for Finance | <input type="checkbox"/> Enforcement | <input type="checkbox"/> Policy Management |
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| | <input type="checkbox"/> OCC | |

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
De Long, Brad	DD	9/28/93	DAS for Economic Policy	2-0563
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date



DEPARTMENT OF THE TREASURY
WASHINGTON

93

124248
125982

TO: Secretary Bentsen
Deputy Secretary Altman
FROM: Marina Weiss/Alan Cohen
DATE: October 1, 1993
SUBJECT: Health Care Reform: Jurisdiction, Estimates,
and Other Miscellaneous Issues

SUMMARY: This discussion of issues relating to jurisdiction, on-budget scoring, and estimates of the health care reform bill follows a 9-20-93 memo to you from Michael Levy [copy attached].

RECOMMENDATION: In brief, we recommend taking certain affirmative cautionary steps on the question of the appropriate committee venue for the mandate/benefits package portion of the plan. If you agree with the recommendation relating to jurisdiction, then we will need some guidance about whether you wish to raise these issues orally or by memo to the First Lady and/or President.

Specifically, we recommend that you encourage the President, the First Lady, Ira Magaziner and other interested White House staff to weigh jurisdiction carefully when writing the legislative language of the Administration's Health Reform proposal. Since this health reform plan is such a sweeping proposal -- more than one trillion dollars annually, or 14% of GDP -- it is important to take steps now to ensure that future changes in benefits/subsidies are adequately financed. This can be accomplished by either

- (1) referring provisions related to both the benefits and the mandate/subsidies to the tax writing committees; or
- (2) by using a multiple jurisdiction mechanism [ERISA model] to force careful deliberation and funding of future changes; or
- (3) by sending all parts of the legislation to the Labor Committees. This option should only be chosen if a limitation is placed on the total cost of Federal subsidies.

With regard to on-budget versus off-budget scoring of premiums, we suggest you take the position that employer payments under the mandate should not be displayed as Federal receipts and expenditures...though we continue to be concerned that the CBO may deem employer contributions to be Federal taxes, and therefore on-budget receipts.

Finally, with regard to cost estimates, because there has been some slippage in the cost estimates, we recommend you continue to answer questions about the numbers by focusing on the methodology used to validate the estimates rather than taking a position on

specific numbers at this time. The HCFA actuaries and Treasury estimators believe they will have a fairly good set of estimates available by October 12 [assuming certain ambiguities in the proposal are cleared up...an effort that is currently underway and being coordinated by OMB].

Also, in case you missed the press coverage, we thought you would want to know that Senator Jeffords (R-Vt.) has made a public commitment to cosponsor the Administration's health reform bill. As you recall, Governor Dean of Vermont has been successful in getting a commitment from the White House to allow states to establish single payer systems under the reform plan.

OPTIONS:

- Send all key components to Finance
- Use ERISA style solution
- Send all key components to Labor; impose limitation on total cost of subsidies
- Other

lots of work

Communication Method:

- a. I will raise orally with the First Lady and President staff to prepare talking points
- b. I prefer to raise in a memo to the First Lady [President] -- staff to prepare draft
- c. Let's discuss

DISCUSSION:

I. Jurisdiction and the Need for Adequate Future Funding: As you know, the President's health reform proposal is likely to contain provisions in the jurisdiction of many Congressional committees. Specifically, in addition to the legislative interest of Ways and Means, Finance, the Labor Committees and Energy and Commerce, the bill is also expected to include material that lies within the jurisdiction of the Judiciary Committees, Government Affairs [Operations], Veterans, Small Business, Armed Services, Budget, Appropriations, and Indian Affairs. Non-legislative committees such as Aging and Joint Economic may also hold hearings on issues of interest to their Members.

While much of the jurisdictional division of labor is already well defined, new issues over which the Federal government currently has little responsibility are expected to be addressed

We believe that we need as full an understanding of the impact of jurisdiction on future financing as possible -- particularly if we continue to support open ended funding of the employer and individual subsidies. Given the relatively loose eligibility determination process, open ended funding of subsidies could create significant financial exposure for the Federal treasury.

There are three broad options for the Administration to consider:

Option 1

The best "good government" approach would have a single committee in each house handle the benefits/mandate and subsidies. Severing the link between benefits and financing by assigning them to different committees has the effect of decoupling responsibility for improving coverage from the requirement that expansions in the benefit package be properly funded. When dealing with open ended entitlements, experience with this type of bifurcation (Medicaid, Black Lung) has been difficult -- leading to stalemate when changes in law are needed, friction between committees over proposals to modify the underlying statute, and directives from the Budget Committees that the tax writing panels raise revenues needed to fund program expansions with which they do not agree.

Taking the one-Committee approach would ensure that, when changes in the program are proposed, the Members experience countervailing pressures to increase benefits -- and to pay for the increases. *agree*

Since the Administration's current proposal envisions open ended Federal funding of the subsidies, and the cost of the subsidies is determined by the cost of the benefit package, the tax writers would be the logical venue for the benefits/mandate/subsidies.

Option 2

However, if you are inclined to support the First Lady's preference to route this bill to the Labor Committees, then a less efficient but effective mechanism for assuring "prudent decision making" is to spread responsibility among several committees -- as is currently done with ERISA. Multiple jurisdiction reduces efficiency because involving several committees inevitably results in countervailing pressures that make it somewhat more difficult to change the status quo.

Option 3

A third alternative would be to send everything - the benefits the premiums and the subsidies -- to Labor. However, if this approach is used, the subsidy pool should be limited by appropriation [or an entitlement cap]. This alternative would contain Federal fiscal exposure, but would not limit the fiscal

in the bill. The creation of these new Federal responsibilities -- especially the defined benefits package, the mandate on employers and individuals, the subsidies, and the regulation of health insurance -- is already generating tension between Committees.

Universal coverage is the centerpiece and the most costly portion of the President's health reform initiative. Universal coverage is achieved by mandating that employers and individuals purchase health insurance. Central to the viability of this mandate are the individual and employer subsidies. As currently envisioned, Federal funding of the subsidies will be an open ended entitlement for which individuals and firms qualify on the basis of certain criteria relating to income/firm size/wage. Determinations of eligibility will be done by State-based alliances, but [with the exception of continuation of the current State contribution to Medicaid], the Federal government will bear 100% of subsidy costs.

The Ways and Means and Finance Committees will claim jurisdiction over the health reform bill by arguing that the premiums are, in fact, taxes on employers not unlike the contributions required under the Social Security Act. In addition, Chairman Rostenkowski will describe the global budget enforcement mechanism as a "tax" rather than an "assessment" on health plans and employers -- thereby justifying their claim that Ways and Means should be the appropriate venue for the mandate/benefits/subsidies.

Chairman Moynihan, and Senators Dole and Packwood will aggressively argue the Russell Long position that entitlement to benefits and financing should be kept together in order to prevent unfunded future expansion of benefits and subsidies. Predictably, these Senators will seek jurisdiction for the Finance Committee. Senator Moynihan has made it clear to the First Lady and to Treasury staff that he would be very upset if the Administration tried to steer jurisdiction away from Finance.

However, a very good case will be made by Senator Kennedy that the mandate is similar to the requirement that employers abide by certain Federally established standards [OSHA, minimum wage]. In other words, the employer mandate feature of the proposal is not a tax increase and therefore falls within the jurisdiction of the House and Senate Labor Committees.

This is an issue that will be hotly debated on the Hill, and may or may not be resolved by the parliamentarian [in part on the basis of CBO's treatment of the contributions] as Ways and Means and Finance would wish. While the First Lady has expressed her preference for a Labor Committee referral in private meetings, publicly she has sidestepped the issue of jurisdiction by saying that the Administration would not presume to intrude on the Congress' prerogative to determine which Committees should handle this bill.

impact of new costs to employers and individuals subject to the mandate. However, it may be politically infeasible to obtain enactment of the health reform bill without guaranteeing individuals and firms open ended access to the subsidies they are expecting.

II. On Budget vs. Off Budget Premiums: Approximately \$313 billion is spent annually on private health insurance. The new expenditures expected under the mandate into taxes would raise that number to approximately \$400 billion. If, for budget purposes, these expenditures are displayed on-budget -- the President's initiative could be characterized as an extraordinary expansion of the Federal government's role in the national economy.

It is therefore imperative that individual and employer contributions not be displayed on the Federal budget. Instead, the Administration should insist that the mandate is to be funded in the traditional way that insurance is purchased -- through premium contributions. To increase the probability that CBO does not treat these contributions as on-budget, very careful drafting must occur. I recommend that you speak with the first Lady to insist that Treasury participate in this drafting process.

III. Cost Estimates: The estimating process continues, both at HCFA and here at the Treasury. We are seeing some slippage in the numbers, though as you know the preliminary estimates leaked earlier this month contained room for slippage -- \$91b in deficit reduction, the opportunity to slow the long term care benefit transition, and a 2% "fudge" factor built into the premiums.

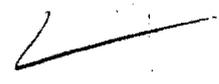
Nevertheless, there is growing concern among the Governors about the proposal to extinguish altogether the disproportionate share payments under Medicaid. Anxiety is also increasing over the very deep Medicare cuts proposed to meet the 124b target are not holding up to scrutiny by the actuaries. The most significant cuts in Medicare now on the table are a permanent 14% reduction in capital payments [the Budget Agreement included a temporary 10% cut in capital], a permanent freeze on any increases in payments to physicians except for primary care services, reducing on a permanent basis the annual hospital update to 1% below the rate of hospital inflation. If, as currently expected, the White House details the cuts proposed to meet the targets, these policies will be widely criticized.

In addition to the erosion of the savings expected from spending cuts, the Treasury estimators believe that the \$51b revenue gain shown in preliminary tables [from shifting deductible health care spending by employers into wages and other taxable compensation] will diminish when the next set of estimates is run. This change is expected to occur because of the decision to run the new estimates on the basis of the mid-session economic assumptions. [Under the mid-session modifications, the CPI rate of growth increased from the 2.7% level projected earlier to 3.5%.

Therefore, the gap between anticipated spending under current law and under health reform has narrowed -- reducing the level of scorable savings and the level of revenue raised.]

Since the estimates are changing with almost daily refinements in policies and assumptions, we recommend strongly that you continue to underscore your confidence in the process of vetting the numbers associated with the President's health reform proposal, but that you steer clear of validating any specific numbers until the estimates are complete and the Administration takes an official position on a specific set of numbers.

certainly
2/1/08



TO: Secretary Bentsen
 Deputy Secretary Altman
 FROM: Marina Weiss
 DATE: October 1, 1993
 SUBJECT: Health Care Reform: Jurisdiction, Estimates,
 and Other Miscellaneous Issues

SUMMARY: This discussion of issues relating to jurisdiction and estimates of the health care reform bill follows a 9-20-93 memo to you from Michael Levy [copy attached].

RECOMMENDATION: In brief, we recommend taking certain affirmative cautionary steps on the question of the appropriate committee venue for the mandate/benefits package portion of the plan. If you agree with the recommendations relating to jurisdiction, then we will need some guidance about whether you wish to raise these issues orally or by memo to the First Lady and/or President.

Specifically, we recommend that you encourage the President, the First Lady, Ira Magaziner and other interested White House staff to weigh jurisdiction carefully when writing the legislative language of the Administration's Health Reform proposal. Since this health reform plan is such a sweeping proposal -- more than one trillion dollars annually, or 14% of GDP -- it is important to take steps now to ensure that future changes in benefits/subsidies are adequately financed. This can be accomplished by (1) referring provisions related to both the benefits and the mandate/subsidies to the tax writing committees; by (2) by using a multiple jurisdiction mechanism [ERISA model] to force careful deliberation and funding of future changes; or (3) by limiting the pool of Federal dollars available to fund subsidies.

Secondly, we suggest you take the position that employer payments under the mandate should not be displayed as Federal receipts and expenditures...though we continue to be concerned that the CBO may deem employer contributions to be Federal taxes, and therefore on-budget receipts.

Thirdly, because there has been some slippage in the cost estimates, we recommend you continue to answer questions about the numbers by focusing on the methodology used to validate the estimates rather than taking a position on specific numbers at this time. The HCFA actuaries and Treasury estimators believe they will have a fairly good set of estimates available by October 12 [assuming certain ambiguities in the proposal are cleared up...an effort that is currently underway and being

coordinated by OMB].

Finally, in case you missed the press coverage, we thought you would want to know that Senator Jeffords (R-Vt.) has made a public commitment to cosponsor the Administration's health reform bill. As you recall, Governor Dean of Vermont has been successful in getting a commitment from the White House to allow states to establish single payer systems under the reform plan.

OPTIONS:

Agree with staff recommendations on jurisdictional issues
(Circle option you wish to exercise)

- a. I will raise orally with the First Lady and President staff to prepare talking points
- b. I prefer to raise in a memo to the First Lady [President] -- staff to prepare draft

Disagree as noted in the margins

Let's discuss

Other:

DISCUSSION:

I. Jurisdiction and the Need for Adequate Future Funding: As you know, the President's health reform proposal is likely to contain provisions in the jurisdiction of many Congressional committees. Specifically, in addition to the legislative interest of Ways and Means, Finance, the Labor Committees and Energy and Commerce, the bill is also expected to include material that lies within the jurisdiction of the Judiciary Committees, Government Affairs [Relations], Veterans, Small Business, Armed Services, Budget, Appropriations, and Indian Affairs. Non-legislative committees such as Aging and Joint Economic may also hold hearings on issues of interest to their Members.

While much of the jurisdictional division of labor is already well defined, new issues over which the Federal government currently has little responsibility are expected to be addressed in the bill. The creation of these new Federal responsibilities -- especially the defined benefits package, the mandate on employers and individuals, the subsidies, and the regulation of health insurance -- is already generating tension between Committees.

Universal coverage is the centerpiece and the most costly portion of the President's health reform initiative. Universal coverage is achieved by mandating that employers and individuals purchase health insurance. Central to the viability of this mandate are the individual and employer subsidies. As currently envisioned, Federal funding of the subsidies will be an open ended entitlement for which individuals and firms qualify on the basis of certain criteria relating to income/firm size/wage. Determinations of eligibility will be done by State-based alliances, but [with the exception of continuation of the current State contribution to Medicaid], the Federal government will bear 100% of subsidy costs.

The Ways and Means and Finance Committees will claim jurisdiction over the health reform bill by arguing that the premiums are, in fact, taxes on employers not unlike the contributions required under the Social Security Act. In addition, Chairman Rostenkowski will describe the global budget enforcement mechanism as a "tax" rather than an "assessment" on health plans and employers -- thereby justifying their claim that Ways and Means should be the appropriate venue for the mandate/benefits/subsidies.

Chairman Moynihan, and Senators Dole and Packwood will aggressively argue the Russell Long position that entitlement to benefits and financing should be kept together in order to prevent unfunded future expansion of benefits and subsidies. Predictably, these Senators will seek jurisdiction for the Finance Committee.

However, a very good case will be made by Senator Kennedy that the mandate is similar to the requirement that employers abide by certain Federally established standards [OSHA, minimum wage]. In other words, the employer mandate feature of the proposal is not a tax increase and therefore falls within the jurisdiction of the House and Senate Labor Committees.

This is an issue that will be hotly debated on the Hill, and may or may not be resolved by the parliamentarian [in part on the basis of CBO's treatment of the contributions] as Ways and Means and Finance would wish. While the First Lady has expressed her preference for a Labor Committee referral in private meetings, publicly she has sidestepped the issue of jurisdiction by saying that the Administration would not presume to intrude on the Congress' prerogative to determine which Committees should handle this bill.

As the Administration's legislative initiative is prepared for transmittal to the Hill, we recommend you make the following points.

- o First, we should not move forward without understanding the impact of jurisdiction on future financing -- particularly if we continue to support open ended funding of the employer and

individual subsidies. Given the relatively loose eligibility determination process, open ended funding of subsidies could create significant financial exposure for the Federal treasury.

o Secondly, if the Administration sends up legislative language, it will be impossible to remain neutral on the issue of jurisdiction because jurisdiction is, in part, driven by the way in which bills are drafted.

o Third, if the Administration does weigh in on jurisdiction, there are three options we should consider for the benefits/mandate/subsidies provisions.

Option 1

Severing the link between benefits and financing by assigning them to different committees has the effect of decoupling responsibility for improving coverage from the requirement that expansions in the benefit package be properly funded. When dealing with open ended entitlements, experience with this type of bifurcation (Medicaid, Black Lung) has been difficult -- leading to stalemate when changes in law are needed, friction between committees over proposals to modify the underlying statute, and directives from the Budget Committees that the tax writing panels raise revenues needed to fund program expansions with which they do not agree.

The best "good government" approach would have a single committee in each house handle the benefits/mandate and subsidies. Taking this approach would ensure that, when changes in the program are proposed, the Members experience countervailing pressures increase benefits -- and to pay for the increases. Since the Administration's current proposal envisions open ended Federal funding of the subsidies, and the cost of the subsidies is determined by the cost of the benefit package, the tax writers would be the logical venue for the benefits/mandate/subsidies.

Option 2

However, if you are inclined to support the First Lady's preference to route this bill to the Labor Committees, then a less efficient but effective mechanism for assuring "prudent decision making" is to spread responsibility among several committees -- as is currently done with ERISA. Multiple jurisdiction reduces efficiency because involving several committees inevitably results in countervailing pressures that make it somewhat more difficult to change the status quo.

Option 3

A third alternative under which the subsidy pool is limited by appropriation [or an entitlement cap] could be used independently or added to Option 2 above. This alternative would contain Federal fiscal exposure, but would not the limit the fiscal

impact of new costs to employers and individuals subject to the mandate. Under this approach, the exposure of the Federal government would be predictable and controllable, therefore the unlimited exposure problem goes away. However, it may be politically infeasible to obtain enactment of the health reform bill without guaranteeing individuals and firms open ended access to the subsidies they are expecting.

II. On Budget vs. Off Budget Premiums: Approximately 320b is spent annually on health care premiums. The new expenditures expected under the mandate into taxes would raise that number to approximately 410b. If, for budget purposes, these expenditures are displayed on-budget -- the President's initiative could be characterized as an extraordinary expansion of the Federal government's role in the national economy.

It is therefore imperative that individual and employer contributions not be displayed on the Federal budget. Instead, the Administration should insist that the mandate is to be funded in the traditional way that insurance is purchased -- through premium contributions. For budget purposes, maintaining this distinction requires....Alan, what will we say here?

III. Cost Estimates: The estimating process continues, both at HCFA and here at the Treasury. We are seeing some slippage in the numbers, though as you know the preliminary estimates leaked earlier this month contained room for slippage -- \$91b in deficit reduction, the opportunity to slow the long term care benefit transition, and a 2% "fudge" factor built into the premiums.

Nevertheless, there is growing concern among the Governors about the proposal to extinguish altogether the disproportionate share payments under Medicaid. Anxiety is also increasing over the very deep Medicare cuts proposed to meet the 124b target are not holding up to scrutiny by the actuaries. The most significant cuts in Medicare now on the table are a permanent 14% reduction in capital payments [the Budget Agreement included a temporary 10% cut in capital], a permanent freeze on any increases in payments to physicians except for primary care services, reducing on a permanent basis the annual hospital update to 1% below the rate of hospital inflation. If, as currently expected, the White House details the cuts proposed to meet the targets, these policies will be widely criticized.

In addition to the erosion of the savings expected from spending cuts, the Treasury estimators believe that the \$51b revenue gain shown in preliminary tables [from shifting deductible health care spending by employers into wages and other taxable compensation] will diminish when the next set of estimates is run. This change is expected to occur because of the decision to run the new estimates on the basis of the mid-session economic assumptions. [Under the mid-session modifications, the CPI rate of growth increased from the 2.7% level projected earlier to 3.5%. Therefore, the gap between anticipated spending under current law

and under health reform has narrowed -- reducing the level of scorable savings and the level of revenue raised.]

Since the estimates are changing with almost daily refinements in policies and assumptions, we recommend strongly that you continue to underscore your confidence in the process of vetting the numbers associated with the President's health reform proposal, but that you steer clear of validating any specific numbers until the estimates are complete and the Administration takes an official position on a specific set of numbers.



DEPARTMENT OF THE TREASURY
WASHINGTON

126124

ASSISTANT SECRETARY

October 4, 1993

MEMORANDUM FOR SECRETARY BENTSEN
ROGER ALTMAN
FRANK NEWMAN
LES SAMUELS
MICHAEL LEVY
LINDA ROBERTSON
JACK DEVORE
JOAN LOGUE KINDER
JOSH STEINER
ED KNIGHT
BEN NYE
KEVIN VARNEY

FROM: Alicia Munnell *AM*
SUBJECT: Update on Health Care War Room Meetings

Events:

Secretary Shalala will testify before several of the committees that the First Lady addressed last week. She begins with Energy and Commerce on Tuesday.

Congressional staffers are requesting additional health care briefings. The "Health Care University" may resume later this week.

The President is speaking on health care in San Francisco this morning before a convention of the AFL-CIO. Tomorrow he will address the American Association of Retired Persons in Los Angeles.

War Room staff will do "affirmative scheduling" of surrogates to speak before seniors and business groups in the coming weeks.

Miscellaneous:

In a speech on Saturday to the California Grocers Association, former President George Bush said he came away impressed with President Clinton's nationally televised address on health care. "The speech he gave was absolutely terrific and it made me see how inarticulate I was," he said. "I served between Ronald Reagan and Bill Clinton, two very good communicators."

AM



DEPARTMENT OF THE TREASURY
WASHINGTON

126163

BRIEFING

October 5, 1993

ASSISTANT SECRETARY

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Alicia Munnell *gmo / AM*
Assistant Secretary for Economic Policy

SUBJECT: HEALTH CARE ECONOMIC IMPACT PRESS CONFERENCE

DATE AND TIME: October 6, 1:30 P.M.

LOCATION: White House, West Wing Briefing Room

PARTICIPANTS: Mark Gearan
Robert Rubin
Laura Tyson
Robert Reich
Erskine Bowles
White House Press Corps

TREASURY: Secretary Bentsen

BRIEFING:

Wednesday at 1:30 the Administration is briefing the White House press corps on the economic impact of health care reform. The briefing will be held in the West Wing Briefing Room. The stated purpose is to provide the press with more detailed information on the economic impact of the Health Security Plan, and to follow through on CEA Chair Tyson's commitment to have a briefing which addresses the employment issue.

Note that financing issues are not the topic for the briefing.

At the briefing three Administration reports on the economic impact of the health care reform plan will be released:

- The Cost of Failing to Reform Health Care, by Laura D'Andrea Tyson
- Economic Effects of Health Care Reform, by Robert Reich and Laura D'Andrea Tyson
- The Health Security Act: The Benefits to Business, by Erskine Bowles

You are scheduled to follow Mark Gearan (who will introduce the briefing) and Mr. Rubin (who will be master of ceremonies, and tell anecdotes about the eagerness of CEOs for cost containment). You will speak before Laura Tyson (who will discuss the economic impact of failing to reform health care), Robert Reich (who will discuss the effect of reform on employment), and Erskine Bowles (who will discuss the impact of reform on small business).

Your role is to set out an overall framework for the economic impact of reform so that the press corps will have a sense of the broader context into which the three reports to be released tomorrow fit.

Ilene Zeldin is preparing a draft of your remarks, working from an Economic Policy outline. You should feel very comfortable making statements about the long run positive economic impact of health care reform. The major aim of the reform is to restructure the health care system so that resources are used more efficiently. The benefits to business from successful cost containment are potentially large. Workers benefit from the increase in labor force mobility that reform will make possible. Cost containment will raise wages, which should pull more people into the labor force and increase employment in the long run.

As you know, the controversial area is the possible expectation of reductions in employment in the first one to five years after reform. Economists generally sympathetic to the Administration are likely to produce estimates of net employment reductions on the order of 100,000-400,000. This is a very small magnitude relative to an economy in which 120 million are at work, and at most a small reduction in the rate at which the number of Americans employed is likely to grow over the next four years.

BACKGROUND: SUMMARY OF REPORTS TO BE ISSUED AT THE PRESS BRIEFING

The Cost of Failing to Reform Health Care focuses on the extraordinary growth of health care spending in the past decade and the continued growth of spending projected for the future. It sets out the consequences for American wages and living standards—stagnation—if the upward spiral in health care costs should continue. It assesses the burden that continued rises in health care costs will place on those businesses that today provide insurance. And it lays out the impact on the federal deficit of a failure to control the size of government health programs: a deficit that begins to rise again after 1998 at a

rapid pace.

Economic Effects of Health Care Reform begins with a sharp attack on the relevance and the credibility of studies critical of the Administration proposal that have been carried out by the Employment Policies Institute and by CONSAD Research Corporation. It continues with a discussion of how existing economic models do not provide definitive answers to many essential issues in evaluating health care reform—hence “it seems irresponsible to produce one set of estimates to summarize the plan.”

It concludes by stating that the broad outlines of the economic impact are clear:

- Cost containment and increased health-sector productivity generated by managed competition increase living standards and wages.
- Little or no aggregate employment impact in the short run of one to five years. Likely employment benefits in the longer run of ten or more years.
- A great deal of restructuring—jobs destroyed matched by jobs created—both within the health care industry, and between firms that face health care costs different from those they face now.
- Large and tangible benefits from the elimination of “job lock” and the provision of health care security.

Treasury staff believe that the Economic Effects of Health Care Reform may fail to be an effective report: it is too defensive and focuses too tightly on some possible defects in and arguments against the plan. The staff-level authors, Treasury staff believe, find themselves in a difficult situation because Ira Magaziner ignored many of their proposals, and the White House now demands that they validate the policy choices made. Reporters may pick up this subliminal uneasiness in the document.

The Benefits to Business is a clear and effective summary of the plan. It effectively presents the benefits to business—administrative simplification, increased bargaining power through the Health Alliances, and employer premium caps.



DEPARTMENT OF THE TREASURY
WASHINGTON

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina Weiss and Brad DeLong

SUBJECT: Draft Q and A's for Health Reform Press Conference

DATE: October 6, 1993

ACTION FORCING EVENT:

White House press conference to release Labor Department/CEA reports on economic impacts of health reform.

RECOMMENDATION:

These Q and A's are for your use in preparing for the press conference.

OCTOBER 6 WHITE HOUSE PRESS CONFERENCE

Health Reform Questions and Draft Responses

QUESTION: Mr. Secretary, as you know there is widespread skepticism about the veracity of the cost estimates surrounding this health reform plan. As chief economic spokesman for the Administration, what do you think of these estimates? Are you satisfied that they are credible?

DRAFT RESPONSE: As Bob Rubin mentioned at the beginning of this press conference, we are not here to talk about cost estimates...we are here to release two excellent reports on the importance and impact of health reform for our economy.

But with Bob's indulgence, I want to try to lay to rest -- at least for today -- some of the anxiety that seems to surround the preliminary numbers you have been citing in your press reports.

Very frankly, I am perplexed about the amount of skepticism that the press seems to have about these estimates.

As you know very well, the leaked September 7 document was clearly labeled draft and preliminary and, in my judgment, should be treated as such...this health plan is a work in progress.

The HHS actuaries, the Treasury estimators and the Urban Institute are engaged in a very complex estimating process. As you might expect, some of these estimates are relatively straightforward and can be done fairly quickly -- for example, it is not particularly difficult to estimate the savings that result from certain reductions in Medicare spending, nor is it especially difficult to estimate the impact of raising the tobacco tax.

However, it is complicated to try to assess the budgetary impact of the combined effects of community rating insurance policies, creation of a new subsidy system for small employers, and extending health insurance coverage to early retirees. Moreover, we are trying to make informed judgments about the speed with which States will be able to come into the new system and set up alliances. And of course we have to make some reasonable assumptions about how many and which employers are likely to come into these alliances, and how many will choose to set up corporate alliances. In addition, as the First Lady and the President consult with Members of Congress, some of the provisions of the bill are being modified...and those changes often have an impact on the numbers.

In short, cut us some slack! We are doing our level best to come up with solid, conservative estimates. We have told you what we are doing...we have asked non-governemnt actuaries and estimators to review our assumptions and our methods of estimating...and we

have promised to give you the numbers as soon as we have them.

And today I will take one further pledge, we will not release numbers until we are confident they are the best we can produce...and if you or Members on the Hill can improve on the estimates as this bill goes through the legislative process, then we will welcome your constructive suggestions.

QUESTION: Mr. Secretary, I appreciate your willingness to take that pledge, but we continue to be peppered with numbers from some of the White House's most senior staff. These are not numbers we made up, we have been told, for example, that the early retiree provisions would add only \$4.5b to the cost of the President plan. In fact, Mrs. Clinton so testified on the Hill last week.

Yet, less than 24 hours later, Ira Magaziner revised that estimate upward to more than \$6b. And we hear rumors it may be going up even more. What are we to make of these "leaks?" Are they to be dismissed as preliminary and unreliable?

DRAFT RESPONSE: My response stands. Dr. Tyson and Secretary Reisch deserve our attention. Let's not turn this occasion into a press conference about cost estimates that are not yet finished.

QUESTION: Mr. Secretary, the last time this group held a press conference you were absent and the Treasury was represented by Deputy Secretary Altman. May we assume your time is devoted primarily to NAFTA and that you are less engaged in the health reform debate?

DRAFT RESPONSE: No, you may not so assume. During the economic team's last press conference on health reform I was in New York delivering a speech to the Economic Club...and Deputy Secretary Altman ably represented the Department.

Of course I am engaged in NAFTA, but I am also deeply involved in health reform...and have been since January when I was named by the President to sit on the First Lady's task force.

Treasury staff have been working with Ira and others at the White House throughout the year on this issue...and both Deputy Secretary Altman and I have been involved in many meetings with the President and First Lady as issues are considered and decisions made with respect to the Administration's proposal.



DEPARTMENT OF THE TREASURY
WASHINGTON

124135

ASSISTANT SECRETARY

October 5, 1993

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Alicia Munnell *AMM*
SUBJECT: Economic Impact of Health Care

SUMMARY:

The purpose of the economic briefing is to follow through on Laura Tyson's commitment to address the impact of health care reform on employment. Your role is to set out an overall framework for the economic impact of reform in order to create a context into which to place more detailed comments by Tyson, Reich, and Bowles.

Although the immediate impact of the health care proposal on jobs is uncertain, the long run implications are very positive. You should feel very comfortable about emphasizing the favorable impact of reform on economic growth, wages, employment, and competitiveness.

DISCUSSION:

Ilene Zeldin is preparing your brief remarks, working from an Economic Policy outline. These remarks will focus on the long-run beneficial effects of health care reform on the economy. You should feel comfortable making a number of very positive statements.

The most important point to emphasize is that health care reform will move economic resources from an industry where they are being used inefficiently into the broader economy where they will be used more efficiently. A better allocation of resources will lead to higher levels of output; the economy will undoubtedly have higher levels of GDP with health care reform than without.

Reform will improve the welfare of workers in a number of ways:

- o By making health insurance benefits portable, employees will no longer have to fear the health insurance consequences of changing jobs or starting their own business. As a result, workers will be employed in those activities where they will be most productive.
- o By restraining the growth of health care costs, employees will see more of their compensation in the form of cash wages and bigger pay checks.

o Higher levels of productivity and reduced health care costs will raise wages, which should pull more people into the labor force and increase employment in the long run.

Business will also benefit from health care reform. The majority of firms that provide health insurance will save money, as they are able to purchase their insurance for less. Companies will also see a reduction in their administrative costs as they escape from an avalanche of paper work. Increased profits will lead to further investment and growth.

Finally, health care reform will eliminate the major source of growth in federal spending, thereby ensuring that large deficits will not re-emerge in the late 1990s. Declining deficits as a percent of GDP will ensure low interest rates and a hospitable climate for investment and growth.

In short, health care reform will have very positive effects on the economy and on workers.

As you know, the controversial area is the expectation of job loss in the first one to five years after reform. Economists sympathetic to the Administration will produce estimates of net employment reductions on the order of 100,000 to 400,000. It is important to remember that these are estimated reductions from projected growth -- not actual reductions in the number of people employed -- and that these are very small numbers in an economy of 120 million workers.

Despite the small magnitude, the White House does not want to admit to any employment loss. The only response is throw up your hands and indicate that it is not possible to tell what will happen in the short run when one seventh of the economy is in transition. In the long run, health care reform will definitely help the economy.

Finally, three documents will be handed out at the meeting and a brief description of each is attached.

SUMMARY OF REPORTS TO BE ISSUED AT PRESS BRIEFING

The Cost of Failing to Reform Health Care focuses on the extraordinary growth of health care spending in the past decade and the continued growth of spending projected for the future. It sets out the consequences for American wages and living standards -- stagnation -- if the upward spiral in health care costs should continue. It assesses the burden that continued rises in health care costs will place on those businesses that today provide insurance. And it lays out the impact on the federal deficit of a failure to control the size of government health programs: a deficit that begins to rise again after 1998 at a rapid pace.

Economic Effects of Health Care Reform begins with a sharp attack on the relevance and credibility of studies critical of the Administration proposal that have been produced by the Employment Policies Institute and by CONSAD Research Corporation. It continues with a discussion of how existing economic models do not provide definitive answers to many essential issues in evaluating health care reform-hence "it seems irresponsible to produce one set of estimates to summarize the plan."

It concludes by stating that the broad outlines of the economic impact are clear:

- o Cost containment and increased health-sector productivity generated by managed competition increase living standards and wages.
- o Little or no aggregate employment impact in the short run of one to five years. Likely employment benefits in the longer run of ten or more years.
- o A great deal of restructuring-jobs destroyed matched by jobs created-both within the health care industry, and between firms that face health care costs different from those they face now.
- o Large and tangible benefits from the elimination of "job lock" and the provision of health care security.

The Benefits to Business is a clear and effective summary of the plan. It effectively presents the benefits to business-administrative simplification, increased bargaining power through the Health Alliances, and employer premium caps.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

120153

SECRETARY OF THE TREASURY

October 6, 1993

MEMORANDUM FOR THE FIRST LADY

FROM: Lloyd Bentsen 
SUBJECT: Health Care Reform Drafting

As we all work to finalize the details of the Administration's health care proposal, it becomes important to ensure that the actual legislative language accurately reflects the decisions that are made. Because many of the financing issues were not decided until late in the process, the drafting of those provisions has necessarily been delayed. However, I am becoming increasingly concerned that many of these important issues will not be allocated the drafting time and resources necessary to ensure that they work properly.

To date, the Treasury Department has not been involved in any drafting of the health reform plan and has received only a very rough draft of one relatively minor issue -- the tax treatment of long term care insurance.

We anticipate that considerable drafting attention will be required with respect to a wide variety of tax issues included in the plan. In addition, there are a number of issues that have not been characterized as taxes, but that directly relate to areas in which the Treasury Department and the Internal Revenue Service have considerable expertise. Attached for your information is a listing of these items.

I hope that we can bring our experience to bear by being directly involved in the drafting of the relevant portions of the legislation and in commenting on those issues where Treasury/IRS input might improve the product. In addition, we will need to review the legislative language on certain issues in order to ensure that the policies reflected in the draft statute are consistent with the policies that have been estimated.

I look forward to hearing from you or the relevant members of the drafting team on these issues in the near future.

Attachment

TREASURY DEPARTMENT DRAFTING ISSUES IN HEALTH CARE REFORM

- . Tobacco taxes
- . Tax cap proposal and rules eliminating the use of so-called cafeteria plans to provide health benefits.
- . Tax treatment of benefits paid under new long term care program.
- . Taxation of long-term care insurance and accelerated death benefits.
- . Disclosure of tax information to alliances and others.
- . Information reporting with respect to Medicare as a secondary payer.
- . Tax incentives for health care professionals in underserved areas.
- . Payroll tax as a sanction to ensure state establishment of regional alliances.
- . Changes in ERISA preemption and sanctions (jointly with the Department of Labor).
- . Tax credit for the disabled.
- . Assessments on employers outside the alliance (so-called corporate assessment).
- . Early retiree issues, including the possibility of a one-time assessment on firms benefiting from retiree health changes; the impact on existing tax-favored retiree health prefunding vehicles (401(h) accounts and VEBAs); and the possibility of means testing the government subsidy.
- . Availability of tax-exempt financing for Regional Alliances.
- . Means-related Medicare Part B premiums.
- . Extension Medicare HI to tax to all state & local government employees.
- . Impact on so-called COBRA health care continuation rules.
- . Tax treatment of entities affected by proposal (regional and corporate alliances; plans and providers).
- . Establishment of trust fund for self funded health plans.
- . EMPLOYEE HEALTH BENEFITS FUND/Reserve Fund.

Establishment of National Health Reform revolving fund for investment in the start-up cost VA Health Plans.

ISSUES WHERE TREASURY AND IRS HAVE CONSIDERABLE EXPERTISE

Premium Collection -- Although the premiums will be collected by the regional alliances, there will be considerable parallels between the collection of these mandated premium payments and the collection of tax revenues. Treasury and IRS input on these issues will help to improve the draft.

Subsidies -- Although, the subsidies will be provided through the alliances, as noted, as wide variety of questions must still be answered in designing the subsidy scheme, including (i) the appropriate definition of payroll in determining eligibility for employer subsidies; (ii) designing rules to prevent abuse through employer reorganization; outsourcing of low wage workers or misclassification of employees as independent contractors; (iii) the appropriate definition of income for eligibility for the individual/family subsidy; and (iv) verification of eligibility for the individual/family subsidy. The Treasury Department and IRS have been dealing with similar issues for years in connection with the collection of income and payroll taxes and through the administration of the Earned Income Tax Credit.

Assessments on Plans -- The plan currently includes an assessment on plans in the alliance for a variety of purposes, including the funding of academic health centers. This essentially involves the imposition of a Federal premium tax, although it must be carefully drafted to avoid the appearance of being such a tax. The Treasury Department has done considerable analysis on the method for implementing such a tax.

Budgets -- The estimates of the effects of the mandate on Federal receipts are sensitive to the assumptions regarding cost containment. In order to minimize revenue loss, the budget caps must be effective.



ASSISTANT SECRETARY

ACTION

MEMORANDUM

LSB

TO: SECRETARY BENTSEN
FROM: LES SAMUELS
DATE: OCTOBER 7, 1993
RE: ATTACHED MEMORANDA

Attached are memoranda on a number of subjects related to health care reform. These are the first installment of a series of memoranda asking for your approval and/or guidance regarding certain aspects of the health care reform proposal.

Specifically, the memos address the following issues:

- Definition of Payroll
- Tax Treatment of Blue Cross/Blue Shield Organizations
- Long Term Care Insurance
- Prefunding of Retiree Health Benefits
- Tax Exempt Financing

cc: R. Altman
A. Munnell
M. Weiss

October 7, 1993

MEMORANDUM FOR SECRETARY BENTSEN

From: David Weisbach (622-1129)
Through: Leslie Samuels
Re: Definition of payroll for small businesses

SUMMARY -- There are two related health care issues with respect to S corporations and other small businesses. First, to determine employer subsidies under health care reform, we must define "payroll." There are strong reasons to define payroll based on employment tax definitions. Second, under current law, S corporation owners can largely avoid employment taxes attributable to income from their business by recharacterizing wages as dividends. The incentive to recharacterize wages as dividends will be exacerbated by basing the employer subsidies on average payroll. agr

ISSUES

1. Definition of payroll for health care reform and employer subsidies:

Background: The definition of payroll for health care reform will determine how the 7.9% cap on premiums is determined and the extent to which small businesses are eligible for the small business subsidies. The current draft of the health care plan does not include a definition of payroll.

Problem 1: How should payroll be defined?

Recommendation: Payroll should be defined consistently with employment tax definitions (i.e., as FICA wages and SECA earnings). 20

Pro: Defining payroll consistently with employment tax definitions reduces taxpayer burden and eases administration.

Con: This approach increases the need to close loopholes in the employment tax discussed below.

Decision:

Agree: Disagree: Let's Discuss:

Problem 2: Should the payroll of a company include self-employment earnings of owners? Compensation of owners is frequently higher than those of employees. Including earnings of owners in payroll, therefore, will limit the ability of small businesses to qualify for the subsidy.

Recommendation: Include self-employment earnings in payroll.

Pro: Including self-employment earnings is consistent with the decision to base the subsidy on average wages. Any other approach could increase the subsidy cost by granting a subsidy to the owner of the small business.

A recent Wall Street Journal article pointed out this loophole. The staff of Ways & Means have suggested that our bill should prevent this possible abuse.

Con: This may limit the class of businesses eligible for the subsidy. The subsidy is supposed to prevent employers from laying off low wage workers because of the health care mandate. It is the wages of the employees that are relevant for this determination.

Decision:

Agree: FNB Disagree: _____ Let's Discuss: ✓

2. Employment tax avoidance:

Background: Defining payroll based on the employment tax definitions will increase the need to close loopholes in the employment tax rules. In particular, the S corporation employment tax rules should be corrected as part of health care reform.

Under current law, shareholders of S Corporations are taxed on their wages under FICA; corporate distributions of non-wage income are not subject to employment tax. General partners, however, are taxed under SECA on their entire distributive share of partnership income (subject to certain limits). For purposes other than employment tax, such as the taxation of fringe benefits, S corporations shareholders are treated as partners if they hold more than two percent of the stock. *person income tax*

Problem: S corporations can disguise wages as distributions or some form of income other than compensation. This problem was exacerbated by the removal of the HI wage cap. Defining payroll under the employment tax definitions will further increase the incentive to disguise wages. Partnerships and sole proprietors cannot disguise wages because they are subject to SECA tax on all of their business income. ✓

Recommendation: As part of health care reform, revise the employment tax rules to limit the ability of S corporations to disguise wages and payroll. The revisions should include treating two percent shareholders of S corporations as generally

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Agree: FNB Disagree: _____ Let's Discuss: ✓

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Recommendation: As part of health care reform, revise the employment tax rules to limit the ability of S corporations to disguise wages and payroll. The revisions should include treating two percent shareholders of S corporations as generally

subject to SECA tax if they are employed by the corporation and rules which limit the SECA tax on capital income of S corporations and partnerships. ?

Data show that a significant portion of S corporation income is attributable to capital. Without some rules to exclude this income, we could significantly increase the tax on capital. Any rule which attempts to reduce the tax on capital income, however, will increase complexity. We have not yet determined the most workable approach but believe that some adjustment is appropriate. Possibilities we are exploring include: (i) allowing a "reasonable" return on capital; (ii) drawing a bright line such that a fixed percentage of income is attributable to both capital and labor (i.e., such as 30 percent of the income); and (iii) specific rules based on the type of business (e.g., all income from service businesses is subject to SECA). The same rules should apply to partnerships and sole proprietorships; we should treat all small businesses the same. *very*
arbit
+ comp

The rules for limited partners should be conformed to the S corporation rules. Under current law, limited partners are not subject to SECA tax, even if they work for the partnership. Two percent *plus* limited partners, however, should be subject to the same rules as two percent S corporation shareholders.

Pro: The recommendation prevents avoidance of employment taxes and health care premiums. The recommendation also levels the playing field between S corporations, partnerships, and sole proprietorships. Finally, the recommendation may raise several billion dollars (estimates of the proposal without the capital income limitations are about \$9 billion over five years). 

Con: The recommendation may have the effect of taxing the capital income of S corporation owners. It will also increase the tax burden on this type of small businesses.

Decision:

Agree: _____ Disagree: _____ Let's Discuss: *LWS*

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Mike Kaufman (622-1787)
THROUGH: Leslie B. Samuels
Assistant Secretary (Tax Policy)
SUBJECT: Blue Cross/Blue Shield Companies

BACKGROUND:

Blue Cross/Blue Shield organizations (Blues) are entitled to a special deduction. The Blues deduction for a company is calculated as the difference between 25 percent of its health claims (including claims expenses) and its adjusted surplus. The Blues deduction is included in the base of the alternative minimum tax as an adjustment.

The Blues deduction was designed to encourage companies to write health insurance policies for individuals and small groups for a reasonable premium, without excluding persons with pre-existing medical problems. The Blues can provide such insurance for small group business by charging community-rated rather than experience-rated premiums.

ISSUE:

Should repeal of the special Blues deduction be proposed as part of the national health care proposal?

RECOMMENDATION:

We recommend that the Blue Cross/Blue Shield deduction should be repealed for both regular and minimum tax purposes. The repeal should be effective on 1/1/97, the date on which all states are required to establish an alliance. Once fully effective, the proposal would raise approximately \$250 million per year.

Another option might be to phase-out the tax benefits to provide the Blues to help cover the costs of adjusting to the new health plan requirements and the tax changes. The deduction could be phased out ratably over a 3-year period. We do not, however, feel such a phase-out is necessary.

DECISION:

 Agree Disagree Let's discuss

Would they have a disproportionate share of pre-existing, etc until '97. Wouldn't it take 2 or 3 years to equate the unit?

DISCUSSION:

The health insurance reform proposal of the Administration would prevent any insurance company from denying enrollment to an applicant because of health, employment, or financial status. It would also prevent insurance companies from charging higher premiums to persons more likely to incur higher medical costs because of pre-existing conditions, age, or other factors related to risk. The health proposal would effectively require all plans receiving premiums through health alliances to meet the test of charging community-rated premiums that Blue Cross/Blue Shield insurers now writing community-rated policies must meet in order to retain the special Blues deduction.

If all insurers are required to charge community-rated premiums to all customers in order to do business, a subsidy to Blue Cross/Blue Shield companies would no longer be needed to make health insurance with community-rated premiums available to the public. Uniform tax rules for all insurance companies selling community-rated policies are needed to provide a framework for effective market competition between Blue Cross/Blue Shield companies and other health insurers.

MEMORANDUM TO SECRETARY BENTSEN

THRU: Leslie B. Samuels
Assistant Secretary (Tax Policy)

FROM: Beth A. Brooke
Taxation Specialist

SUBJECT: Long-Term Care Insurance Provisions of Health Care Reform

The purpose of this memorandum is to highlight tax issues and make recommendations with respect to the long-term care insurance provisions contained in the health care reform proposal. The long-term care insurance provisions of the health reform proposal and our recommendations generally follow the tax provisions set forth in the long-term care bill (S. 1693) that you introduced in the last Congress, with some differences (discussed below) that were incorporated to accommodate concerns expressed by members of the health care task force and HHS.

BACKGROUND

The primary purpose of S. 1693 (the Bill) was to clarify that long-term care expenses of chronically ill individuals would be treated as medical expenses for tax purposes and that benefits paid under qualified long-term care insurance contracts would not be taxable.

The Bill provided the policyholder with favorable tax treatment (i.e., premium deductibility and tax-free benefits) to the extent that a qualified long-term care insurance policy paid benefits of no more than \$100 per day to the policyholder. The \$100 per day benefit could be spent for any use by the recipient without jeopardizing this favorable tax treatment. If the policy provided benefits in excess of \$100 per day, favorable tax treatment was provided to the extent that the excess payments represented a reimbursement of qualified long-term care service expenditures. In other words, a reimbursement policy (one which reimburses for qualified long-term care services) received favorable tax treatment.

However, if payments in excess of \$100 per day were made under the policy without regard to how the payments were used by the recipient, the policy did not constitute a qualified long-term care contract and favorable tax treatment was only applied to the extent that the benefits were used to pay for qualified long-term care services. Accordingly, reimbursement policies were treated somewhat more favorably than policies that

reimbursed on a per diem basis, regardless of how the insurance benefits were expended by the recipient.

RECOMMENDATION

Tax Treatment of Long-Term Care Insurance

Under our recommendation, favorable tax treatment would be provided for a qualified long-term care insurance policy. A policy must satisfy specific requirements to be viewed as the "standard" qualified long-term care benefit policy. The standard long-term care insurance policy would be required to:

- 1) satisfy the NAIC Long-Term Care Insurance Model Act provisions,
- 2) condition eligibility for benefits on being unable to perform two activities of daily living (ADLs) or on suffering severe cognitive impairment,
- 3) not allow prefunding or cash values, and
- 4) limit benefits to \$150 per day (indexed for inflation) without regard to actual incurred long-term care expenses.

Our recommendation would create a level playing field between long-term care insurance policies that reimburse for actual long-term care expenses (reimbursement policies) and long-term care insurance policies that provide a fixed periodic benefit regardless of actual expenses (per diem policies). Also, our recommendation would follow the framework in which the health care proposal treats standard and supplemental health benefits for tax purposes.

Deductibility of Long-Term Care Expenses

As under the Bill, we recommend that the definition of medical care be expanded to include qualified long-term care services. However, qualified long-term services would be defined to tighten the current deductibility rules for medical care related to long-term care expenses. The reason for the stricter deductibility rules is to (1) somewhat restrict an individual's ability to deduct nursing home care and home care costs unless they are sufficiently ill or impaired, and (2) to encourage the purchase of tax-favored, private long-term care insurance in order to lessen the governmental burden of providing further entitlements. The stricter rules would require certification with respect to needing assistance with two ADLs or severe cognitive impairment. Also, room and board would not be deductible.

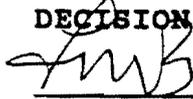
Cafeteria Plans

We further recommend that qualified long-term care insurance coverage cannot be purchased by employees with before-tax dollars through a cafeteria plan. This is also consistent with the Bill. The favorable tax treatment provided for qualified long-term care insurance coverage is sufficiently generous. This approach is also consistent with the elimination of health benefits provided through cafeteria plans under the health reform package.

Accelerated Death Benefits

Also, we recommend that the Internal Revenue Code be amended to include the provision from the Bill to allow accelerated death benefits received by an individual expected, due to terminal illness, to die within 12 months to be excluded from taxable income. While proposed regulations have been issued to that effect, there is concern about the statutory authority for those regulations. Our recommendation would clarify the statute. Your previous memorandum to the First Lady on this issue recommended inclusion of this provision.

DECISION



Agree

Disagree

Let's Discuss

DISCUSSION

A point of contention with the Department of Health and Human Services was on the definition of a qualified long-term insurance contract. Our recommendation reflects a possible compromise that we have discussed with HHS. Politically, our recommendation of a cap on the tax-free payments on all long-term care should be acceptable to Senator Mitchell who, as you may recall, has expressed opposition to the proposal to cap per diem policies. Mrs. Clinton has mentioned her desire to accommodate Senator Mitchell, and we are comfortable with the package recommended from a tax policy perspective.

We also wanted you to be aware that other parts of the health reform bill contemplate significant Federal regulation of long-term care insurance by HHS.

MEMORANDUM

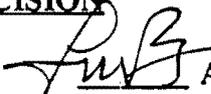
To: Secretary Bentsen
From: Harlan Weller (622-1001)
Through: Les Samuels
Date: October 7, 1993
Re: Pre-funding of Retiree Medical Benefits

SUMMARY -- In response to FASB's recent requirement that employer recognize the cost of their promises to provide post-retirement medical benefits to their employees, many employers have scaled back their promises. The advent of Health Reform will mean that even fewer employers will be providing post-retirement medical benefits; and for each of those employers, the dollar amounts involved will be sharply reduced. This memo addresses the implications of these changes on the Code provisions that permit employers to pre-fund for their future liability on a tax-favored basis.

RECOMMENDATION

We recommend that employers that continue to provide substantial retiree medical benefits would still be able to pre-fund for those benefits that may be provided on an tax-favored basis under the so-called VEBA rules of the Code (with some modifications). We also recommend that this opportunity be used to eliminate the Code provisions that permit an employer to append a retiree medical benefit onto their qualified pension plans.

DECISION

 Agree _____ Disagree _____ Let's Discuss _____

DISCUSSION

Current Law

Current law provides two different vehicles that employers may use to pre-fund retiree medical expenses -- Section 401(h) accounts and welfare benefit funds under section 419 (most commonly these are voluntary employee beneficiary associations, VEBAs). Each of these vehicles allows for deductions for actuarially determined employer contributions that are expected to be necessary to provide for future medical benefits, subject to certain limits. In the case of a Section 401(h) account the limit is 25 % of the contributions to the associated pension or annuity plan (other than contributions to fund past service credits). In the case of a VEBA (other than a collectively bargained VEBA or certain VEBAs covering 10 or more employers) the limit is indirect -- employers are required to use current nominal costs for determine future medical costs (i.e., they can't anticipate any future medical inflation). In addition, income in such a VEBA (other than a collectively bargained VEBA) is subject to tax as unrelated business income (UBIT).

Need for a single pre-funding vehicle

Although employers will have a significant reduction in their liability for retirees as a result of Health Care Reform, employers might still provide for any of the following benefits for their retirees:

1. "Employer" or "employee" premium for pre-age 55 retirees
2. "Employee" premium for age 55-64 retirees ("employer" premium is paid by government)
3. Supplemental benefits for pre-65 retirees (including cost-sharing)
4. Medicare premiums for post-65 retirees
5. Medigap coverage for post-65 retirees

The availability of two different pre-funding vehicles, each with its advantages and disadvantages, that are intended to serve the same purpose does not make sense. If it is desirable to provide a vehicle for prefunding, then a single vehicle should be designed. Employers should not have to analyze which vehicle maximizes their tax advantage -- and should not be able to combine two vehicles in order to exceed any limits on funding that are appropriate.

Which vehicle should survive ?

We recommend that section 401(h) accounts be eliminated. This would leave VEBA's (as modified) available for prefunding retiree medical benefits. We believe that the current rules applicable to section 401(h) accounts are overly generous in terms of tax breaks. In addition, it makes little sense to tie the availability of post-retirement medical funding to the amount of the pension or annuity contribution.

Proposed modification to VEBA rules

We would clarify the VEBA rules to support IRS efforts to curb current abuses in the following ways:

1. Pre-funding would only apply to benefits that will be excludable from income for the retiree (i.e., not for items that are not excludable under the tax cap proposal such as private rooms and other supplemental benefits).
2. The post-retirement medical VEBA must be kept separate from any other funds.
3. The amount of contribution to the VEBA should be based on actuarial methods using reasonable assumptions funding over average working lives with a minimum of 10 years.

MEMORANDUM FOR: SECRETARY BENTSEN

FROM: Mitch Rapaport (622-0871)

THROUGH: Les Samuels

SUBJECT: Health care--tax-exempt bond issues

The materials released to date on health care reform present two significant issues relating to tax-exempt bonds, the issuance of tax-exempt bonds by States to fund the required guaranty funds and the issuance of short-term, tax-exempt debt for the benefit of the health care alliances. We have been told that the health care plan does not contemplate expanding tax-exempt financings. However, in some cases current law may have to be modified to prevent potential revenue loss under the current tax-exempt bond rules.

1. State guaranty funds.

Background. The draft of the health care plan provides that each State must operate a guaranty fund to provide for plan defaults. Under the plan, these guaranty funds may borrow against future assessments in order to meet obligations of a failed plan.

Issue. Should these borrowings qualify as tax-exempt bonds so that a State could borrow either to provide necessary initial capital for the guaranty fund or to meet claims as they arise?

Recommendation. States should not be permitted to issue tax-exempt bonds to provide funds for the guaranty funds.

Discussion. Operators of the guaranty funds may want to borrow to provide a significant initial fund balance, rather than after incurring a large loss that the fund could not pay without borrowing. The desire to provide coverage for extraordinary losses and the ability to issue tax-exempt bonds would make this pattern of funding very likely. Under current tax law, bonds issued for this type of use generally are considered "hedge bonds" and cannot be issued as tax-exempt bonds. We recommend that the law not be changed to permit these borrowings to be tax-exempt.

The hedge bond rules would also generally prevent the issuance of tax-exempt debt by guaranty funds to meet claims as they arise. If, however, a guaranty fund otherwise has insufficient funds on hand to meet actual claims, the hedge bond rules would permit the issuance of tax-exempt bonds. Thus, the ability to borrow on a tax-exempt basis could operate as an

incentive for guaranty funds to maintain little or no capital and, instead, issue federally subsidized, tax-exempt debt as the need to pay claims arises. Under current law, there are no limits on these types of borrowings. This type of financing could lead to the issuance of significant amounts of tax-exempt debt and a large revenue loss. We recommend that guaranty funds should not be permitted to issue tax-exempt bonds for this purpose.

Tax-exempt bonds are an inefficient method of providing a subsidy. These guaranty funds are likely to be very large, with the potential for a significant increase in tax-exempt bond volume. This new volume of tax-exempt bonds would come at a significant cost to the federal government and would also be likely to increase tax-exempt interest rates, leading to higher interest costs for State and local governments and further decreasing the efficiency of tax-exempt bonds as a subsidy. The existing rules appropriately prohibit the issuance of tax-exempt bonds earlier than necessary for expenditure. Although operated by the States, the cost of operating these guaranty funds will be borne by nongovernmental persons (i.e., the participating health plans) and there is no reason to provide subsidized, tax-exempt financing for this purpose.

Decision:

 Agree

_____ Disagree

_____ Let's discuss.

2. Power of alliances to borrow.

Background. The draft of the health care plan provides that alliances have the power to borrow to cover short-term cash flow shortages created by the mismatching of required payments to plans and receipts of premium payments and subsidies. Alliances may be organized as governmental entities, non-profit organizations, or corporations. Under the current draft it appears that many alliances could issue tax-exempt debt to cover cash flow shortages.

Issue. Should alliances be permitted to borrow on a tax-exempt basis to fund cash flow shortfalls?

Recommendation. Current law should be modified to prohibit alliances from issuing or otherwise benefitting from tax-exempt bonds used to cover cash flow shortfalls.

Discussion. Under current tax law, borrowings to meet cash flow shortfalls would qualify for tax-exempt status in the case of alliances that are either governmental entities or nonprofit organizations created under section 501(c)(3), but not for corporate alliances (unless formed as nonprofit organizations). A section 501(c)(3) organization, however, generally may not be

the beneficiary of more than \$150 million of outstanding tax-exempt bonds. The ability to borrow on a tax-exempt basis for cash-flow deficits would be likely to result in the issuance of significant amounts of additional short-term tax-exempt debt, especially given the potential for investment arbitrage that these borrowings would provide. Based on our initial estimates, this could result in a revenue loss over 5 years in the \$2 billion range. In addition, these borrowings would also result in a significant increase in short-term, tax-exempt rates, increasing the borrowing costs of all State and local governments. Since the revenues and expenses of alliances should be relatively predictable, the benefit of the tax-exemption seems to be outweighed by the revenue loss. Finally, regardless of the choice of entity, these alliances are created for the benefit of the individuals being insured and this portion of the cost of health care should not be subsidized with tax-exempt bonds.

Decision:

[Handwritten signature]

Agree

Disagree

Let's discuss.